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Department of Veterans Affairs

Volume II
Medical Programs &
Information Technology Programs

Congressional Submission

FY 2014 Funding and
FY 2015 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 Civilian Health and Medical Program of the Department of Veterans Affairs **(**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 Servicemembers in 2013 through 2015.

FY 2014

The 2014 President's Budget is requesting $157.5 million in additional funding above last year's advance appropriations request of $54.462 billion to meet Veterans' medical care needs, for a total direct appropriations request of $54.620 billion. In addition to the 2014 appropriation request, VA anticipates the Medical Care Collections Fund (MCCF) to reach $3.064 billion. VA will transfer at least $15 million to the Department of Defense (DoD)-VA Health Care Sharing Incentive Fund, as mandated by law, for a total 2014 budget authority of $57.669 billion. VA also estimates that it will receive $265 million in reimbursements which will allow the Veterans Health Administration (VHA) to meet its 2014 total obligation authority of $57.934 billion and support over 6.5 million unique patients.

FY 2015 Advance Appropriations Request

The 2014 President's Budget requests $55.634 billion (excluding collections) in advance appropriations for the VA medical care program in 2015. In addition to the advance appropriations request, VA anticipates the MCCF to reach $3.174 billion. As in 2014, VA will transfer at least $15 million to the DoD-VA Health Care Sharing Incentive Fund for a total 2015 budget authority of $58.793 billion. Advance appropriations enable 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 6.6 million unique patients and fulfill our commitment to Veterans to provide timely and accessible high-quality medical services.

VA's 2014 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 care, expanding health care access, and improving Veteran mental health.

Medical Care Budget Authority
(dollars in thousands)

Description	2012 Actual 1/	2013 Budget Estimate	2013 Current Estimate 2/ 3/	2014 Estimate 4/	2015 Adv. Approp. 5/	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Appropriation:							
Medical Services	$39,517,585	$41,519,000	$41,360,000	$43,714,500	$45,015,527	$2,354,500	$1,301,027
Medical Support & Compliance	$5,405,482	$5,746,000	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Medical Facilities	$5,388,838	$5,441,000	$5,447,000	$4,872,000	$4,739,000	($575,000)	($133,000)
Total Appropriations	$50,311,905	$52,706,000	$52,553,000	$54,619,500	$55,634,227	$2,066,500	$1,014,727
MCCF Collections	$2,814,245	$2,966,000	$2,841,000	$3,064,000	$3,174,000	$223,000	$110,000
Total Budget Authority	$53,126,150	$55,672,000	$55,394,000	$57,683,500	$58,808,227	$2,289,500	$1,124,727
Full Time Equivalent (FTE)	257,655	262,912	267,524	275,308	281,780	7,784	6,472

1/ 2012 reflects all transfers.
2/ Total budget authority does not reflect $1,762 million as shown in the President's Budget Appendix. This funding represents the annualized level provided by the continuing resolution (P.L. 112-175). This funding is anticipated to be cancelled upon enactment of either a 2013 full-year continuing resolution or regular appropriation and is therefore not shown. Most of this funding is an unintended result of the mechanism by which the Congress rescinded a portion of the enacted 2012 advance appropriations and appropriated the same amounts with two-year availability. The rescissions do not recur as a term and condition under P.L. 112-175, but the appropriations do. The additional funding provided to the three accounts is as follows: Medical Services $1,409 million, Medical Support and Compliance $101 million, and Medical Facilities $252 million.
3/ 2013 reflects DoD-VA Health Care Sharing Incentive Fund (JIF) transfer and Hurricane Sandy supplemental funding. It does not reflect anticipated transfers to the Joint DoD-VA Medical Facility Demonstration Fund (Demonstration Fund).
4/2014 reflects a realignment of functions as described in the next section. 2014 does not reflect transfers to the JIF or to the Demonstration Fund
5/ 2015 does not reflect transfers to the JIF or the Demonstration Fund.

FY 2014 Realignment of Functions

- **Biomedical Engineering Services –** As with the 2014 advance appropriations request, the 2014 President's Budget 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 appropriations 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.

The 2014 President's Budget also proposes a realignment of funding between the medical care and Information Technology Systems (IT) appropriations, as specified below. The net effect of this realignment is that costs of $4.495 million and 80 FTE will be funded out of medical care appropriations instead of IT.

- **Austin Human Resources (HR) Support Services –** The Budget proposes that costs of $6.346 million and 53 FTE be funded out of the Medical Support and Compliance appropriation instead of the IT appropriation. The Office of Information Technology (OIT) determined that the Human Resources (HR) support services staff better served VHA operations. In 2012 and 2013, the staff were supported by OIT on a reimbursable basis.

- **Clinical Applications Coordinator (CAC) –** The Budget proposes that costs of $6.138 million and 53 CAC FTE be funded out of the Medical Services appropriation instead of the IT appropriation. CACs are a mixture of IT specialists and Title 38 employees who provide direct support to clinical services and coordinate facility efforts in support of VHA's Medical Center Management. These CACs are present in OIT as the result of the 2006 realignment, but their role and responsibilities in clinical systems training are better aligned with VHA responsibilities.

- **Information Technology Support Staff –** The Budget proposes that costs of $7.989 million and 26 FTE from the VHA Office of Informatics and Analytics be funded out of the IT appropriation instead of the Medical Support and Compliance appropriation. VHA has determined through a detailed operational analysis that a portion of these staff functions are more IT in nature, and should be aligned within OIT. This transfer includes some funding for support contracts.

Medical Patient Caseload

For 2014, we expect to treat over 6.5 million unique patients, an increase of 1.3% over the anticipated number of patients treated in 2013. Of those 6.5 million patients, we project we will treat over 4.5 million Veterans in Priorities 1-6, an increase of more than 71,000, or 1.6%, over 2013. VA also provides medical care to non-Veterans; this population is expected to increase by nearly 18,000 patients, or 2.6%, during the same time period. In 2014, VA anticipates treating over 674,000 OEF/OIF/OND Veterans, an increase of over 67,000 patients, or 11.1%, over the 2013 level. In 2015, we are expecting to treat nearly 6.6 million unique patients, an increase of nearly 66,000 patients or 1% over the 2014 level.

Unique Patients 1/

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	4,389,110	4,392,645	4,460,272	4,531,287	4,586,513	71,015	55,226
Priorities 7-8	1,291,264	1,324,467	1,289,861	1,287,261	1,282,923	(2,600)	(4,338)
Subtotal Veterans	5,680,374	5,717,112	5,750,133	5,818,548	5,869,436	68,415	50,888
Non-Veterans 2/	652,717	607,925	676,576	694,470	709,382	17,894	14,912
Total Unique Patients	6,333,091	6,325,037	6,426,709	6,513,018	6,578,818	86,309	65,800
OEF/OIF/OND (Incl. Above)	539,970	610,416	607,362	674,754	742,146	67,392	67,392

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for 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 predominately 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, and morbidity; Veterans' reliance on VA versus other health care providers; and VA's degree of health care management. The changing demand for VA health care reflects Veterans' increasing reliance on pharmaceuticals; the advanced aging of many World War II, Korean and Vietnam Veterans in greater need of health care; and the outcome of high Veteran satisfaction with the health care delivery. The 2014 and 2015 levels reflect the increased costs of emerging medical care requirements resulting from the implementation of the Affordable Care Act (P.L. 111-148 and P.L. 111-152), the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163), and the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154).

The following table displays, on an obligation basis, the estimated resources by major category that VA projects to incur.

VA Medical Care Obligations by Program
(dollars in millions)

Description	2012 Actual 1/	2013 Budget Estimate 2/	2013 Current Estimate 1/	2014 Estimate 1/	2015 Advance Approp. 1/	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Health Care Services:							
Ambulatory Care	$23,611	$23,948	$24,133	$24,345	$25,403	$212	$1,058
Inpatient Care	$10,419	$10,541	$10,573	$10,729	$10,888	$156	$159
Rehabilitation Care	$615	$651	$646	$679	$714	$33	$35
Mental Health Care	$6,010	$6,184	$6,485	$6,957	$7,463	$472	$506
Prosthetics Care	$2,082	$2,586	$2,280	$2,478	$2,684	$198	$206
Dental Care	$690	$762	$715	$741	$768	$26	$27
Total Health Care Services	$43,427	$44,672	$44,832	$45,929	$47,920	$1,097	$1,991
Long-Term Care:							
VA Community Living Centers (VA CLC)	$3,486	$3,701	$3,686	$4,023	$4,153	$337	$130
Community Nursing Home	$617	$767	$663	$726	$762	$63	$36
State Home Nursing	$800	$947	$923	$1,013	$1,118	$90	$105
State Home Domiciliary	$58	$58	$60	$62	$64	$2	$2
Subtotal	$4,961	$5,473	$5,332	$5,824	$6,097	$492	$273
Total Non-Institutional Care	$1,344	$1,749	$1,576	$1,813	$1,887	$237	$74
Long-Term Care Total	$6,305	$7,222	$6,908	$7,637	$7,984	$729	$347
Other Health Care Programs:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,315	$1,386	$1,442	$1,574	$1,708	$132	$134
Readjustment Counseling	$181	$197	$197	$205	$213	$8	$8
Subtotal	$1,496	$1,583	$1,639	$1,779	$1,921	$140	$142
Congressional Action:							
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$115	$278	$377	$385	$393	$8	$8
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$0	$0	$0	$85	$85	$85	$0
Indian Health Services (P.L. 111-148)	$0	$52	$52	$52	$52	$0	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$0	$0	$53	$47	$72	($6)	$25
Subtotal, Congressional Action	$115	$330	$482	$569	$602	$87	$33
Initiatives:							
Activations	$503	$792	$787	$799	$130	$12	($669)
DoD/VA Integrated DES Enhancement	$32	$22	$22	$19	$19	($3)	$0
Strategic Planning Major Initiatives							
Homelessness: Zero Homelessness	$1,023	$1,352	$1,352	$1,393	$1,000	$41	($393)
New Models of Care	$738	$433	$452	$258	$0	($194)	($258)
Enhanced Veterans Experience and Access to Healthcare	$90	$120	$65	$40	$0	($25)	($40)
Improving Veteran Mental Health	$35	$20	$20	$17	$0	($3)	($17)
Improve the Quality of Health Care while Reducing Costs	$96	$51	$51	$6	$0	($45)	($6)
Establish World-Class Health Informatics Capability	$8	$10	$37	$0	$0	($37)	$0
Subtotal	$1,990	$1,986	$1,977	$1,714	$1,000	($263)	($714)
Initiatives Total	$2,525	$2,800	$2,786	$2,532	$1,149	($254)	($1,383)
VA Legislative Proposals:							
Total	$0	($27)	($8)	($30)	($29)	($22)	$1
Proposed Savings:							
Acquisition Proposals	$0	$0	($150)	($370)	($370)	($220)	$0
Travel Campaign to Cut Waste	$0	$0	($50)	($50)	($50)	$0	$0
Patient-Centered Community Care	$0	$0	$0	($13)	($13)	($13)	$0
Corporate Office Reduction	$0	$0	$0	($24)	($24)	($24)	$0
New VISN Structure	$0	$0	$0	($25)	($25)	($25)	$0
Subtotal, Proposed Savings	$0	$0	($200)	($482)	($482)	($282)	$0
Operational Improvements (Non-Add) 3/:							
Fee Care Payments Consistent with Medicare	($528)	($362)	($362)	($406)	($406)	($44)	$0
Fee Care Savings	($88)	($200)	($200)	($200)	($200)	$0	$0
Clinical Staff and Resource Realignment	($198)	($151)	($151)	($151)	($151)	$0	$0
Medical & Administrative Support Savings	($133)	($150)	($150)	($150)	($150)	$0	$0
Acquisition Improvements	($200)	($355)	($355)	($355)	($355)	$0	$0
VA Real Property Cost Savings & Innovation Plan	($90)	($66)	($66)	($66)	($66)	$0	$0
Subtotal, Operational Improvements	($1,237)	($1,284)	($1,284)	($1,328)	($1,328)	($44)	$0
Total Obligations	$53,868	$56,580	$56,439	$57,934	$59,065	$1,495	$1,131

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

1/ VA transferred $65 million in 2012; $15 million in 2013 and anticipates transferring $15 million in 2014 and 2015 to DoD-VA Health Care Incentive Fund

2/ 2013 Agent Orange and Amyotrophic Lateral Sclerosis are included in Health Care Services

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

Update of the 2014 Advance Appropriations Request and Approach to 2015 Advance Appropriations

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 85% 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 more accurately reflect the projected medical demands of enrolled Veterans.

VA's approach to advance appropriations for Medical Care is to provide essential funding to ensure continuity of health care services for Veterans in the event of budget delays. The 2015 advance appropriations request will be revisited during the 2015 budget process. At that time, any necessary adjustments will be made based on updated data and workload requirements.

In 2014, funding shown for initiatives reflects the total estimated costs of these programs. Final 2015 funding levels for these initiatives will be determined during the 2015 budget process when updated data and metrics on these programs' funding needs are available.

Medical Care Programs Major Funding

The justification for the 2014 funding level and the 2015 advance appropriations request is provided below, on an obligation basis, corresponding to the obligation estimates, by program, on the previous table.

In 2014, the $57.934 billion in obligations is comprised of $54.605 billion for appropriation funding, $3.064 billion for collections, and $265 million for reimbursements. In 2015, the $59.065 billion in obligations is comprised of $55.619 billion for appropriation funding, $3.174 billion for collections, and $272 million for reimbursements.

Below, the funding in parenthesis represents the 2014 funding level and 2015 advance appropriations request on an obligation basis. Workload estimates can be found in the "Summary of Workloads for VA and Non-VA Facilities" chart in the Executive Summary Charts chapter.

Health Care Services:

- **($45.929 billion in 2014)**
- **($47.920 billion in 2015)**

VA projects the following medical services:

Ambulatory Care:

- **($24.345 billion in 2014)**
- **($25.403 billion in 2015)**

This includes funding for ambulatory care in 152 VA hospital-based and 850 community-based clinics. Contract fee care is 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.

Inpatient Care:

- **($10.729 billion in 2014)**
- **($10.888 billion in 2015)**

VA delivers inpatient acute hospital care in its hospitals and through inpatient contract care.

Rehabilitation Care:

- **($679 million in 2014)**
- **($714 million in 2015)**

These services include inpatient and outpatient blind and vision rehabilitation programs (including the Blind Rehabilitation and Spinal Cord Injury and Disorders programs), adjustment to blindness counseling, patient and family education, and assistive technology. VA is expanding the Blind Rehabilitation program to accommodate the increased workload due to additional numbers of these injuries among OEF/OIF/OND Veterans. The mission of Spinal Cord Injury and Disorders (SCI/D) Services is to promote the health, independence, quality of life and productivity of individuals with spinal cord injury and disorders through efficient delivery of acute rehabilitation, psychological, social, vocational, medical and surgical care, professional training, as well as patient and family education.

Mental Health Care:

- **($6.957 billion in 2014)**
- **($7.463 billion in 2015)**

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. MHS 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 IVMH was tracked through the Major Initiative monthly reporting process during 2011 and 2012, and through the routine reporting processes in Mental Health Services beginning in 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 and inpatient 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) Veterans.
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. 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 and 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 2012, VA medical centers have implemented 96% of the Handbook requirements.

VA is working closely with DoD and the Department of Health and Human Services (HHS) to implement President Barack Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Service Members, and Military Families," signed on August 31, 2012. The executive order reaffirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The executive order strengthens suicide prevention efforts, supports recovery-oriented mental health services through peer counseling, and supports VA in using a variety of recruitment strategies to hire 1,600 new mental health clinicians and 300 administrative personnel in support of mental health programs.

As of January 29, 2013, 3,262 mental health professionals and administrative support have been hired and are providing services to Veterans since the start of VA's Mental Health Hiring Initiative in April, 2012. Of these, 1,058 mental health providers have been hired specifically as part of the initiative to add 1,600 mental health professionals by June 30, 2013. A comprehensive recruitment and hiring plan is also being implemented to ensure that 800 peer specialists are hired and trained by December 31, 2013, including: identification of sites needing additional peer specialist positions, distribution of sufficient funding to facilities, and certification training to meet appropriate standards.

VHA has developed and implemented an aggressive recruiting and marketing effort to fill vacancies in mental health care occupations. This effort includes the following actions: working directly with mental health provider associations and training programs, conducting numerous media advertising efforts, developing a professional recruitment contract, and using incentives such as pay flexibilities and loan repayment to promote hiring of mental health professionals. Additionally, VA partners with the National Rural Recruitment and Retention Network for outreach to difficult-to-recruit areas and is partnering with the HHS to collaborate on pilots that increase access to underserved areas.

More information is provided in the Selected Program Highlights Chapter.

Prosthetics Care:

- **($2.478 billion in 2014)**
- **($2.684 billion in 2015)**

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. This includes, but is not limited to, artificial limbs, hearing aids, and home oxygen; items that improve accessibility such as ramps and vehicle modifications, wheelchairs and mobility aids; and devices surgically placed in the veteran, such as stents.

Dental Care:

- **($741 million in 2014)**
- **($768 million in 2015)**

The largest cohort of Veterans eligible for dental care is Veterans with 100% service-connected disability. These Veterans are eligible for lifelong comprehensive dental care as needed. VA has seen an over 40% increase in these patients over the last 5 years. Also included are dental benefits to all newly discharged OEF/OIF/OND Veterans with service-connected, non-compensable dental conditions or disabilities shown to have been in existence at the time of discharge or release from active duty. Homeless Veterans enrolled in certain residential treatment programs are also eligible for dental treatment so that VA can improve their health and quality of life by eliminating pain and infection, as well as increasing their likelihood of employment.

This funding also provides essential dental services to Veterans with a "medical condition negatively impacted by poor dentition" who are eligible for only limited dental care by VA. These patients include poorly controlled diabetic patients, patients with head or neck cancer, organ transplant patients

and others. Proper dental treatment contributes to improved medical outcomes and well-being for these Veterans. Additionally, Veterans enrolled in title 38 Chapter 31 Vocational Rehabilitation programs are eligible for focused dental care while enrolled in the program.

Long-Term Care:

- **($7.637 billion in 2014)**
- **($7.984 billion in 2015)**

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 veterans who wish 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 four venues: VA Community Living Centers (CLCs); Community Nursing Homes; State Veterans Nursing Homes; and State Veterans Home Domiciliaries.

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.

Non-Institutional Long-Term Care:
VA's approach to non-institutional long-term care is based on the premise that the most desirable location for long-term care services is at home or in a community environment unless the appropriate care can only be delivered in an institutional setting. Living at home, or close-by in the community, provides Veterans with a higher quality of life. Non-institutional long-term care programs and services include: VA and State adult day health care, home-based primary care, purchased skilled home health care and other home care programs.

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

- **($1.574 billion in 2014)**
- **($1.708 billion in 2015)**

The Veterans Health Care Expansion Act of 1973, P.L. 93-82, authorized VA to provide a health benefits program which shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001, P.L. 107-14, extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65. 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; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense TRICARE Program. CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service, and State Victims of Crime Compensation Programs.

The Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163, section 102, further expanded CHAMPVA to include primary family caregivers of certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through the existing CHAMPVA Program when the primary family caregiver has no other health care coverage (including Medicare and Medicaid).

CHAMPVA programs also include Foreign Medical Program (FMP), Spina Bifida Health Care Program, and Children of Women Vietnam Veterans Health Care Program (CWVV).

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 where the VA Outpatient Clinic has jurisdiction of the health care services. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions.

Spina Bifida Health Care Program - Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, P.L. 104-204, section 421, VA administers the Spina Bifida Health Care Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003, P.L. 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 only for medical services associated with spina bifida; under the Veterans' Mental Health and Other Care Improvements Act of 2008, P.L. 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, P.L. 106-419, section 401, VA administers the CWVV program for children with certain birth defects born to women Vietnam Veterans. The CWVV Program provides reimbursement only for covered birth defects.

Readjustment Counseling:

- **($205 million in 2014)**
- **($213 million in 2015)**

This funding is required to provide readjustment counseling services at 300 VA Vet Centers across the country. 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.

Congressional Action:

Caregivers and Veterans Omnibus Health Services Act (P.L. 111-163):

- **($385 million in 2014)**
- **($393 million in 2015)**

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 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. This funding level supports both the bill's Title I requirements for caregiver support and the remaining requirements included in Titles II – X.

Affordable Care Act (P.L. 111-148/P.L. 111-152):

- **($85 million in 2014)**
- **($85 million in 2015)**

The Patient Protection and Affordable Care Act (P.L. 111-148) was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act (P.L. 111-152) was enacted on March 30, 2010. These two laws are collectively referred to as the "Affordable Care Act" (ACA). The ACA represents comprehensive reform of the health care delivery system and is intended to expand access to coverage, control health care costs, and improve the Nation's health care delivery system. Beginning in 2014, many uninsured Americans, including Veterans, will have access to quality, affordable health insurance choices through Health Insurance Marketplaces, also known as Exchanges, and may be eligible for premium tax credits and cost-sharing reductions. The Medicaid expansion provision allows states to expand Medicaid eligibility to up to 138% of the Federal Poverty Level. The ACA also provides individuals the option of obtaining health insurance coverage or making a payment when filing their tax returns.

When these key provisions of ACA are implemented in 2014, some Veterans will have with new options for obtaining health care. VA believes that the relationship it has established with enrolled Veterans and the special health care services it provides to many enrollees will be key factors in a Veteran's decision to remain enrolled with and utilize VA health care. VA recognizes that the additional options available under the ACA may lead some Veterans to choose non-VA providers, while other Veterans may newly enroll with VA in order to satisfy the individual mandate. The 2014 and 2015 requests reflect the estimated cost impacts due to the current assumption that VA will experience a net enrollment increase from ACA impacts.

VA has been an active partner with Federal agencies in developing ACA implementation regulations and will continue to monitor how implementation impacts the VA health care system.

Indian Health Services (P.L. 111-148):

- **($52 million in 2014)**
- **($52 million in 2015)**

Consistent with the Administration's goal to increase access to care for Veterans and with the Affordable Care Act, VA and the Indian Health Service (IHS) signed the VA-IHS National Reimbursement Agreement in December 2012. This Agreement will facilitate reimbursement by VA to IHS for direct health care services provided to eligible American Indian and Alaska Native Veterans in IHS facilities. The Agreement also paves the way for future agreements negotiated between VA and tribal health programs, in addition to those already in existence.

Camp Lejeune (P.L. 112-154):

- **($47 million in 2014)**
- **($72 million in 2015)**

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services for 15 specified illnesses and conditions to certain Veterans who were stationed at Camp Lejeune, North Carolina for at least 30 days between 1957 and 1987. Family members of such Veterans who resided (or were in utero) at Camp Lejuene for at least 30 days during that period are eligible for hospital care and medical services for the same specified illness and conditions. Hospital care and medical services may only be furnished to family members to the extent and in the amount provided in advance in appropriations Acts for such purpose. In addition, VA may only provide reimbursement for such hospital care and medical services provided to a family member after all other claims and remedies against third parties for such care and services have been exhausted. Care for Veterans covered under this authority began on the date of enactment, August 6, 2012. In 2015, VA expects to start treating family members and has budgeted $25 million for that purpose, included in the above funding level.

Initiatives:

In 2014, funding shown for initiatives reflects the total estimated costs of these programs. Final 2015 funding levels for these initiatives will be determined during the 2015 budget process when updated data and metrics on these programs' true funding needs are available.

Activations:

- **($799 million in 2014)**
- **($130 million in 2015)**

Facility activations 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).

DoD/VA Integrated Disability Evaluation System (IDES) Enhancement:

- **($19 million in 2014)**
- **($19 million in 2015)**

The Integrated Disability Evaluation System (IDES) strives to implement an integrated mechanism to provide wounded, ill, and injured Servicemembers 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 Servicemembers and truly implement a seamless transition from DoD to VA.

Strategic Planning Major Initiatives:

Homelessness: Zero Homelessness:

- **($1.393 billion in 2014)**
- **($1.000 billion in 2015)**

On a single night in January 2012, 62,619 Veterans were homeless; however, it is estimated that over the course of the year, approximately 144,842 Veterans experienced homelessness.[1] VA is committed to preventing and ending homelessness among Veterans and is poised to assist homeless and at-risk Veterans through the provision of a comprehensive continuum of care that includes Outreach/Education, Prevention, Treatment, Income/Employment/Benefits, and Housing/Supportive Services provided in collaboration with Federal, state, local governments and community partners.

The VA Plan to End Homelessness among Veterans became a primary initiative of the Department and was incorporated into VA's Transformational Initiatives, where it is referred to as Eliminate Veteran Homelessness (EVH). The efforts are integrated Department-wide and include the support of the National Cemetery Administration (NCA) and the Veterans Benefits Administration (VBA). The Office of Public and Intergovernmental Affairs (OPIA) Homeless Veterans Initiatives Office (HVIO) is the lead organization for this initiative. HVIO has primary responsibility for the initiative's internal and external communication strategies, federal- and state-level interagency collaborations, and national policy development. The administration of VA's clinical homeless programs is aligned within VHA, Office of the Deputy Under Secretary for Operations and Management, which is accountable for the budget execution of VHA's Homeless Veterans Programs, and for the provision of clinical intervention and treatment services for homeless and at-risk Veterans. The VBA, NCA, and the Office of Asset Enterprise Management (OAEM) are collaborative partners in the EVH initiative that operate within their respective budgets -- separate from VHA's Homeless Veteran Programs -- and are accountable to their own leadership for their performance.

[1] **U.S. Department of Housing and Urban Development.** ***The 2012 Point-in-Time Estimates of Homelessness: Volume I of the 2012 Annual Homeless Assessment Report to Congress.*** November 2012.

VA is positioned to assist homeless and at-risk Veterans in achieving their optimal level of functioning and quality of life through the provision of a comprehensive continuum of care that address the psychosocial factors surrounding homelessness while building the capacity of available residential, rehabilitative, transitional, and permanent housing supply. The continuum includes both prevention and treatment services. These services include but are not limited to: primary and specialty medical care, mental health and substance use disorder treatment, case management, outreach, vocational rehabilitation/ employment services, housing, and coordination of related services with VBA and NCA. This continuum includes VA Medical Centers (VAMCs), Public Housing Authorities (PHAs), and Continuums of Care (CoCs), as well as a range of public and private nonprofit providers. The intent is for every eligible Veteran to have access to a safe, stable environment, and that there will be sufficient capacity so that all Veterans willing to accept services will be able to leave the streets and enter shelter/housing in order to stabilize and begin rebuilding their lives.

Since the inception of the EVH transformational initiative, VA has not only expanded existing programs and developed new programs, but has increased efforts to: develop partnerships with federal and state agencies, Veterans Service Organizations, national advocacy groups, and community-based providers; enhance outreach efforts to agencies as well as to individual Veterans; increase data collection and reporting methods by working closely with federal agencies and local continuums of care; and develop new methods to explore evidence-based research and test best practice models.

Additionally, VA has made unprecedented efforts to promote the services available to Veterans who are homeless or might become homeless through its comprehensive approach to outreach (media and 'boots on the ground'), the implementation of an at-risk clinical reminder in VAMC out-patient settings, and continued interaction and collaboration with public and private sector partners. The total number of Veterans served in VHA's specialized programs for homeless or at-risk Veterans in 2012 was 200,094, an increase of 27% from 2011. VA has also increased its capacity to provide services for Veterans in need. These increases, combined with the new programs and outreach VA has launched in the past year, make VA optimistic that the number of homeless Veterans will continue to decline.

New Models of Care:

- **($258 million in 2014)**

In FY 2013, VA began transitioning components of the Major Initiatives (MI) that were mature into normal business operations. An Integrated Health Operating Plan (IHOP) was developed to consolidate initiatives that were not ready for transition, which now includes most of the New Models of Care (NMOC) MI, some of the remaining components of the MI to Enhance the Veteran Experience and Access to Healthcare (EVEAH), and a few projects from other MIs. The 2014 funding level supports the components of these MIs that have not transitioned to sustainment and thus remain in the IHOP. The narrative below describes these remaining components.

NMOC is a portfolio of large initiatives created to fundamentally improve the experience for America's Veterans when accessing VA healthcare services. This initiative is aimed at transforming our primary care services into a patient centered medical home model (through our Patient Aligned Care Teams, or PACT), aligning our specialty care services to better support PACT teams and their patients, and improving access by adopting various eHealth technologies. The Patient Centered Care cultural transformation has been realigned with this portion of the IHOP for better integration.

Over the last four years, we have put the structure in place to bring the vision of the MI to fruition and have begun the training and process reengineering required to change clinical and business processes. Additionally, we have developed tools to monitor progress and assess the outcomes we hope to achieve – improved patient satisfaction, access, and efficiency. This is a long journey and we do not expect to see these outcomes in the short-term. We know from reviewing the literature and from benchmarking with other healthcare organizations that it takes 7-10 years to see fully realize the results of these efforts. Consequently, we have monitored intermediate milestones centered on structure and process outcomes.

Patient Aligned Care Teams

The Patient Aligned Care Team (PACT) is the cornerstone of this effort. VHA benchmarked with numerous private sector organizations that have well-developed medical home models of primary care. These models all use teams of healthcare professionals to provide comprehensive, longitudinal, and coordinated care. They usually

include behavioral health coaches to help patients learn to better manage their health and healthcare goals.

Over the past two years, we have provided resources to all VA medical centers to expand staffing of our primary care programs and set standards for our PACT teams. These teams are composed of a principle provider (physician or nurse practitioner), a RN care manager, a LPN or medical assistant, and a clerk. Clinical pharmacists, social workers, nutritionists, and behavioral health coaches support the PACT teams. Last year, we expanded this program to include our Women's Health Clinics. We have invested in training for these teams to ensure they have the skills to function as high performing medical home teams and coached them in redesigning their clinical and business processes to make this transition. By the end of this year we hope to have trained about half of all PACT teams. We have developed specific metrics, known as PACT Compass metrics, to measure our progress toward the goals that we have set for these teams. The measures include, but are not limited to, the following:

- PACT staffing ratio (structural metric)
- Primary care panel size (structural measure)
- Appointment availability within 7 days of the Desired Date (process measure)
- Same day appointment availability with the Primary care provider (process measure)
- Continuity with the assigned PACT Team (process measure)
- Follow up within 2 days of discharge (process measure)
- Ratio of telephone encounters to face-to-face encounters (process measure)
- Utilization of home telehealth, including telephone encounters with the patient's team (process measure)

Prevention

The prevention sub-initiative incorporates health promotion and disease prevention clinical interventions seamlessly across the continuum of care and is delivered in a variety of ways matched to the Veteran's needs and preferences. The long-term objective of the this effort is to reduce morbidity and premature mortality associated with unhealthy lifestyle behaviors and chronic disease and to increase overall health-related quality of life and well-being through the development and implementation of infrastructure and processes that will 1) routinely identify and offer evidence-based intervention to Veterans with risky health behaviors and poorly controlled chronic conditions, 2) increase patient activation and involvement in managing

their own health and health care, and 3) help healthy Veterans remain healthy. Through this effort, the National Center for Prevention has developed health coaching programs and established training for VHA clinicians. They have acquired a web-based Health Risk Assessment tool and the final customization is being completed. They have also developed a patient education library that will be linked to the HRA results.

Women's Health

The women's health sub-initiative addresses the needs of our current and future women Veterans population since women comprise one of the fastest growing cohorts of Veterans utilizing VA health care services. This shift in demographics has presented a challenge to the VA, and VA has intensely focused on improving access, services, resources, and facilities to make healthcare more accessible and more sensitive to gender-specific needs.

The Women's Health Program has been working through the MI to ensure that female Veterans have access to a primary care provider who can meet all of her primary care needs. This includes gender-specific and mental health care in the context of a continuous patient-clinician relationship. These primary care services also meet all the PACT requirements. Through the utilization of connected health technology (discussed below) and collaborations within the VA, this initiative will continue to improve the delivery and coordination of care for women Veterans in a timely, accessible, patient-centered manner with dignity and privacy.

Specialty Care

The specialty care sub-initiative is transforming the delivery of specialty care to truly support PACT in a Veteran-centric medical home. The specialty care sub-initiative focuses on increasing access to specialty care through programs such as Electronic Consultation (E-Consults), Specialty Care Team Based Models (SC-PACT) and Telehealth. The E-Consult processes allows specialty providers to provide consultative advice to primary care clinicians without requiring the patient to travel for a face-to-face visit. In many circumstances, the consultant can review the medical record and provide advice without seeing the patient. If the specialist feels they need to see the patient, they can always schedule an appointment. We have also put a new program in place where primary care clinicians can book an appointment into a regularly scheduled video teleconferenced clinic with a specialist. They can bring difficult clinical problems to

these sessions and get expert advice. The Specialty Care Team (SCT) is also collaborating with Telehealth Services to support the expansion of specialty telehealth programs that provide additional alternatives to face-to-face appointments; and implementing Secure Messaging as a tool for patient communication and care coordination.

Connected Health
Also central to NMOC are the various efforts we have undertaken to connect patients to a virtual world of health care services. We are greatly expanding telehealth services that will allow better monitoring of patients with chronic diseases in their homes. These services can monitor patient status and relay that information to care managers, as well as remind patients to take medication, monitor blood sugars, or adhere to other aspects of their care. We have established numerous pilots in which we are exploring ways to connect patients to services through clinical video telehealth (CVT). For example, we have a surgeon in Kansas providing post-operative care through CVT, relieving patients of having to drive long distances for simple wound checks. A team at the Portland VAMC is providing rehabilitation and prosthetics services to patients living in rural Oregon. Patients can now access these highly specialized services much closer to home. Our mental health providers have been testing our ability to provide counseling and psychotherapy over a simple webcam attached to the patient's home computer. We have also been deploying secure messaging so that patients can communicate with clinical teams by secure email. We have just begun developing mobile applications that patients can download to mobile devices to provide clinical advice or to access various services. We are developing a collection of mobile applications we call "Mobile Family Caregiver" that will be tested with family members taking care of highly disabled Veterans.

Patient Centered Care (PCC) Culture Transformation
Patient-centered care is the overarching goal of all our major initiatives, but the PCC Culture Transformation supports the specific culture change necessary to become a more patient centered healthcare system.

At the core of PCC Culture Transformation Initiative is an entirely new approach to healthcare 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 healthcare: 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 requires healthcare teams to have new skills, processes, and tools that incorporate integrative health coaching at the core of healthcare delivery.

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 the functions of each department and program office are aligned with intention and design.

- **Enhanced Veteran Experience and Access to Healthcare (EVEAH): ($40 million in 2014)**

Most of the components of EVEAH are mature and have transitioned into normal business operations. A small component of the System Redesign sub-initiative remains to support the continued enhancement of our PACT and Specialty Care work.

Systems Redesign Efforts

These efforts are focused on improving the access and efficiency of VA's inpatient clinical services through modules that will ultimately connect to provide real-time utilization data. These applications, once developed and deployed, will allow VA to track inpatient bed management, emergency unit flow, and operating room workflow. Systems Redesign is working with clinicians and staff in both primary and specialty care in the Patient Aligned Care Teams (PACT) model to educate and train individuals throughout the system in the principles and techniques critical to successful implementation across the system.

Transitioned To Sustainment

The following is a brief description of the work that has now transitioned into normal business operations (sustainment).

Veteran Transportation Service
Expand Health Care Access for Veterans has expanded the Veteran Transportation Network from the original 4 pilots and is now active at 87 sites throughout the system. A mobility manager who coordinates scheduling as well as identifying and joining with community partners is in place in facilities as the program expands. The program is also working closely with VA's Office of Rural Health to improve the network of transportation serves that connect rural veterans and those veterans who, because of disability or infirmity, need transportation assistance to access VA services. This service provides for continuity of care for those physically infirm or disabled Veterans who often have complex medical conditions requiring healthcare services.

Personalized Patient Handbook
VHA has provided personalized healthcare benefits handbooks to the first three priority groups in 2012. It is anticipated that by April 2013, all priority groups will have received these personalized healthcare benefits handbooks. These personalized handbooks provide individualized information for Veterans to inform them of the specific healthcare services pertaining to them. This not only helps Veterans but also employees as they guide the Veterans to those services and where they may access these services. We are now working to make this handbook available electronically.

Point of Care Self Service Kiosks
Kiosks provide Veterans with the ability to check in quickly and easily using their Veterans Identification Card. Veterans may not only check into their clinic appointments but may also update their administrative information in this process, respond to a survey, be provided directions to their appointment, and print off a listing of their future appointments. While this is a significant advancement, VetLink kiosks will ultimately be capable of collecting valuable clinical data prior to the patients visit with their healthcare provider. As of February 2013, more than 1.4 million patient interactions have taken place at 754 kiosks presently installed at 16 sites and their associated CBOCs. By the end of 2013, an additional 50+ sites should have kiosks in place. Other functionality scheduled for release in 2013 includes offering patients the ability to submit a Release Of Information (ROI) form and request beneficiary-travel reimbursement from a kiosk. We are also actively developing clinical software that includes giving patients the ability to review their outpatient medications list. This specific functionality queries pharmacy records, shows the Veteran a picture of the

dispensed medication, and asks the Veteran to confirm that they are still taking it – if not, why not. The functionality is also tied to reviewing allergy records and allowing patients the ability to indicate medications not on file with the VA. We will ultimately be able to collect other clinical information about their interim health events and provide valuable patient education at the point of care. We hope that patients will ultimately be able to do this through My HealtheVet before leaving home for their appointment.

System Redesign

Our "Fix the Phones" initiative is designed as a pilot involving three networks. This ambitious project will enable Veterans to have an effective communication link with PACT teams as well as other healthcare providers in a more efficient manner. The multi-year pilot is designed to determine the best approach to a centralized call system, the data capabilities needed to support clinical operations, and the best ways to effectively ensure benefit to both Veterans and staff. The pilots have been funded and are currently operational.

Improving Veteran Mental Health

- **($17 million in 2014)**

Nearly 31% of the patients VHA sees during a given year have a mental health diagnosis, and there are increasing numbers of Veterans who are being diagnosed with both mental health conditions and co-morbid medical problems. In order to address this challenge, VHA has significantly invested in its mental health care workforce, hiring more than 7,600 new mental health care workers since 2005, and the mental health system is dedicated to provide Veteran-centered, recovery-oriented, evidence-based care.

To execute this goal VA must provide Veterans with meaningful choices among effective treatments, balancing biological and biomedical approaches to care with psychological and psychosocial strategies. Knowing that mental health is not only a function of medical care but also family and community support networks, VA works to connect Veterans with support services through technology and in their communities. VA also partners with DoD to identify and develop the most effective practices for addressing mental health issues associated with military service, and provide the appropriate mental health services throughout the full continuum of service delivery.

Improve the Quality of Health Care while Reducing Costs

- **($6 million in 2014)**

  In 2014, $6 million is provided for VA to further assess and develop efficiencies and successful practices by analyzing the delivery and reimbursement of health care within other Federal health programs, such as DoD's Defense Health Program and Medicare. This assessment will help to drive future innovation as VA strives to continually improve health outcomes, quality of care, and access to services while responsibly managing public resources.

Legislative Proposals:

- **(-$30 million in 2014)**
- **(-$29 million in 2015)**

There are two new 2014 legislative proposals that have budgetary savings: VA payment for medical foster homes and Veteran Transportation Services. There are two new legislative proposals that have costs: Sunset for health professional scholarship program and waiver of 24-month eligibility requirement for emergency treatment. In addition, there are three proposals from 2013 resubmitted in 2014 that have budgetary savings: making VA a smoke-free environment, the removal of the requirement that VA reimburse certain employees appointed under title 38 for expenses incurred for continuing professional education, and clarification of breach of agreement under the Employee Incentive Scholarship Program. See the Proposed Legislation chapter (page 1G-1) for a detailed description of these proposals.

Proposed Savings:

- **(-$482 million in 2014)**
- **(-$482 million in 2015)**

VA is continuing to identify savings that will result in the VA healthcare system operating more efficiently and help the Nation better meet its fiscal challenges. VA is proposing $370 million in new acquisition savings and $112 million in improved operations. In addition to these savings, embedded in the actuarial model used to project VA health care requirements is $257 million of clinical and pharmaceutical savings, due to assumptions about how VA manages its system compared to private-sector health care systems. .

The new acquisition savings and improved operations initiatives include the following:

Acquisition Savings:

- **(-$370 million in 2014)**
- **(-$370 million in 2015)**

Specific acquisition initiatives include:

- Sourcing of Generic Pharmaceuticals - VA Acquisition Regulations require the use of Federal Supply Schedule (FSS) contracts before VA makes open market purchases. The intent of this requirement was to ensure that VA pays the lowest price possible for goods and services. In practice, however, the rule has had the opposite effect, with many generic drugs available through direct contracts at prices well below FSS prices. By exempting pharmaceuticals from this requirement, VA will use spot contracts for purchasing generic pharmaceuticals to take advantage of periodic price reductions.

- Reverse Auctions – The Government Accountability Office (GAO) has approved the use of Reverse Auctions to increase efficiency and enhance competition. By increasing the use of reverse auction tools, VA will drive increased price competition into commodities and standard service contracts.

- Pharmacy Prime Vendor Discounts - VA has negotiated a new five-year contract that includes higher discounts than the previous contract.

- Increased use of Medical Surgical Prime Vendor – Increased use of this procurement method will generate rebates from the distributor, reducing VA cost for these items.

- Strategic Sourcing – Establishment of national contracts will introduce improved pricing associated with volume discounts.

- Medical Sharing Agreements – Increased negotiation of Sharing Agreement contracts under VA's title 38, § 8153 authority will result in reduced prices for medical services and support contracts.

- **Employee Travel Reduction (-$50 million in 2014 and in 2015)** – In support of the President's Campaign to Cut Waste, employee travel will be capped in 2014 and 2015 at the budgeted level for 2013. Savings were also achieved in 2013.

- **Patient-Centered Community Care (-$13 million in 2014 and in 2015)** - Patient-Centered Community Care (PC3) will provide centrally supported health care contracts throughout VHA for purchasing Non-VA Medical Care. Savings will be achieved by standardizing Non-VA Care processes and rates through contractual agreements, replacing more costly

individual authorizations for purchasing health care services from non-VA sources.

- **Corporate Office Reduction (-$24 million in 2014 and in 2015)** – VA's medical program offices located at the VA Central Office in Washington, DC, will have their annual recurring budgets, compared to 2013 levels, reduced by approximately 1% in both 2014 and 2015.

- **New VISN Structure (-$25 million in 2014 and in 2015)** – VA's 21 Veteran Integrated Service Networks (VISNs) are being reorganized around a standard staffing structure for each VISN. Each VISN Director has authority to customize a portion of the new VISN structure, but the majority of the staffing will be standard for each VISN. Total VISN staffing will be reduced by this initiative by realigning current staff who are excess to the new structure to fill other vacancies within VA.

Operational Improvements:

- **(-$1.328 billion in 2014)**
- **(-$1.328 billion in 2015)**

In the 2012 and 2013 President's Budgets, VA proposed six operational improvements dealing with acquisition, fee care, energy, and other administrative savings. In 2012, VA successfully completed these improvements with estimated savings of $1.2 billion, our target level. The savings from these improvements are now embedded in VA's baseline estimates of resource needs. This information is included to inform the reader and close out this effort.

Medical Care Collections Fund

In 2014, VA estimates collections of $3.064 billion, representing an increase of $223 million, 7.8% over the 2013 level.

Medical Care Collections Fund
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Medical Care Collections Fund:							
Pharmacy Co-payments	$706,784	$759,000	$724,000	$799,000	$879,000	$75,000	$80,000
3rd Party Insurance Collections	$1,745,716	$1,792,000	$1,760,000	$1,778,000	$1,791,000	$18,000	$13,000
3rd Party RX Insurance	$101,815	$33,000	$100,000	$100,000	$110,000	$0	$10,000
1st Party Other Co-payments	$183,688	$188,000	$188,000	$189,000	$190,000	$1,000	$1,000
Enhanced-Use Revenue	$9,671	$2,000	$2,000	$2,000	$2,000	$0	$0
Long-Term Care Co-Payments	$3,088	$4,000	$4,000	$4,000	$4,000	$0	$0
Comp. Work Therapy Collections	$58,835	$57,000	$57,000	$57,000	$57,000	$0	$0
Parking Fees	$3,732	$4,000	$4,000	$4,000	$4,000	$0	$0
Comp. & Pension Living Expenses	$1,559	$2,000	$2,000	$2,000	$2,000	$0	$0
Subtotal Collections	$2,814,888	$2,841,000	$2,841,000	$2,935,000	$3,039,000	$94,000	$104,000
Legislative Proposals:							
Allow VA to Release Patient info to Health Plans	$0	$34,000	$0	$35,000	$37,000	$35,000	$2,000
VA as a Participating Provider	$0	$91,000	$0	$94,000	$98,000	$94,000	$4,000
Total Collections	$2,814,888	$2,966,000	$2,841,000	$3,064,000	$3,174,000	$223,000	$110,000

1/ Collections of $2,814,887,821 were received by VA in 2012. Due to a 1-month lag in timing from when the funds are received and transferred into the Medical Services account, $2,814,245,219 was transferred to the Medical Services account in 2012, which reflect collections from September 2011 through August 2012. The funds collected in September 2012 were transferred in 2013.

The Balanced Budget Act of 1997 (P. L. 105-33) established the VA Medical Care Collections Fund (MCCF). The legislation required that amounts collected or recovered after June 30, 1997, be deposited into the MCCF and used to furnish medical care and services to Veterans and to cover expenses incurred to collect amounts owed for the medical care and services furnished.

The VHA Chief Business Office (CBO) has implemented an expanded revenue enhancement plan including a series of 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 are 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 nearly $2.815 billion in 2012, 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 be approximately $2.841 billion in 2013. The projected challenges with growth from third party collections are attributable to current economic market conditions and a shift in workload to the over 65 population, where Veterans become Medicare eligible and VA is no longer able to bill and collect. Additionally, commercial health insurers are shifting more responsibility to the patient for health care costs including co-payments and deductibles, which VA cannot collect. Despite the current constraints affecting collections growth, VA continues to pursue opportunities for improved revenue performance as addressed by initiatives described below.

Two legislative proposals, if enacted, will enable VA to increase collections in 2014. The first allows the release of patient information and would have an estimated $35 million impact on collections. The proposal would allow VA to bill health plans for each admission or episode of care of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia, if the care is non-service connected. The second proposal would increase collections by an estimated $94 million. This proposal would require that VA 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.

Consolidated Patient Account Centers

A major driver of VA's revenue optimization strategy is the Congressionally mandated deployment of Consolidated Patient Account Centers (CPACs). In 2012, traditional VHA business office functions were consolidated into seven regional centers of excellence. This initiative has transformed VHA billing and collections activities to more closely align with industry best practices including standardized operating processes, extensive use of business tools and increased levels of accountability at all levels of the organization.

National Revenue Contracts Office

This initiative is designed to leverage VHA's size and financial purchasing power to develop national/regional contracts for vendors who provide support for revenue-cycle activities. The CPAC Payer Relations Office (PRO) continues to aggressively pursue strategies to effectively manage relationships with third-party payers. The CPAC PRO staff is currently working on new or re-verification of existing third-party payer agreements. VHA is also providing mentoring and training to payer relations staff to improve the operationalizing of completed payer agreements.

The Revenue Contracts Management Program 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 VA's establishment of national and regional Blanket Purchase Agreements (BPA) for coding, insurance identification/verification products and services, billing, third-party account receivables follow-up, and general revenue support services to include services such as pre-registration and first party waiver packages; currently 76 BPAs are in place. VA 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, VA 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. These electronic processes require ongoing updating to maintain compliance with industry standards for Electronic Data Interchange (EDI) processing.

Veterans Equitable Resource Allocation (VERA)

VERA is the primary methodology that VA uses to distribute financial resources. The VERA General Purpose allocation is based on historical workload and utilization of health care services by Veterans. The VERA Specific Purpose allocation includes funding for prosthetics, state home per diems, clinical trainee salaries, readjustment counseling, the homeless grant and per diem program, the state nursing home program, major initiatives, CHAMPVA, Spina Bifida, and the foreign medical program, as well as other program office operations. VA generally allocates 94% of the appropriation within 30 days of enactment of an appropriation or, when an advance appropriation is provided, within 30 days after the beginning of the fiscal year.

The following estimated allocations for 2014 and 2015 are provided in accordance with the Veterans Health Care Budget and Transparency Act of 2009 (P.L. 111-81), which provided authority for advance appropriations for the three VA Medical Care appropriations. These estimated allocations are subject to change based on updated workload as that data becomes available. These estimated allocations do not include estimated collections or estimated reimbursements.

Veterans Equitable Resource Allocation

(dollars in thousands)

Description	2012	2013	2014 Preliminary Estimate	2015 Preliminary Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Appropriation:						
Medical Services	$39,517,585	$41,360,000	$43,699,500	$45,000,527	$2,339,500	$1,301,027
Medical Support & Compliance	$5,405,482	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Medical Facilities	$5,388,838	$5,447,000	$4,872,000	$4,739,000	($575,000)	($133,000)
Total	$50,311,905	$52,553,000	$54,604,500	$55,619,227	$2,051,500	$1,014,727
Allocation Overview:						
Estimated VERA General Purpose Allocation to VISNs	$38,445,800	$39,897,449	$41,695,121	$42,440,536	$1,797,672	$745,415
Estimated VERA Specific Purpose Allocation to VISNs & Prgs	$11,866,105	$12,655,551	$12,909,379	$13,178,691	$253,828	$269,312
Total	$50,311,905	$52,553,000	$54,604,500	$55,619,227	$2,051,500	$1,014,727

Performance

Quality and Timeliness of Care – VA's budget request focuses on the Department'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.

VA measures its impact on population health using the Clinical Practice Guidelines IV and the Prevention Index V to ensure health system actions improve the health of the Veteran community. Clinical Practice Guidelines Index IV assesses the progress and results associated with the management of common chronic diseases that impact the health trajectories of Veterans. The Clinical Practice Guidelines Index IV is expected to reach 93% in 2014, with a strategic target of 94%. Prevention Index V measures VA's efforts in preventing illness through measures such as immunization and screening. VA expects the Prevention Index V to reach 94% in 2014, with a strategic target of 95%.

VA examines wait times for completed appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each Veteran. In 2014, VA will measure wait times for primary care, specialty care, and mental health appointments for new and established patients. In 2013, VHA updated the methodologies to measure wait times for new and established patient appointments to improve reliability and consistency. Therefore, no targets are set in 2013 and 2014 so that baseline performance can be established.

Performance Measure
▪ Percent of New Primary Care Appointments Completed within 14 days of the Create Date for the Appointment[1]
▪ Percent of Established Primary Care Patients with a Scheduled Appointment within 14 days of the Desired Date for the Appointment[2]
▪ Percent of New Specialty Care Appointments Completed within 14 days of the Create Date for the Appointment[1]
▪ Percent of Established Specialty Care Patients with a Scheduled Appointment within 14 days of the Desired Date for the Appointment[2]
▪ Percent of New Mental Health Appointments Completed within 14 days of the create date for the appointment[1] (New)
▪ Percent of Established Mental Health Patients with a Scheduled Appointment within 14 days of the Desired Date for the Appointment[2] (New)

(1) In 2013, VHA updated the methodology to measure wait times for new patient appointments to improve reliability and consistency. Appointments for new patients will use the create date, defined as when the appointment was made and automatically captured by the scheduling system. Therefore, no targets are set in 2013 and 2014 so baseline performance can be established.

(2) In 2013, VHA updated the methodology to measure wait times for established patient appointments to improve reliability and consistency. Appointments for established patients will use the desired date, defined as the agreed upon date determined together by provider and patient. Desired date is measured prospectively to better represent patient satisfaction. Therefore, no targets are set in 2013 and 2014 so baseline performance can be established.

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 $585.7 million in total budgetary resources.

Medical and Prosthetic Research
(dollars in thousands)

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Estimate	2012 to 2014 Increase/ Decrease
Appropriation	$581,000	$582,674	$584,556	$585,664	$4,664
FTE	3,496	3,526	3,526	3,491	(5)

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

- Biomedical Laboratory (BLR&D): Supports preclinical research to understand life processes from the molecular, genomic, and physiological level in regard to diseases affecting Veterans. This work directly supports the development of new diagnostic tests and drugs that improve Veteran health.

- 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.

Medical Care Budget Authority

(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Medical Services:							
Advance Appropriation	$39,649,985	$41,354,000	$41,354,000	$43,557,000	$45,015,527	$2,203,000	$1,458,527
Transfer to North Chicago Demo. Fund, P.L. 112-74	($172,750)	$0	$0	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$21,000	$0	$0	($21,000)	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)	$0	($15,000)	($15,000)	($15,000)	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$55,350	$0	$0	$0	$0	$0	$0
Annual Appropriation Adjustment	$0	$165,000	$0	$157,500	$0	$157,500	($157,500)
Subtotal Appropriation	$39,517,585	$41,519,000	$41,360,000	$43,699,500	$45,000,527	$2,339,500	$1,301,027
Collections	$2,814,245	$2,966,000	$2,841,000	$3,064,000	$3,174,000	$223,000	$110,000
Subtotal Budget Authority	$42,331,830	$44,485,000	$44,201,000	$46,763,500	$48,174,527	$2,562,500	$1,411,027
Medical Support & Compliance:							
Advance Appropriation	$5,535,000	$5,746,000	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Transfer to North Chicago Demo. Fund, P.L. 112-74	($24,168)	$0	$0	$0	$0	$0	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($50,000)	$0	$0	$0	$0		
Transfer fr Support & Compliance (1%), P.L. 112-74	($55,350)	$0	$0	$0	$0	$0	$0
Subtotal Appropriation	$5,405,482	$5,746,000	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Medical Facilities:							
Advance Appropriation	$5,426,000	$5,441,000	$5,441,000	$4,872,000	$4,739,000	($569,000)	($133,000)
Transfer to North Chicago Demo. Fund, P.L. 112-74	($37,162)	$0	$0	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$6,000	$0	$0	($6,000)	$0
Subtotal Appropriation	$5,388,838	$5,441,000	$5,447,000	$4,872,000	$4,739,000	($575,000)	($133,000)
Subtotal, Medical Care Appropriations	$50,311,905	$52,706,000	$52,553,000	$54,604,500	$55,619,227	$2,051,500	$1,014,727
Collections	$2,814,245	$2,966,000	$2,841,000	$3,064,000	$3,174,000	$223,000	$110,000
Total Medical Care Appropriations	$53,126,150	$55,672,000	$55,394,000	$57,668,500	$58,793,227	$2,274,500	$1,124,727

Medical & Prosthetic Research

(dollars in thousands)

	2012 Estimate	2013 Budget Estimate	2013 Continuing Resolution	2014 Estimate	2012 to 2014 Increase/ Decrease
Medical & Prosthetic Research:					
Total Budget Authority	$581,000	$582,674	$584,556	$585,664	$4,664

(Dollars in Thousands)	2012 Actual			
Description	Medical Care	Services	Support & Compl.	Facilities
Advance Appropriation	$50,610,985	$39,649,985	$5,535,000	$5,426,000
Transfer to North Chicago Demo. Fund, P.L. 112-74	($234,080)	($172,750)	($24,168)	($37,162)
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$0	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($65,000)	($15,000)	($50,000)	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$0	$55,350	($55,350)	$0
Annual Appropriation Adjustment	$0	$0	$0	$0
Subtotal Appropriation	$50,311,905	$39,517,585	$5,405,482	$5,388,838
Collections	$2,814,245	$2,814,245	$0	$0
Subtotal Budget Authority	$53,126,150	$42,331,830	$5,405,482	$5,388,838
Total Budget Authority	$53,126,150	$42,331,830	$5,405,482	$5,388,838
Reimbursements:				
Sharing & Other Reimbursements	$230,344	$175,699	$37,176	$17,469
Prior Year Recoveries	$0	$0	$0	$0
Subtotal	$230,344	$175,699	$37,176	$17,469
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$871,893	$869,974	$0	$1,919
H1N1 No-Year (P.L. 111-32)	$9,197	$2,534	$6,378	$285
2007 Emergency Supplemental (P.L. 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	($456,184)	($453,747)	$0	($2,437)
H1N1 No-Year (P.L. 111-32)	($8,727)	($2,402)	($6,114)	($211)
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	($6,129)	($1,802)	($1,302)	($3,025)
2-Year	($165,876)	($33,480)	($99,468)	($32,928)
Subtotal	($636,916)	($491,431)	($106,884)	($38,601)
Change in Unobligated Balance (Non-Add)	$525,625	$524,523	($3,766)	$4,868
Lapse	($13,709)	($417)	($11,487)	($1,805)
Obligations	$53,868,410	$43,031,635	$5,427,405	$5,409,370
FTE				
Total FTE	257,655	187,313	47,021	23,321
Direct FTE	254,564	185,531	46,190	22,843
Reimbursable FTE	3,091	1,782	831	478

(Dollars in Thousands)	2013 Budget Estimate			
Description	Medical Care	Services	Support & Compl.	Facilities
Advance Appropriation	$52,541,000	$41,354,000	$5,746,000	$5,441,000
Transfer to North Chicago Demo. Fund, P.L. 112-74	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$0	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	$0	$0	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$0	$0	$0	$0
Annual Appropriation Adjustment	$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 (P.L. 111-32)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 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 (P.L. 111-32)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 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

(Dollars in Thousands)	2013 Current Estimate 1/			
Description	Medical Care	Services	Support & Compl.	Facilities
Advance Appropriation	$52,541,000	$41,354,000	$5,746,000	$5,441,000
Transfer to North Chicago Demo. Fund, P.L. 112-74	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$27,000	$21,000	$0	$6,000
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)	($15,000)	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$0	$0	$0	$0
Annual Appropriation Adjustment	$0	$0	$0	$0
Subtotal Appropriation	$52,553,000	$41,360,000	$5,746,000	$5,447,000
Collections	$2,841,000	$2,841,000	$0	$0
Subtotal Budget Authority	$55,394,000	$44,201,000	$5,746,000	$5,447,000
Total Budget Authority	$55,394,000	$44,201,000	$5,746,000	$5,447,000
Reimbursements:				
Sharing & Other Reimbursements	$408,000	$287,000	$78,000	$43,000
Prior Year Recoveries	$0	$0	$0	$0
Subtotal	$408,000	$287,000	$78,000	$43,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$456,184	$453,747	$0	$2,437
H1N1 No-Year (P.L. 111-32)	$8,727	$2,402	$6,114	$211
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	$6,129	$1,802	$1,302	$3,025
2-Year	$165,876	$33,480	$99,468	$32,928
Subtotal	$636,916	$491,431	$106,884	$38,601
Unobligated Balance (EOY):				
No-Year	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 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)	$636,916	$491,431	$106,884	$38,601
Lapse	$0	$0	$0	$0
Obligations	$56,438,916	$44,979,431	$5,930,884	$5,528,601
FTE				
Total FTE	267,524	194,752	48,604	24,168
Direct FTE	264,293	192,880	47,735	23,678
Reimbursable FTE	3,231	1,872	869	490

1/ Total budget authority does not reflect $1,762 million as shown in the President's Budget Appendix. This funding represents the annualized level provided by the continuing resolution (P.L. 112-175). This funding is anticipated to be cancelled upon enactment of either a 2013 full-year continuing resolution or regular appropriation and is therefore not shown. Most of this funding is an unintended result of the mechanism by which the Congress rescinded a portion of the enacted 2012 advance appropriations and appropriated the same amounts with two-year availability. The rescissions do not recur as a term and condition under P.L. 112-175, but the appropriations do. The additional funding provided to the three accounts is as follows: Medical Services $1,409 million, Medical Support and Compliance $101 million, and Medical Facilities $252 million.

(Dollars in Thousands)	2014 Estimate			
Description	Medical Care	Services	Support & Compl.	Facilities
Advance Appropriation	$54,462,000	$43,557,000	$6,033,000	$4,872,000
Transfer to North Chicago Demo. Fund, P.L. 112-74	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$0	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)	($15,000)	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$0	$0	$0	$0
Annual Appropriation Adjustment	$157,500	$157,500	$0	$0
Subtotal Appropriation	$54,604,500	$43,699,500	$6,033,000	$4,872,000
Collections	$3,064,000	$3,064,000	$0	$0
Subtotal Budget Authority	$57,668,500	$46,763,500	$6,033,000	$4,872,000
Total Budget Authority	$57,668,500	$46,763,500	$6,033,000	$4,872,000
Reimbursements:				
Sharing & Other Reimbursements	$265,000	$200,000	$40,000	$25,000
Prior Year Recoveries	$0	$0	$0	$0
Subtotal	$265,000	$200,000	$40,000	$25,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 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 (P.L. 111-32)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 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	$57,933,500	$46,963,500	$6,073,000	$4,897,000
FTE				
Total FTE	275,308	201,665	49,929	23,714
Direct FTE	272,077	199,793	49,060	23,224
Reimbursable FTE	3,231	1,872	869	490

(Dollars in Thousands)	2015 Advance Appropriations			
Description	Medical Care	Services	Support & Compl.	Facilities
Advance Appropriation	$55,634,227	$45,015,527	$5,879,700	$4,739,000
Transfer to North Chicago Demo. Fund, P.L. 112-74	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$0	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)	($15,000)	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$0	$0	$0	$0
Annual Appropriation Adjustment	$0	$0	$0	$0
Subtotal Appropriation	$55,619,227	$45,000,527	$5,879,700	$4,739,000
Collections	$3,174,000	$3,174,000	$0	$0
Subtotal Budget Authority	$58,793,227	$48,174,527	$5,879,700	$4,739,000
Total Budget Authority	$58,793,227	$48,174,527	$5,879,700	$4,739,000
Reimbursements:				
Sharing & Other Reimbursements	$272,000	$205,000	$41,000	$26,000
Prior Year Recoveries	$0	$0	$0	$0
Subtotal	$272,000	$205,000	$41,000	$26,000
Adjustments to Obligations:				
Unobligated Balance (SOY):				
No-Year	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 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 (P.L. 111-32)	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 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	$59,065,227	$48,379,527	$5,920,700	$4,765,000
FTE				
Total FTE	281,780	206,383	51,110	24,287
Direct FTE	278,549	204,511	50,241	23,797
Reimbursable FTE	3,231	1,872	869	490

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Executive Summary Charts

Employment Summary (FTE)

Account	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Medical Services	187,313	192,377	194,752	201,665	206,383	6,913	4,718
Medical Support & Compliance	47,021	45,814	48,604	49,929	51,110	1,325	1,181
Medical Facilities	23,321	24,721	24,168	23,714	24,287	(454)	573
Total	257,655	262,912	267,524	275,308	281,780	7,784	6,472

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2013 to 2014 Increase/ Decrease
Canteen Service	3,294	3,450	3,500	3,550	50

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Estimate	2012 to 2014 Increase/ Decrease
Medical & Prosthetic Research	3,496	3,526	3,526	3,491	(5)

FTE by Type
Medical Care

Account	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Physicians	17,804	18,073	18,395	18,874	19,312	479	438
Dentists	985	1,058	1,050	1,076	1,100	26	24
Registered Nurses	48,433	49,162	49,991	51,295	52,485	1,304	1,190
LP Nurse/LV Nurse/Nurse Assistant	23,046	23,709	23,791	24,417	24,984	626	567
Non-Physician Providers	11,179	11,398	11,540	11,841	12,116	301	275
Health Technicians/Allied Health	58,199	59,655	61,336	63,690	65,234	2,354	1,544
Wage Board/Purchase & Hire	24,401	26,385	25,278	25,933	26,532	655	599
All Other 1/	73,608	73,472	76,143	78,182	80,017	2,039	1,835
Total	257,655	262,912	267,524	275,308	281,780	7,784	6,472

1/ The Administrative Personnel category includes filing clerks, HR specialists, finance, billing and collection staff, secretaries and receptionists, telephone operators, general managers, police staff, chaplains and other staff that are necessary for the effective operations of VHA medical facilities.

Unique Patients 1/

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	4,389,110	4,392,645	4,460,272	4,531,287	4,586,513	71,015	55,226
Priorities 7-8	1,291,264	1,324,467	1,289,861	1,287,261	1,282,923	(2,600)	(4,338)
Subtotal Veterans	5,680,374	5,717,112	5,750,133	5,818,548	5,869,436	68,415	50,888
Non-Veterans 2/	652,717	607,925	676,576	694,470	709,382	17,894	14,912
Total Unique Patients	6,333,091	6,325,037	6,426,709	6,513,018	6,578,818	86,309	65,800

Obligations by Priority Group

(dollars in thousands)

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	$46,834,016	$48,941,479	$48,940,526	$50,005,248	$50,761,122	$1,064,722	$755,874
Priorities 7-8	$5,249,993	$6,252,943	$5,568,694	$5,847,106	$6,071,452	$278,412	$224,346
Subtotal Veterans	$52,084,009	$55,194,422	$54,509,220	$55,852,354	$56,832,574	$1,343,134	$980,220
Non-Veterans	$1,784,401	$1,385,578	$1,929,696	$2,081,146	$2,232,653	$151,450	$151,507
Total Obligations	$53,868,410	$56,580,000	$56,438,916	$57,933,500	$59,065,227	$1,494,584	$1,131,727

Obligations Per Unique Patient

(dollars)

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	$10,671	$11,142	$10,973	$11,036	$11,067	$63	$31
Priorities 7-8	$4,066	$4,721	$4,317	$4,542	$4,733	$225	$191
Subtotal Veterans	$9,169	$9,654	$9,480	$9,599	$9,683	$119	$84
Non-Veterans	$2,734	$2,279	$2,852	$2,997	$3,147	$145	$150
Total Unique Patients	$8,506	$8,945	$8,782	$8,895	$8,978	$113	$83

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for 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.

Unique Patients [1/]

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	4,389,110	4,392,645	4,460,272	4,531,287	4,586,513	71,015	55,226
Priorities 7-8	1,291,264	1,324,467	1,289,861	1,287,261	1,282,923	(2,600)	(4,338)
Subtotal Veterans	5,680,374	5,717,112	5,750,133	5,818,548	5,869,436	68,415	50,888
Non-Veterans 2/	652,717	607,925	676,576	694,470	709,382	17,894	14,912
Total Unique Patients	6,333,091	6,325,037	6,426,709	6,513,018	6,578,818	86,309	65,800

Unique Enrollees [3/]

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	6,444,197	6,498,081	6,544,536	6,663,644	6,766,636	119,108	102,992
Priorities 7-8	2,318,351	2,310,569	2,353,138	2,366,614	2,373,766	13,476	7,152
Total Enrollees	8,762,548	8,808,650	8,897,674	9,030,258	9,140,402	132,584	110,144

Users as a Percent of Enrollees

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	68.1%	67.6%	68.2%	68.0%	67.8%	-0.2%	-0.2%
Priorities 7-8	55.7%	57.3%	54.8%	54.4%	54.0%	-0.4%	-0.4%
Total Enrollees	64.8%	64.9%	64.6%	64.4%	64.2%	-0.2%	-0.2%

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for 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.

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	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Outpatient Visits (000):							
Ambulatory Care:							
Staff	74,310	76,215	77,272	79,950	82,243	2,678	2,293
Fee	12,875	13,379	13,367	13,939	14,482	572	543
Subtotal	87,185	89,594	90,639	93,889	96,725	3,250	2,836
Readjustment Counseling:							
Visits	1,505	1,508	1,540	1,574	1,637	34	63
Grand Total	88,690	91,102	92,179	95,463	98,362	3,284	2,899
Patients Treated:							
Inpatient Care	630,952	653,863	639,502	644,801	648,443	5,299	3,642
Rehabilitation Care	16,091	16,712	16,465	16,764	17,012	299	248
Mental Health Care Total	155,677	159,942	160,585	164,684	167,185	4,099	2,501
Acute Psychiatry	*98,262*	*100,463*	*99,266*	*100,231*	*100,858*	*965*	*627*
Contract Hospital (Psych)	*17,010*	*14,798*	*18,062*	*19,928*	*21,096*	*1,866*	*1,168*
Psy Residential Rehab	*7,630*	*2,156*	*7,596*	*7,562*	*7,528*	*(34)*	*(34)*
Dom Residential Rehab	*32,775*	*42,525*	*35,661*	*36,963*	*37,703*	*1,302*	*740*
Long-Term Care: Institutional	101,720	103,969	102,752	103,822	104,853	1,070	1,031
Subacute Care	2,196	1,715	1,624	1,175	860	(449)	(315)
Inpatient Facilities, Total	906,636	936,201	920,928	931,246	938,353	10,318	7,107
Average Daily Census:							
Inpatient Care	8,872	9,112	8,989	9,051	9,072	62	21
Rehabilitation Care	1,177	1,148	1,193	1,210	1,229	17	19
Mental Health Care Total	9,212	10,230	9,154	8,994	8,763	(160)	(231)
Acute Psychiatry	*2,705*	*2,781*	*2,637*	*2,548*	*2,445*	*(89)*	*(103)*
Contract Hospital (Psych)	*326*	*284*	*372*	*415*	*455*	*43*	*40*
Psy Residential Rehab	*1,091*	*803*	*881*	*651*	*453*	*(230)*	*(198)*
Dom Residential Rehab	*5,090*	*6,362*	*5,264*	*5,380*	*5,410*	*116*	*30*
Long-Term Care: Institutional	40,846	40,685	41,580	42,465	43,548	885	1,083
Subacute Care	98	69	81	67	57	(14)	(10)
Inpatient Facilities, Total	60,205	61,244	60,997	61,787	62,669	790	882
Length of Stay:							
Inpatient Care	5.1	5.1	5.1	5.1	5.1	0.0	0.0
Rehabilitation Care	26.8	25.1	26.4	26.3	26.4	(0.1)	0.1
Mental Health Care	21.7	23.3	20.8	19.9	19.1	(0.9)	(0.8)
Long-Term Care: Institutional	147.0	142.8	147.7	149.3	151.6	1.6	2.3
Subacute Care	16.3	14.7	18.2	20.7	24.1	2.5	3.4
Dental Procedures (000)	4,089	4,394	4,267	4,437	4,566	170	129
CHAMPVA/FMP/Spina Bifida:							
Outpatient Workloads (000)	12,691	11,862	13,706	14,802	15,987	1,096	1,185

Medical Care
Employment Summary, FTE by Grade, Headquarters

GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
SES	32	32	32	32	0	0
Title 38	183	183	183	183	0	0
15 or higher	118	118	118	118	0	0
14	359	359	359	359	0	0
13	272	272	272	272	0	0
12	120	120	120	120	0	0
11	103	103	103	103	0	0
10	1	1	1	1	0	0
9	52	52	52	52	0	0
8	6	6	6	6	0	0
7	37	37	37	37	0	0
6	12	12	12	12	0	0
5	4	4	4	4	0	0
4	0	0	0	0	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	1,300	1,300	1,300	1,300	0	0

Medical Care
Employment Summary, FTE by Grade, Field

GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
SES	130	135	139	143	4	4
Title 38	76,343	79,455	82,312	84,306	2,857	1,994
15 or higher	493	509	523	534	14	11
14	2,074	2,149	2,183	2,233	34	50
13	9,514	9,874	10,082	10,322	208	240
12	17,742	18,421	18,851	19,310	430	459
11	18,757	19,342	19,523	19,883	181	360
10	2,282	2,373	2,440	2,499	67	59
9	12,969	13,467	13,829	14,167	362	338
8	6,899	7,168	7,406	7,588	238	182
7	16,697	17,325	17,780	18,195	455	415
6	32,586	33,867	34,966	35,810	1,099	844
5	28,535	29,665	30,644	31,375	979	731
4	5,639	5,856	6,038	6,190	182	152
3	1,052	1,091	1,104	1,132	13	28
2	182	188	193	198	5	5
1	61	62	63	64	1	1
Wage Board	24,400	25,277	25,932	26,531	655	599
Total Number of FTE	256,355	266,224	274,008	280,480	7,784	6,472

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

Description:	2013 to 2014
2013 President's Budget:	
Appropriation	$52,706,000
Collections	$2,966,000
Total 2013 President's Budget	**$55,672,000**
Adjustments:	
Adjustment for current estimate of appropriation level	($165,000)
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$27,000
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)
Adjustment to Collections	($125,000)
Total Adjustments	($278,000)
Adjusted FY 2013 Budget Estimate:	
Appropriation	$52,553,000
Collections	$2,841,000
Total Adjusted 2013 Budget Estimate = 2013 Current Estimate	**$55,394,000**
2014 Current Services Increases:	
Health Care Services	$746,061
Payraise Assumption 0.5% for 1/4 FY 2014	$57,363
Payraise Assumption 1.0% for 3/4 FY 2014	$172,728
Other Non-Pay Raise Pay Accounts	$901,209
Long-Term Care	$728,923
CHAMPVA, Spina Bifida, FMP, & CWVV	$132,466
Readjustment Counseling	$8,000
Subtotal	**$2,746,750**
2014 Total Current Services	**$58,140,750**
(% increase over 2013 adjusted)	5.0%
2014 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$8,171
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$85,000
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	($6,000)
Current Major/Supporting Initiatives:	
Activations	$12,000
DoD/VA Integrated DES Enhancement	($3,000)
Strategic Planning Major Initiatives:	
Homelessness: Zero Homelessness	$40,891
New Models of Care	($194,597)
Enhanced Veterans Experience and Access	($24,824)
Improving Veteran Mental Health	($2,567)
Improve the Quality of Health Care while Reducing Costs	($45,157)
Establish World-Class Health Informatics Capability	($37,300)
Proposed Savings:	
Acquisition Proposals	($220,000)
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	($13,000)
Corporate Office Reduction	($24,000)
New VISN Structure	($25,000)
2014 Total Congressional Mandates, Initiatives, & Savings	**($449,383)**
Legislative Proposals	**($22,867)**
Appropriation	$54,604,500
Collections	$3,064,000
2014 Total Budget Authority Request (appropriation + collections)	**$57,668,500**
(% increase over 2013 adjusted)	4.1%

Budget Authority Net Change
VHA Medical Care
2015 Summary of Resource Requirements
(dollars in thousands)

Description:	2014 to 2015
2013 President's Budget, 2014 Estimate:	
Appropriation	$54,462,000
Collections	$3,051,000
Total 2013 President's Budget, 2014 Estimate	**$57,513,000**
Adjustments:	
Annual Appropriation Adjustment	$157,500
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)
Adjustment to Collections	$13,000
Total Adjustments	$155,500
Adjusted FY 2014 Budget Estimate:	
Appropriation	$54,604,500
Collections	$3,064,000
Total Adjusted 2014 Budget Estimate	**$57,668,500**
2015 Current Services Increases:	
Health Care Services	$1,096,412
Payraise Assumption 1.0% for 1/4 FY 2015	$64,728
Other Non-Pay Raise Pay Accounts	$822,772
Long-Term Care	$347,203
CHAMPVA, Spina Bifida, FMP, & CWVV	$133,663
Readjustment Counseling	$7,544
Subtotal	**$2,472,322**
2015 Total Current Services	**$60,140,822**
(% increase over 2014 adjusted)	4.3%
2015 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$8,170
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$0
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$25,000
Current Major/Supporting Initiatives:	
Activations	($668,551)
DoD/VA Integrated DES Enhancement	$0
Strategic P.L.anning Major Initiatives:	
Homelessness: Zero Homelessness	($392,742)
New Models of Care	($257,798)
Enhanced Veterans Experience and Access	($40,000)
Improving Veteran Mental Health	($17,224)
Improve the Quality of Health Care while Reducing Costs	($6,000)
Establish World-Class Health Informatics Capability	$0
Proposed Savings:	
Acquisition Proposals	$0
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	$0
Corporate Office Reduction	$0
New VISN Structure	$0
2015 Total Congressional Mandates, Initiatives, & Savings	**($1,349,145)**
Legislative Proposals	**$1,550**
Appropriation	$55,619,227
Collections	$3,174,000
2015 Total Budget Authority Request (appropriation + collections)	**$58,793,227**
(% increase over 2014 adjusted)	2.0%

Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
10 Personal Services & Benefits:							
Physicians	$4,793,586	$4,989,900	$5,013,500	$5,231,500	$5,426,700	$218,000	$195,200
Dentists	$225,965	$247,600	$243,800	$254,300	$263,700	$10,500	$9,400
Registered Nurses	$5,632,941	$5,749,400	$5,838,500	$6,058,800	$6,235,400	$220,300	$176,600
LP Nurse/LV Nurse/Nurse Assistant	$1,469,947	$1,510,600	$1,531,400	$1,596,500	$1,651,700	$65,100	$55,200
Non-Physician Providers	$1,533,638	$1,562,600	$1,589,300	$1,648,900	$1,696,700	$59,600	$47,800
Health Technicians/Allied Health	$5,292,016	$5,456,500	$5,596,300	$5,862,200	$6,034,800	$265,900	$172,600
Wage Board/Purchase & Hire	$1,453,008	$1,541,300	$1,514,700	$1,574,300	$1,623,100	$59,600	$48,800
Administrative Personnel 1/	$5,440,980	$5,505,700	$5,649,900	$5,873,000	$6,044,900	$223,100	$171,900
Permanent Change of Station	$15,507	$21,200	$16,300	$17,100	$18,400	$800	$1,300
Employee Compensation Pay	$235,276	$278,500	$243,500	$251,900	$260,600	$8,400	$8,700
Subtotal	$26,092,863	$26,863,300	$27,237,200	$28,368,500	$29,256,000	$1,131,300	$887,500
21 Travel & Transportation of Persons:							
Employee	$121,931	$165,000	$121,600	$121,600	$121,600	$0	$0
Beneficiary	$859,879	$966,100	$903,300	$936,900	$971,000	$33,600	$34,100
Other	$56,183	$50,600	$55,900	$55,900	$55,900	$0	$0
Subtotal	$1,037,993	$1,181,700	$1,080,800	$1,114,400	$1,148,500	$33,600	$34,100
22 Transportation of Things	$37,119	$47,400	$39,400	$42,000	$44,700	$2,600	$2,700
23 Communications, Utilites & Other Rent:							
Rental of Equipment	$151,770	$145,000	$171,100	$193,400	$218,500	$22,300	$25,100
Communications	$288,647	$329,400	$314,700	$343,300	$374,500	$28,600	$31,200
Utilities	$519,344	$564,100	$527,800	$579,500	$595,000	$51,700	$15,500
GSA Rent	$26,255	$25,600	$26,700	$27,800	$28,900	$1,100	$1,100
Other Real Property Rental	$418,101	$533,800	$515,600	$598,900	$623,600	$83,300	$24,700
Subtotal	$1,404,117	$1,597,900	$1,555,900	$1,742,900	$1,840,500	$187,000	$97,600
24 Printing & Reproduction:	$32,259	$59,407	$32,300	$32,300	$32,300	$0	$0
25 Other Services:							
Outpatient Dental Fees	$98,077	$115,800	$102,400	$106,900	$111,600	$4,500	$4,700
Medical & Nursing Fees	$1,609,164	$2,099,500	$1,738,000	$1,883,500	$1,958,500	$145,500	$75,000
Repairs to Furniture/Equipment	$182,776	$217,400	$199,800	$199,000	$208,900	($800)	$9,900
Maintenance & Repair Contract Services	$177,608	$186,600	$193,200	$220,400	$226,600	$27,200	$6,200
Contract Hospital	$1,587,081	$1,919,700	$1,753,200	$1,936,800	$2,139,600	$183,600	$202,800
Community Nursing Homes	$616,511	$667,100	$662,200	$724,500	$760,900	$62,300	$36,400
Repairs to Prosthetic Appliances	$194,441	$206,600	$213,900	$235,300	$258,900	$21,400	$23,600
Home Oxygen	$156,682	$190,500	$171,400	$187,000	$202,600	$15,600	$15,600
Personal Services Contracts	$102,109	$132,800	$105,500	$108,900	$112,400	$3,400	$3,500
House Staff Disbursing Agreement	$593,117	$626,300	$636,000	$682,500	$732,400	$46,500	$49,900
Scarce Medical Specialists	$173,194	$195,300	$178,400	$183,800	$189,300	$5,400	$5,500

Obligations by Object
Medical Care Total
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$2,621,230	$2,650,600	$2,908,231	$2,953,300	$2,232,627	$45,069	($720,673)
Administrative Contract Services	$1,884,458	$2,939,637	$2,316,785	$2,302,500	$2,045,800	($14,285)	($256,700)
Training Contract Services	$60,187	$105,900	$61,800	$64,300	$66,000	$2,500	$1,700
CHAMPVA	$929,305	$973,100	$1,018,900	$1,112,600	$1,207,000	$93,700	$94,400
Subtotal	$10,985,941	$13,226,837	$12,259,716	$12,901,300	$12,453,127	$641,584	($448,173)
26 Supplies & Materials:							
Provisions	$113,661	$116,100	$114,900	$118,600	$122,400	$3,700	$3,800
Drugs & Medicines	$4,865,136	$4,934,600	$5,089,700	$5,349,700	$5,651,900	$260,000	$302,200
Blood & Blood Products	$73,589	$86,100	$77,000	$80,900	$85,500	$3,900	$4,600
Medical/Dental Supplies	$1,259,687	$1,468,000	$1,339,500	$1,427,700	$1,520,700	$88,200	$93,000
Operating Supplies	$274,680	$303,700	$290,300	$303,200	$318,800	$12,900	$15,600
Maintenance & Repair Supplies	$155,544	$173,200	$163,900	$159,000	$157,900	($4,900)	($1,100)
Other Supplies	$234,580	$424,906	$245,700	$257,800	$269,100	$12,100	$11,300
Prosthetic Appliances	$1,772,019	$2,081,800	$1,946,100	$2,111,300	$2,282,300	$165,200	$171,000
Home Respiratory Therapy	$40,859	$37,200	$44,800	$48,900	$53,300	$4,100	$4,400
Subtotal	$8,789,755	$9,625,606	$9,311,900	$9,857,100	$10,461,900	$545,200	$604,800
31 Equipment	$2,619,533	$1,816,600	$1,901,000	$1,310,000	$1,406,000	($591,000)	$96,000
32 Lands & Structures:							
Non-Recurring Maintenance	$1,491,107	$710,450	$1,335,300	$709,800	$460,600	($625,500)	($249,200)
All Other Lands & Structures	$215,521	$168,300	$207,800	$252,900	$252,900	$45,100	$0
Subtotal	$1,706,628	$898,450	$1,543,100	$962,700	$713,500	($580,400)	($249,200)
41 Grants, Subsidies & Contributions:							
State Home	$851,942	$764,900	$975,100	$1,066,200	$1,172,600	$91,100	$106,400
Homeless Programs	$309,981	$497,900	$502,500	$536,100	$536,100	$33,600	$0
Subtotal	$1,161,923	$1,262,800	$1,477,600	$1,602,300	$1,708,700	$124,700	$106,400
43 Imputed Interest	$279	$0	$0	$0	$0	$0	$0
Total, Obligations	$53,868,410	$56,580,000	$56,438,916	$57,933,500	$59,065,227	$1,494,584	$1,131,727

1/ The Administrative Personnel category includes filing clerks, HR specialists, finance, billing and collection staff, secretaries and receptionists, telephone operators, general managers, police staff, chaplains and other staff that are necessary for the effective operations of VHA medical facilities.

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Medical Services

Medical Services
Budgetary Resources
(dollars in thousands)

Description	2012 Actual 1/	2013 Budget Estimate	2013 Current Estimate 2/ 3/	2014 Estimate 4/	2015 Adv. Approp. 5/	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Appropriation.....	$39,517,585	$41,519,000	$41,360,000	$43,714,500	$45,015,527	$2,354,500	$1,301,027
Collections.....	$2,814,245	$2,966,000	$2,841,000	$3,064,000	$3,174,000	$223,000	$110,000
Total.....	$42,331,830	$44,485,000	$44,201,000	$46,778,500	$48,189,527	$2,577,500	$1,411,027

1/ 2012 reflects all transfers.
2/ Total budget authority–in this and all tables for this account that display budget authority–does not reflect $1,409 million as shown in the President's Budget Appendix. Please see explanation as provided in footnote 1/ on page 1A-37.
3/ 2013 reflects DoD-VA Health Care Sharing Incentive Fund (JIF) transfer and Hurricane Sandy supplemental funding. It does not reflect anticipated transfers to the Joint DoD-VA Medical Facility Demonstration Fund (Demonstration Fund).
4/2014 reflects a realignment of functions (see FY 2014 Realignment of Functions section for additional details). 2014 does not reflect transfers to the JIF or to the Demonstration Fund.
5/ 2015 does not reflect transfers to the JIF or the Demonstration Fund.

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); $157,500,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2013; and, in addition, $45,015,527,000, plus reimbursements, shall become available on October 1, 2014, and shall remain available until September 30, 2015: Provided, That, of the amount made available on October 1, 2014, under this heading, $1,400,000,000 shall remain available until September 30, 2016: Provided further, That notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs:

Provided further, That notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: Provided further, That notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs.

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

FY 2014 Realignment of Functions

- **Biomedical Engineering Services –** As with the 2014 advance appropriations request, the 2014 President's Budget 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 appropriations 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.

- **Clinical Applications Coordinator (CAC) –** The Budget proposes that costs of $6.138 million and 53 CAC FTE be funded out of the Medical Services appropriation instead of the Information Systems Technology (IT) appropriation. CACs are a mixture of IT specialists and Title 38 employees who provide direct support to clinical services and coordinate facility efforts in support of VHA's Medical Center Management. These CACs are present in the Office of Information Technology as the result of the 2006 realignment, but their role and responsibilities in clinical systems training are better aligned with VHA responsibilities.

2014 Funding and 2015 Advance Appropriations Request

The justification for the 2014 funding and the 2015 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	2012 Actual 1/	2013 Budget Estimate 2/	2013 Current Estimate 1/	2014 Estimate 1/	2015 Advance Approp. 1/	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Health Care Services:							
Ambulatory Care	$18,758,385	$19,337,779	$18,656,220	$18,958,205	$19,957,552	$301,985	$999,347
Inpatient Care	$8,251,317	$8,122,920	$8,437,864	$8,719,560	$8,934,000	$281,696	$214,440
Rehabilitation Care	$459,650	$477,407	$492,977	$534,405	$573,128	$41,428	$38,723
Mental Health Care	$4,520,923	$4,457,315	$5,013,297	$5,572,692	$6,111,404	$559,395	$538,712
Prosthetics Care	$1,790,818	$2,586,000	$1,989,332	$2,190,576	$2,397,886	$201,244	$207,310
Dental Care	$514,731	$414,666	$541,828	$577,812	$609,212	$35,984	$31,400
Total Health Care Services	$34,295,824	$35,396,087	$35,131,518	$36,553,250	$38,583,182	$1,421,732	$2,029,932
Long-Term Care:							
VA Community Living Centers (VA CLC)	$2,508,754	$2,564,502	$2,696,261	$3,139,319	$3,309,108	$443,058	$169,789
Community Nursing Home	$608,809	$757,726	$653,922	$715,436	$751,388	$61,514	$35,952
State Home Nursing	$799,953	$946,772	$922,258	$1,012,296	$1,117,026	$90,038	$104,730
State Home Domiciliary	$58,014	$57,455	$59,754	$61,445	$63,802	$1,691	$2,357
Subtotal	$3,975,530	$4,326,455	$4,332,195	$4,928,496	$5,241,324	$596,301	$312,828
Total Non-Institutional Care	$1,129,012	$1,476,523	$1,391,147	$1,592,641	$1,657,324	$201,494	$64,683
Long-Term Care Total	$5,104,542	$5,802,978	$5,723,342	$6,521,137	$6,898,648	$797,795	$377,511
Other Health Care Programs:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,233,041	$1,290,780	$1,339,650	$1,459,852	$1,590,480	$120,202	$130,628
Readjustment Counseling	$152,277	$169,412	$168,826	$177,901	$185,924	$9,075	$8,023
Subtotal	$1,385,318	$1,460,192	$1,508,476	$1,637,753	$1,776,404	$129,277	$138,651
Congressional Action:							
Caregivers & Veterans Omnibus Hlth Svcs (PL 111-163)	$113,133	$264,100	$371,500	$379,551	$387,600	$8,051	$8,049
Affordable Care Act (PL 111-148/P.L. 111-152)	$0	$0	$0	$85,000	$85,000	$85,000	$0
Indian Health Services (PL 111-148)	$0	$52,000	$52,000	$52,000	$52,000	$0	$0
Camp Lejeune - Veterans and Family (PL 112-154)	$0	$0	$53,000	$47,000	$72,000	($6,000)	$25,000
Subtotal, Congressional Action	$113,133	$316,100	$476,500	$563,551	$596,600	$87,051	$33,049
Initiatives:							
Activations	$366,203	$601,403	$573,200	$581,945	$94,738	$8,745	($487,207)
DoD/VA Integrated DES Enhancement	$25,698	$3,234	$17,663	$15,255	$15,255	($2,408)	$0
Strategic Planning Major Initiatives							
Homelessness: Zero Homelessness	$879,851	$1,063,816	$1,208,431	$1,249,322	$856,580	$40,891	($392,742)
New Models of Care	$664,848	$398,957	$407,627	$232,287	$0	($175,340)	($232,287)
Enhanced Veterans Experience and Access	$79,783	$102,416	$57,352	$35,390	$0	($21,962)	($35,390)
Improving Veteran Mental Health	$22,279	$5,254	$12,685	$11,040	$0	($1,645)	($11,040)
Improve the Quality of Health Care while Reducing Costs	$94,156	$48,656	$50,200	$6,000	$0	($44,200)	($6,000)
Establish World-Class Health Informatics Capability	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,740,917	$1,619,099	$1,736,295	$1,534,039	$856,580	($202,256)	($677,459)
Initiatives Total	$2,132,818	$2,223,736	$2,327,158	$2,131,239	$966,573	($195,919)	($1,164,666)
VA Legislative Proposals:							
Subtotal	$0	($27,093)	($7,563)	($30,430)	($28,880)	($22,867)	$1,550
Proposed Savings:							
Acquisition Proposals	$0	$0	($150,000)	($370,000)	($370,000)	($220,000)	$0
Travel Campaign to Cut Waste	$0	$0	($30,000)	($30,000)	($30,000)	$0	$0
Patient-Centered Community Care	$0	$0	$0	($13,000)	($13,000)	($13,000)	$0
Corporate Office Reduction	$0	$0	$0	$0	$0	$0	$0
New VISN Structure	$0	$0	$0	$0	$0	$0	$0
Subtotal, Proposed Savings	$0	$0	($180,000)	($413,000)	($413,000)	($233,000)	$0
Operational Improvements (Non-Add) 3/:							
Fee Care Payments Consistent with Medicare	($528,000)	($361,700)	($361,700)	($406,000)	($406,000)	($44,300)	$0
Fee Care Savings	($88,000)	($200,000)	($200,000)	($200,000)	($200,000)	$0	$0
Clinical Staff and Resource Realignment	($198,000)	($150,800)	($150,800)	($150,800)	($150,800)	$0	$0
Medical & Administrative Support Savings	($133,000)	($150,000)	($150,000)	($150,000)	($150,000)	$0	$0
Acquisition Improvements	($200,000)	($355,000)	($355,000)	($355,000)	($355,000)	$0	$0
VA Real Property Cost Savings & Innovation Plan	$0	$0	$0	$0	$0	$0	$0
Subtotal, Operational Improvements	($1,147,000)	($1,217,500)	($1,217,500)	($1,261,800)	($1,261,800)	($44,300)	$0
Total Obligations	$43,031,635	$45,172,000	$44,979,431	$46,963,500	$48,379,527	$1,984,069	$1,416,027

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

1/ VA transferred $15 million in 2012; $15 million in 2013 and anticipates transferring $15 million in 2014 and 2015 to DoD-VA Health Care Incentive Fund

2/ Agent Orange and Amyotrophic Lateral Sclerosis are included in Health Care Services

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

Below, the funding in parenthesis represents the 2014 funding level and 2015 advance appropriations request on an obligation basis. Workload estimates can be found in the "Summary of Workloads for VA and Non-VA Facilities" chart in the Executive Summary Charts chapter.

Health Care Services:

- **($36.553 billion in 2014)**
- **($38.583 billion in 2015)**

VA projects the following medical services:

Ambulatory Care:

- **($18.958 billion in 2014)**
- **($19.958 billion in 2015)**

This includes funding for ambulatory care in 152 VA hospital-based and 850 community-based clinics. Contract fee care is 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.

Inpatient Care:

- **($8.720 billion in 2014)**
- **($8.934 billion in 2015)**

VA delivers inpatient acute hospital care in its hospitals and through inpatient contract care.

Rehabilitation Care:

- **($534 million in 2014)**
- **($573 million in 2015)**

These services include inpatient and outpatient blind and vision rehabilitation programs (including the Blind Rehabilitation and Spinal Cord Injury and Disorders programs), adjustment to blindness counseling, patient and family education, and assistive technology. VA is expanding the Blind Rehabilitation program to accommodate the increased workload due to additional numbers of these injuries among OEF/OIF/OND Veterans. The mission of Spinal Cord Injury and Disorders (SCI/D) Services is to promote the health, independence, quality of life and productivity of individuals with spinal cord injury and disorders through efficient delivery of acute rehabilitation, psychological, social, vocational, medical and surgical care, professional training, as well as patient and family education.

Mental Health Care:

- **($5.573 billion in 2014)**
- **($6.111 billion in 2015)**

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. MHS 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 IVMH was tracked through the Major Initiative monthly reporting process during 2011 and 2012, and through the routine reporting processes in Mental Health Services beginning in 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 and inpatient 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) Veterans.
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. 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 and 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 2012, VA medical centers have implemented 96% of the Handbook requirements.

VA is working closely with DoD and the Department of Health and Human Services (HHS) to implement President Barack Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Service Members, and Military Families," signed on August 31, 2012. The executive order reaffirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The executive order strengthens suicide prevention efforts, supports recovery-oriented mental health services through peer counseling, and supports VA in using a variety of recruitment strategies to hire 1,600 new mental health clinicians and 300 administrative personnel in support of mental health programs.

As of January 29, 2013, 3,262 mental health professionals and administrative support have been hired and are providing services to Veterans since the start of VA's Mental Health Hiring Initiative in April, 2012. Of these, 1,058 mental health providers have been hired specifically as part of the initiative to add 1,600 mental health professionals by June 30, 2013. A comprehensive recruitment and hiring plan is also being implemented to ensure that 800 peer

specialists are hired and trained by December 31, 2013, including: identification of sites needing additional peer specialist positions, distribution of sufficient funding to facilities, and certification training to meet appropriate standards.

VHA has developed and implemented an aggressive recruiting and marketing effort to fill vacancies in mental health care occupations. This effort includes the following actions: working directly with mental health provider associations and training programs, conducting numerous media advertising efforts, developing a professional recruitment contract, and using incentives such as pay flexibilities and loan repayment to promote hiring of mental health professionals. Additionally, VA partners with the National Rural Recruitment and Retention Network for outreach to difficult-to-recruit areas and is partnering with the HHS to collaborate on pilots that increase access to underserved areas.

More information is provided in the Selected Program Highlights Chapter.

Prosthetics Care:

- **($2.191 billion in 2014)**
- **($2.398 billion in 2015)**

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. This includes, but is not limited to, artificial limbs, hearing aids, and home oxygen; items that improve accessibility such as ramps and vehicle modifications, wheelchairs and mobility aids; and devices surgically placed in the veteran, such as stents.

Dental Care:

- **($578 million in 2014)**
- **($609 million in 2015)**

The largest cohort of Veterans eligible for dental care is Veterans with 100% service-connected disability. These Veterans are eligible for lifelong comprehensive dental care as needed. VA has seen an over 40% increase in these patients over the last 5 years. Also included are dental benefits to all newly discharged OEF/OIF/OND Veterans with service-connected, non-compensable dental conditions or disabilities shown to have been in existence at the time of discharge or release from active duty. Homeless Veterans enrolled in certain residential treatment programs are also eligible for dental treatment so that VA can improve their health and quality of life by eliminating pain and infection, as well as increasing their likelihood of employment.

This funding also provides essential dental services to Veterans with a "medical condition negatively impacted by poor dentition" who are eligible for only limited dental care by VA. These patients include poorly controlled diabetic patients, patients with head or neck cancer, organ transplant patients and others. Proper dental treatment contributes to improved medical outcomes and well-being for these Veterans. Additionally, Veterans enrolled in title 38 Chapter 31 Vocational Rehabilitation programs are eligible for focused dental care while enrolled in the program.

Long-Term Care:

- **($6.521 billion in 2014)**
- **($6.899 billion in 2015)**

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 veterans who wish 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 four venues: VA Community Living Centers (CLCs); Community Nursing Homes; State Veterans Nursing Home; and State Veterans Home Domiciliaries.

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.

Non-Institutional Long-Term Care:
VA's approach to non-institutional long-term care is based on the premise that the most desirable location for long-term care services is at home or in a community environment unless the appropriate care can only be delivered in an institutional setting. Living at home, or close-by in the community, provides Veterans with a higher quality of life. Non-institutional long-term care programs and services include: VA and State adult day health care, home-based primary care, purchased skilled home health care and other home care programs.

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

- **($1.460 billion in 2014)**
- **($1.590 billion in 2015)**

The Veterans Health Care Expansion Act of 1973, P.L. 93-82, authorized VA to provide a health benefits program which shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001, P.L. 107-14, extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65. 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; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense TRICARE Program. CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service, and State Victims of Crime Compensation Programs.

The Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163, section 102, further expanded CHAMPVA to include primary family caregivers of certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through the existing CHAMPVA Program when the primary family caregiver has no other health care coverage (including Medicare and Medicaid).

CHAMPVA programs also include Foreign Medical Program (FMP), Spina Bifida Health Care Program, and Children of Women Vietnam Veterans Health Care Program (CWVV).

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 where the VA Outpatient Clinic has jurisdiction of the health care services. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions.

Spina Bifida Health Care Program - Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, P.L. 104-204, section 421, VA administers the Spina Bifida Health Care Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003, P.L. 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 only for medical services associated with spina bifida; under the Veterans' Mental Health and Other Care Improvements Act of 2008, P.L. 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, P.L. 106-419, section 401, VA administers the CWVV program for children with certain birth defects born to women Vietnam Veterans. The CWVV Program provides reimbursement only for covered birth defects.

Readjustment Counseling:

- **($178 million in 2014)**
- **($186 million in 2015)**

This funding is required to provide readjustment counseling services at 300 VA Vet Centers across the country. 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.

Congressional Action:

Caregivers and Veterans Omnibus Health Services Act (P.L. 111-163)

- **($380 million in 2014)**
- **($388 million in 2015)**

The Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 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. This funding level supports both the bill's Title I requirements for caregiver support and the remaining requirements included in Titles II – X.

Affordable Care Act (P.L. 111-148/P.L. 111-152)

- **($85 million in 2014)**
- **($85 million in 2015)**

The Patient Protection and Affordable Care Act (P.L. 111-148) was enacted on March 23, 2010 and the Health Care and Education Reconciliation Act (P.L. 111-152) was enacted on March 30, 2010. These two laws are collectively referred to as the "Affordable Care Act" (ACA). The ACA represents comprehensive reform of the health care delivery system and is intended to expand access to coverage, control health care costs, and improve the Nation's health care delivery system. Beginning in 2014, many uninsured Americans, including Veterans, will have access to quality, affordable health insurance choices through Health Insurance Marketplaces, also known as Exchanges, and may be eligible for premium tax credits and cost-sharing reductions. The Medicaid expansion provision allows states to expand Medicaid eligibility to up to 138% of the Federal Poverty Level. The ACA also provides individuals the option of obtaining health insurance coverage or making a payment when filing their tax returns.

When these key provisions of ACA are implemented in 2014, some Veterans will have with new options for obtaining health care. VA believes that the relationship it has established with enrolled Veterans and the special health care services it provides to many enrollees will be key factors in a Veteran's decision to remain enrolled with and utilize VA health care. VA recognizes that the additional options available under the ACA may lead some Veterans to choose non-VA providers, while other Veterans may newly enroll with VA in order to satisfy the individual mandate. The 2014 and 2015 requests reflect the estimated cost impacts due to the current assumption that VA will experience a net enrollment increase from ACA impacts.

VA has been an active partner with Federal agencies in developing ACA implementation regulations and will continue to monitor how implementation impacts the VA health care system.

Indian Health Services (P.L. 111-148)

- **($52 million in 2014)**
- **($52 million in 2015)**

Consistent with the Administration's goal to increase access to care for Veterans and with the Affordable Care Act, VA and the Indian Health Service (IHS) signed the VA-IHS National Reimbursement Agreement in December 2012. This Agreement will facilitate reimbursement by VA to IHS for direct health care services provided to eligible American Indian and Alaska Native Veterans in IHS facilities. The Agreement also paves the way for future

agreements negotiated between VA and tribal health programs, in addition to those already in existence.

Camp Lejeune (P.L. 112-154)
- **($47 million in 2014)**
- **($72 million in 2015)**

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services for 15 specified illnesses and conditions to certain Veterans who were stationed at Camp Lejeune, North Carolina for at least 30 days between 1957 and 1987. Family members of such Veterans who resided (or were in utero) at Camp Lejuene for at least 30 days during that period are eligible for hospital care and medical services for the same specified illness and conditions. Hospital care and medical services may only be furnished to family members to the extent and in the amount provided in advance in appropriations Acts for such purpose. In addition, VA may only provide reimbursement for such hospital care and medical services provided to a family member after all other claims and remedies against third parties for such care and services have been exhausted. Care for Veterans covered under this authority began on the date of enactment, August 6, 2012. In 2015, VA expects to start treating family members and has budgeted $25 million for that purpose, included in the above funding level.

Initiatives:

In 2014, funding shown for initiatives reflects the total estimated costs of these programs. Final 2015 funding levels for these initiatives will be determined during the 2015 budget process when updated data and metrics on these programs' funding needs are available.

Activations
- **($582 million in 2014)**
- **($95 million in 2015)**

Facility activations 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).

DoD/VA Integrated Disability Evaluation System (IDES) Enhancement
- **($15 million in 2014)**
- **($15 million in 2015)**

The Integrated Disability Evaluation System (IDES) strives to implement an integrated mechanism to provide wounded, ill, and injured Servicemembers

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 Servicemembers and truly implement a seamless transition from DoD to VA.

Strategic Planning Major Initiatives:

Homelessness: Zero Homelessness

- **($1.249 billion in 2014)**
- **($857 million in 2015)**

On a single night in January 2012, 62,619 Veterans were homeless; however, it is estimated that over the course of the year, approximately 144,842 Veterans experienced homelessness.[1] VA is committed to preventing and ending homelessness among Veterans and is poised to assist homeless and at-risk Veterans through the provision of a comprehensive continuum of care that includes Outreach/Education, Prevention, Treatment, Income/Employment/Benefits, and Housing/Supportive Services provided in collaboration with Federal, state, local governments and community partners.

The VA Plan to End Homelessness among Veterans became a primary initiative of the Department and was incorporated into VA's Transformational Initiatives, where it is referred to as Eliminate Veteran Homelessness (EVH). The efforts are integrated Department-wide and include the support of the National Cemetery Administration (NCA) and the Veterans Benefits Administration (VBA). The Office of Public and Intergovernmental Affairs (OPIA) Homeless Veterans Initiatives Office (HVIO) is the lead organization for this initiative. HVIO has primary responsibility for the initiative's internal and external communication strategies, federal- and state-level interagency collaborations, and national policy development. The administration of VA's clinical homeless programs is aligned within VHA, Office of the Deputy Under Secretary for Operations and Management, which is accountable for the budget execution of VHA's Homeless Veterans Programs, and for the provision of clinical intervention and treatment services for homeless and at-risk Veterans. The VBA, NCA, and the Office of Asset Enterprise Management (OAEM) are collaborative partners in the EVH initiative that operate within their respective budgets -- separate from VHA's Homeless Veteran

[1] **U.S. Department of Housing and Urban Development.** ***The 2012 Point-in-Time Estimates of Homelessness: Volume I of the 2012 Annual Homeless Assessment Report to Congress***. November 2012.

Programs -- and are accountable to their own leadership for their performance.

VA is positioned to assist homeless and at-risk Veterans in achieving their optimal level of functioning and quality of life through the provision of a comprehensive continuum of care that address the psychosocial factors surrounding homelessness while building the capacity of available residential, rehabilitative, transitional, and permanent housing supply. The continuum includes both prevention and treatment services. These services include but are not limited to: primary and specialty medical care, mental health and substance use disorder treatment, case management, outreach, vocational rehabilitation/ employment services, housing, and coordination of related services with VBA and NCA. This continuum includes VA Medical Centers (VAMCs), Public Housing Authorities (PHAs), and Continuums of Care (CoCs), as well as a range of public and private nonprofit providers. The intent is for every eligible Veteran to have access to a safe, stable environment, and that there will be sufficient capacity so that all Veterans willing to accept services will be able to leave the streets and enter shelter/housing in order to stabilize and begin rebuilding their lives.

Since the inception of the EVH transformational initiative, VA has not only expanded existing programs and developed new programs, but has increased efforts to: develop partnerships with federal and state agencies, Veterans Service Organizations, national advocacy groups, and community-based providers; enhance outreach efforts to agencies as well as to individual Veterans; increase data collection and reporting methods by working closely with federal agencies and local continuums of care; and develop new methods to explore evidence-based research and test best practice models.

Additionally, VA has made unprecedented efforts to promote the services available to Veterans who are homeless or might become homeless through its comprehensive approach to outreach (media and 'boots on the ground'), the implementation of an at-risk clinical reminder in VAMC out-patient settings, and continued interaction and collaboration with public and private sector partners. The total number of Veterans served in VHA's specialized programs for homeless or at-risk Veterans in 2012 was 200,094, an increase of 27% from 2011. VA has also increased its capacity to provide services for Veterans in need. These increases, combined with the new programs and outreach VA has launched in the past year, make VA optimistic that the number of homeless Veterans will continue to decline.

New Models of Care

- **($232 million in 2014)**

In FY 2013, VA began transitioning components of the Major Initiatives (MI) that were mature into normal business operations. An Integrated Health Operating Plan (IHOP) was developed to consolidate initiatives that were not ready for transition, which now includes most of the New Models of Care (NMOC) MI, some of the remaining components of the MI to Enhance the Veteran Experience and Access to Healthcare (EVEAH), and a few projects from other MIs. The 2014 funding level supports the components of these MIs that have not transitioned to sustainment and thus remain in the IHOP. The narrative below describes these remaining components.

NMOC is a portfolio of large initiatives created to fundamentally improve the experience for America's Veterans when accessing VA healthcare services. This initiative is aimed at transforming our primary care services into a patient centered medical home model (through our Patient Aligned Care Teams, or PACT), aligning our specialty care services to better support PACT teams and their patients, and improving access by adopting various eHealth technologies. The Patient Centered Care cultural transformation has been realigned with this portion of the IHOP for better integration.

Over the last four years, we have put the structure in place to bring the vision of the MI to fruition and have begun the training and process reengineering required to change clinical and business processes. Additionally, we have developed tools to monitor progress and assess the outcomes we hope to achieve – improved patient satisfaction, access, and efficiency. This is a long journey and we do not expect to see these outcomes in the short-term. We know from reviewing the literature and from benchmarking with other healthcare organizations that it takes 7-10 years to see fully realize the results of these efforts. Consequently, we have monitored intermediate milestones centered on structure and process outcomes.

Patient Aligned Care Teams

The Patient Aligned Care Team (PACT) is the cornerstone of this effort. VHA benchmarked with numerous private sector organizations that have well-developed medical home models of primary care. These models all use teams of healthcare professionals to provide comprehensive, longitudinal, and coordinated care. They usually

include behavioral health coaches to help patients learn to better manage their health and healthcare goals.

Over the past two years, we have provided resources to all VA medical centers to expand staffing of our primary care programs and set standards for our PACT teams. These teams are composed of a principle provider (physician or nurse practitioner), a RN care manager, a LPN or medical assistant, and a clerk. Clinical pharmacists, social workers, nutritionists, and behavioral health coaches support the PACT teams. Last year, we expanded this program to include our Women's Health Clinics. We have invested in training for these teams to ensure they have the skills to function as high performing medical home teams and coached them in redesigning their clinical and business processes to make this transition. By the end of this year we hope to have trained about half of all PACT teams. We have developed specific metrics, known as PACT Compass metrics, to measure our progress toward the goals that we have set for these teams. The measures include, but are not limited to, the following:

- PACT staffing ratio (structural metric)
- Primary care panel size (structural measure)
- Appointment availability within 7 days of the Desired Date (process measure)
- Same day appointment availability with the Primary care provider (process measure)
- Continuity with the assigned PACT Team (process measure)
- Follow up within 2 days of discharge (process measure)
- Ratio of telephone encounters to face-to-face encounters (process measure)
- Utilization of home telehealth, including telephone encounters with the patient's team (process measure)

Prevention

The prevention sub-initiative incorporates health promotion and disease prevention clinical interventions seamlessly across the continuum of care and is delivered in a variety of ways matched to the Veteran's needs and preferences. The long-term objective of the this effort is to reduce morbidity and premature mortality associated with unhealthy lifestyle behaviors and chronic disease and to increase overall health-related quality of life and well-being through the development and implementation of infrastructure and processes that will 1) routinely identify and offer evidence-based intervention to Veterans with risky health behaviors and poorly controlled chronic

conditions, 2) increase patient activation and involvement in managing their own health and health care, and 3) help healthy Veterans remain healthy. Through this effort, the National Center for Prevention has developed health coaching programs and established training for VHA clinicians. They have acquired a web-based Health Risk Assessment tool and the final customization is being completed. They have also developed a patient education library that will be linked to the HRA results.

Women's Health
The women's health sub-initiative addresses the needs of our current and future women Veterans population since women comprise one of the fastest growing cohorts of Veterans utilizing VA health care services. This shift in demographics has presented a challenge to the VA, and VA has intensely focused on improving access, services, resources, and facilities to make healthcare more accessible and more sensitive to gender-specific needs.

The Women's Health Program has been working through the MI to ensure that female Veterans have access to a primary care provider who can meet all of her primary care needs. This includes gender-specific and mental health care in the context of a continuous patient-clinician relationship. These primary care services also meet all the PACT requirements. Through the utilization of connected health technology (discussed below) and collaborations within the VA, this initiative will continue to improve the delivery and coordination of care for women Veterans in a timely, accessible, patient-centered manner with dignity and privacy.

Specialty Care
The specialty care sub-initiative is transforming the delivery of specialty care to truly support PACT in a Veteran-centric medical home. The specialty care sub-initiative focuses on increasing access to specialty care through programs such as Electronic Consultation (E-Consults), Specialty Care Team Based Models (SC-PACT) and Telehealth. The E-Consult processes allows specialty providers to provide consultative advice to primary care clinicians without requiring the patient to travel for a face-to-face visit. In many circumstances, the consultant can review the medical record and provide advice without seeing the patient. If the specialist feels they need to see the patient, they can always schedule an appointment. We have also put a new program in place where primary care clinicians can book an appointment into a regularly scheduled video teleconferenced

clinic with a specialist. They can bring difficult clinical problems to these sessions and get expert advice. The Specialty Care Team (SCT) is also collaborating with Telehealth Services to support the expansion of specialty telehealth programs that provide additional alternatives to face-to-face appointments; and implementing Secure Messaging as a tool for patient communication and care coordination.

Connected Health

Also central to NMOC are the various efforts we have undertaken to connect patients to a virtual world of health care services. We are greatly expanding telehealth services that will allow better monitoring of patients with chronic diseases in their homes. These services can monitor patient status and relay that information to care managers, as well as remind patients to take medication, monitor blood sugars, or adhere to other aspects of their care. We have established numerous pilots in which we are exploring ways to connect patients to services through clinical video telehealth (CVT). For example, we have a surgeon in Kansas providing post-operative care through CVT, relieving patients of having to drive long distances for simple wound checks. A team at the Portland VAMC is providing rehabilitation and prosthetics services to patients living in rural Oregon. Patients can now access these highly specialized services much closer to home. Our mental health providers have been testing our ability to provide counseling and psychotherapy over a simple webcam attached to the patient's home computer. We have also been deploying secure messaging so that patients can communicate with clinical teams by secure email. We have just begun developing mobile applications that patients can download to mobile devices to provide clinical advice or to access various services. We are developing a collection of mobile applications we call "Mobile Family Caregiver" that will be tested with family members taking care of highly disabled Veterans.

Patient Centered Care (PCC) Culture Transformation

Patient-centered care is the overarching goal of all our major initiatives, but the PCC Culture Transformation supports the specific culture change necessary to become a more patient centered healthcare system.

At the core of PCC Culture Transformation Initiative is an entirely new approach to healthcare 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

healthcare: 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 requires healthcare teams to have new skills, processes, and tools that incorporate integrative health coaching at the core of healthcare delivery.

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 the functions of each department and program office are aligned with intention and design.

Enhanced Veteran Experience and Access to Healthcare (EVEAH)

- **($35 million in 2014)**

  Most of the components of EVEAH are mature and have transitioned into normal business operations. A small component of the System Redesign sub-initiative remains to support the continued enhancement of our PACT and Specialty Care work.

  Systems Redesign Efforts

  These efforts are focused on improving the access and efficiency of VA's inpatient clinical services through modules that will ultimately connect to provide real-time utilization data. These applications, once developed and deployed, will allow VA to track inpatient bed management, emergency unit flow, and operating room workflow. Systems Redesign is working with clinicians and staff in both primary and specialty care in the Patient Aligned Care Teams (PACT) model to educate and train individuals throughout the system in the principles and techniques critical to successful implementation across the system.

Transitioned To Sustainment
The following is a brief description of the work that has now transitioned into normal business operations (sustainment).

Enhanced Veteran Experience and Access to Healthcare

Veteran Transportation Service
Expand Health Care Access for Veterans has expanded the Veteran Transportation Network from the original 4 pilots and is now active at 87 sites throughout the system. A mobility manager who coordinates scheduling as well as identifying and joining with community partners is in place in facilities as the program expands. The program is also working closely with VA's Office of Rural Health to improve the network of transportation serves that connect rural veterans and those veterans who, because of disability or infirmity, need transportation assistance to access VA services. This service provides for continuity of care for those physically infirm or disabled Veterans who often have complex medical conditions requiring healthcare services.

Personalized Patient Handbook
VHA has provided personalized healthcare benefits handbooks to the first three priority groups in 2012. It is anticipated that by April 2013, all priority groups will have received these personalized healthcare benefits handbooks. These personalized handbooks provide individualized information for Veterans to inform them of the specific healthcare services pertaining to them. This not only helps Veterans but also employees as they guide the Veterans to those services and where they may access these services. We are now working to make this handbook available electronically.

Point of Care Self Service Kiosks
Kiosks provide Veterans with the ability to check in quickly and easily using their Veterans Identification Card. Veterans may not only check into their clinic appointments but may also update their administrative information in this process, respond to a survey, be provided directions to their appointment, and print off a listing of their future appointments. While this is a significant advancement, VetLink kiosks will ultimately be capable of collecting valuable clinical data prior to the patients visit with their healthcare provider. As of February 2013, more than 1.4 million patient interactions have taken place at 754 kiosks presently installed at 16 sites and their associated CBOCs. By the end of 2013, an additional 50+ sites should have kiosks in place. Other functionality scheduled for release in 2013 includes offering patients the ability to submit a Release Of Information (ROI) form and request

beneficiary-travel reimbursement from a kiosk. We are also actively developing clinical software that includes giving patients the ability to review their outpatient medications list. This specific functionality queries pharmacy records, shows the Veteran a picture of the dispensed medication, and asks the Veteran to confirm that they are still taking it – if not, why not. The functionality is also tied to reviewing allergy records and allowing patients the ability to indicate medications not on file with the VA. We will ultimately be able to collect other clinical information about their interim health events and provide valuable patient education at the point of care. We hope that patients will ultimately be able to do this through My HealtheVet before leaving home for their appointment.

System Redesign

Our "Fix the Phones" initiative is designed as a pilot involving three networks. This ambitious project will enable Veterans to have an effective communication link with PACT teams as well as other healthcare providers in a more efficient manner. The multi-year pilot is designed to determine the best approach to a centralized call system, the data capabilities needed to support clinical operations, and the best ways to effectively ensure benefit to both Veterans and staff. The pilots have been funded and are currently operational.

Improving Veteran Mental Health

- **($11 million in 2014)**

Nearly 31% of the patients VHA sees during a given year have a mental health diagnosis, and there are increasing numbers of Veterans who are being diagnosed with both mental health conditions and co-morbid medical problems. In order to address this challenge, VHA has significantly invested in its mental health care workforce, hiring more than 7,600 new mental health care workers since 2005, and the mental health system is dedicated to provide Veteran-centered, recovery-oriented, evidence-based care.

To execute this goal VA must provide Veterans with meaningful choices among effective treatments, balancing biological and biomedical approaches to care with psychological and psychosocial strategies. Knowing that mental health is not only a function of medical care but also family and community support networks, VA works to connect Veterans with support services through technology and in their communities. VA also partners with DoD to identify and develop the most effective practices for addressing mental health issues associated with military service, and

provide the appropriate mental health services throughout the full continuum of service delivery.

Improve the Quality of Health Care while Reducing Costs

- **($6 million in 2014)**

In 2014, $6 million is provided for VA to further assess and develop efficiencies and successful practices by analyzing the delivery and reimbursement of health care within other Federal health programs, such as DoD's Defense Health Program and Medicare. This assessment will help to drive future innovation as VA strives to continually improve health outcomes, quality of care, and access to services while responsibly managing public resources.

Legislative Proposals

- **(-$30 million in 2014)**
- **(-$29 million in 2015)**

There are two new 2014 legislative proposals that have budgetary savings: VA payment for medical foster homes and Veteran Transportation Services. There are two new legislative proposals that have costs: Sunset for health professional scholarship program and waiver of 24-month eligibility requirement for emergency treatment. In addition, there are three proposals from 2013 resubmitted in 2014 that have budgetary savings: making VA a smoke-free environment, the removal of the requirement that VA reimburse certain employees appointed under title 38 for expenses incurred for continuing professional education, and clarification of breach of agreement under the Employee Incentive Scholarship Program. See the Proposed Legislation chapter (page 1G-1) for a detailed description of these proposals.

Proposed Savings

- **(-$413 million in 2014)**
- **(-$413 million in 2015)**

VA is continuing to identify savings that will result in the VA healthcare system operating more efficiently and help the Nation better meet its fiscal challenges. VA is proposing $370 million in new acquisition savings and $43 million in improved operations.

The new acquisition savings and improved operations initiatives include the following:

Acquisition Savings

- **(-$370 million in 2014)**
- **(-$370 million in 2015)**

Specific acquisition initiatives include:

- Sourcing of Generic Pharmaceuticals - VA Acquisition Regulations require the use of Federal Supply Schedule (FSS) contracts before VA makes open market purchases. The intent of this requirement was to ensure that VA pays the lowest price possible for goods and services. In practice, however, the rule has had the opposite effect, with many generic drugs available through direct contracts at prices well below FSS prices. By exempting pharmaceuticals from this requirement, VA will use spot contracts for purchasing generic pharmaceuticals to take advantage of periodic price reductions.

- Reverse Auctions – The Government Accountability Office (GAO) has approved the use of Reverse Auctions to increase efficiency and enhance competition. By increasing the use of reverse auction tools, VA will drive increased price competition into commodities and standard service contracts.

- Pharmacy Prime Vendor Discounts - VA has negotiated a new five-year contract that includes higher discounts than the previous contract.

- Increased use of Medical Surgical Prime Vendor – Increased use of this procurement method will generate rebates from the distributor, reducing VA cost for these items.

- Strategic Sourcing – Establishment of national contracts will introduce improved pricing associated with volume discounts.

- Medical Sharing Agreements – Increased negotiation of Sharing Agreement contracts under VA's title 38, § 8153 authority will result in reduced prices for medical services and support contracts.

- **Employee Travel Reduction (-$30 million in 2014 and in 2015)** – In support of the President's Campaign to Cut Waste, employee travel will be capped in 2014 and 2015 at the budgeted level for 2013. Savings were also achieved in 2013.

- **Patient-Centered Community Care (-$13 million in 2014 and in 2015)** - Patient-Centered Community Care (PC3) will provide centrally supported health care contracts throughout VHA for purchasing Non-VA Medical Care. Savings will be achieved by standardizing Non-VA Care processes and rates through contractual agreements, replacing more costly

individual authorizations for purchasing health care services from non-VA sources.

Operational Improvements

- **(-$1.262 billion in 2014)**
- **(-$1.262 billion in 2015)**

In the 2012 and 2013 President's Budgets, VA proposed six operational improvements dealing with acquisition, fee care, energy, and other administrative savings. In 2012, VA successfully completed these improvements with estimated savings of $1.2 billion, our target level. The savings from these improvements are now embedded in VA's baseline estimates of resource needs. This information is included to inform the reader and close out this effort.

Medical Care Collections Fund

In 2014, VA estimates collections of $3.064 billion, representing an increase of $223 million, 7.8% over the 2013 level.

Medical Care Collections Fund
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Medical Care Collections Fund:							
Pharmacy Co-payments	$706,784	$759,000	$724,000	$799,000	$879,000	$75,000	$80,000
3rd Party Insurance Collections	$1,745,716	$1,792,000	$1,760,000	$1,778,000	$1,791,000	$18,000	$13,000
3rd Party RX Insurance	$101,815	$33,000	$100,000	$100,000	$110,000	$0	$10,000
1st Party Other Co-payments	$183,688	$188,000	$188,000	$189,000	$190,000	$1,000	$1,000
Enhanced-Use Revenue	$9,671	$2,000	$2,000	$2,000	$2,000	$0	$0
Long-Term Care Co-Payments	$3,088	$4,000	$4,000	$4,000	$4,000	$0	$0
Comp. Work Therapy Collections	$58,835	$57,000	$57,000	$57,000	$57,000	$0	$0
Parking Fees	$3,732	$4,000	$4,000	$4,000	$4,000	$0	$0
Comp. & Pension Living Expenses	$1,559	$2,000	$2,000	$2,000	$2,000	$0	$0
Subtotal Collections	$2,814,888	$2,841,000	$2,841,000	$2,935,000	$3,039,000	$94,000	$104,000
Legislative Proposals:							
Allow VA to Release Patient info to Health Plans	$0	$34,000	$0	$35,000	$37,000	$35,000	$2,000
VA as a Participating Provider	$0	$91,000	$0	$94,000	$98,000	$94,000	$4,000
Total Collections	$2,814,888	$2,966,000	$2,841,000	$3,064,000	$3,174,000	$223,000	$110,000

1/ Collections of $2,814,887,821 were received by VA in 2012. Due to a 1-month lag in timing from when the funds are received and transferred into the Medical Services account, $2,814,245,219 was transferred to the Medical Services account in 2012, which reflect collections from September 2011 through August 2012. The funds collected in September 2012 were transferred in 2013.

The Balanced Budget Act of 1997 (P. L. 105-33) established the VA Medical Care Collections Fund (MCCF). The legislation required that amounts collected or recovered after June 30, 1997, be deposited into the MCCF and used to furnish

medical care and services to Veterans and to cover expenses incurred to collect amounts owed for the medical care and services furnished.

The VHA Chief Business Office (CBO) has implemented an expanded revenue enhancement plan including a series of 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 are 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 nearly $2.815 billion in 2012, 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 be approximately $2.841 billion in 2013. The projected challenges with growth from third party collections are attributable to current economic market conditions and a shift in workload to the over 65 population, where Veterans become Medicare eligible and VA is no longer able to bill and collect. Additionally, commercial health insurers are shifting more responsibility to the patient for health care costs including co-payments and deductibles, which VA cannot collect. Despite the current constraints affecting collections growth, VA continues to pursue opportunities for improved revenue performance as addressed by initiatives described below.

Two legislative proposals, if enacted, will enable VA to increase collections in 2014. The first allows the release of patient information and would have an estimated $35 million impact on collections. The proposal would allow VA to bill health plans for each admission or episode of care of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia, if the care is non-service connected. The second proposal would increase collections by an estimated $94 million. This proposal would require that VA 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.

Consolidated Patient Account Centers

A major driver of VA's revenue optimization strategy is the Congressionally mandated deployment of Consolidated Patient Account Centers (CPACs). In 2012, traditional VHA business office functions were consolidated into seven regional centers of excellence. This initiative has transformed VHA billing and collections activities to more closely align with industry best practices including

standardized operating processes, extensive use of business tools and increased levels of accountability at all levels of the organization.

National Revenue Contracts Office

This initiative is designed to leverage VHA's size and financial purchasing power to develop national/regional contracts for vendors who provide support for revenue-cycle activities. The CPAC Payer Relations Office (PRO) continues to aggressively pursue strategies to effectively manage relationships with third-party payers. The CPAC PRO staff is currently working on new or re-verification of existing third-party payer agreements. VHA is also providing mentoring and training to payer relations staff to improve the operationalizing of completed payer agreements.

The Revenue Contracts Management Program 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 VA's establishment of national and regional Blanket Purchase Agreements (BPA) for coding, insurance identification/verification products and services, billing, third-party account receivables follow-up, and general revenue support services to include services such as pre-registration and first party waiver packages; currently 76 BPAs are in place. VA 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, VA 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. These electronic processes require ongoing updating to maintain compliance with industry standards for Electronic Data Interchange (EDI) processing.

Medical Services
Program Resource Data

Unique Patients [1/]

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	4,389,110	4,392,645	4,460,272	4,531,287	4,586,513	71,015	55,226
Priorities 7-8	1,291,264	1,324,467	1,289,861	1,287,261	1,282,923	(2,600)	(4,338)
Subtotal Veterans	5,680,374	5,717,112	5,750,133	5,818,548	5,869,436	68,415	50,888
Non-Veterans 2/	652,717	607,925	676,576	694,470	709,382	17,894	14,912
Total Unique Patients	6,333,091	6,325,037	6,426,709	6,513,018	6,578,818	86,309	65,800

Unique Enrollees [3/]

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	6,444,197	6,498,081	6,544,536	6,663,644	6,766,636	119,108	102,992
Priorities 7-8	2,318,351	2,310,569	2,353,138	2,366,614	2,373,766	13,476	7,152
Total Enrollees	8,762,548	8,808,650	8,897,674	9,030,258	9,140,402	132,584	110,144

Users as a Percent of Enrollees

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Priorities 1-6	68.1%	67.6%	68.2%	68.0%	67.8%	-0.2%	-0.2%
Priorities 7-8	55.7%	57.3%	54.8%	54.4%	54.0%	-0.4%	-0.4%
Total Enrollees	64.8%	64.9%	64.6%	64.4%	64.2%	-0.2%	-0.2%

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for 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.

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	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Outpatient Visits (000):							
Ambulatory Care:							
Staff	74,310	76,215	77,272	79,950	82,243	2,678	2,293
Fee	12,875	13,379	13,367	13,939	14,482	572	543
Subtotal	87,185	89,594	90,639	93,889	96,725	3,250	2,836
Readjustment Counseling:							
Visits	1,505	1,508	1,540	1,574	1,637	34	63
Grand Total	88,690	91,102	92,179	95,463	98,362	3,284	2,899
Patients Treated:							
Inpatient Care	630,952	653,863	639,502	644,801	648,443	5,299	3,642
Rehabilitation Care	16,091	16,712	16,465	16,764	17,012	299	248
Mental Health Care Total	155,677	159,942	160,585	164,684	167,185	4,099	2,501
Acute Psychiatry	*98,262*	*100,463*	*99,266*	*100,231*	*100,858*	*965*	*627*
Contract Hospital (Psych)	*17,010*	*14,798*	*18,062*	*19,928*	*21,096*	*1,866*	*1,168*
Psy Residential Rehab	*7,630*	*2,156*	*7,596*	*7,562*	*7,528*	*(34)*	*(34)*
Dom Residential Rehab	*32,775*	*42,525*	*35,661*	*36,963*	*37,703*	*1,302*	*740*
Long-Term Care: Institutional	101,720	103,969	102,752	103,822	104,853	1,070	1,031
Subacute Care	2,196	1,715	1,624	1,175	860	(449)	(315)
Inpatient Facilities, Total	906,636	936,201	920,928	931,246	938,353	10,318	7,107
Average Daily Census:							
Inpatient Care	8,872	9,112	8,989	9,051	9,072	62	21
Rehabilitation Care	1,177	1,148	1,193	1,210	1,229	17	19
Mental Health Care Total	9,212	10,230	9,154	8,994	8,763	(160)	(231)
Acute Psychiatry	*2,705*	*2,781*	*2,637*	*2,548*	*2,445*	*(89)*	*(103)*
Contract Hospital (Psych)	*326*	*284*	*372*	*415*	*455*	*43*	*40*
Psy Residential Rehab	*1,091*	*803*	*881*	*651*	*453*	*(230)*	*(198)*
Dom Residential Rehab	*5,090*	*6,362*	*5,264*	*5,380*	*5,410*	*116*	*30*
Long-Term Care: Institutional	40,846	40,685	41,580	42,465	43,548	885	1,083
Subacute Care	98	69	81	67	57	(14)	(10)
Inpatient Facilities, Total	60,205	61,244	60,997	61,787	62,669	790	882
Length of Stay:							
Inpatient Care	5.1	5.1	5.1	5.1	5.1	0.0	0.0
Rehabilitation Care	26.8	25.1	26.4	26.3	26.4	(0.1)	0.1
Mental Health Care	21.7	23.3	20.8	19.9	19.1	(0.9)	(0.8)
Long-Term Care: Institutional	147.0	142.8	147.7	149.3	151.6	1.6	2.3
Subacute Care	16.3	14.7	18.2	20.7	24.1	2.5	3.4
Dental Procedures (000)	4,089	4,394	4,267	4,437	4,566	170	129
CHAMPVA/FMP/Spina Bifida:							
Outpatient Workloads (000)	12,691	11,862	13,706	14,802	15,987	1,096	1,185

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

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate 1/	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Advance Appropriation	$39,649,985	$41,354,000	$41,354,000	$43,557,000	$45,015,527	$2,203,000	$1,458,527
Transfer to North Chicago Demo. Fund, P.L. 112-74	($172,750)	$0	$0	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$21,000	$0	$0	($21,000)	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)	$0	($15,000)	($15,000)	($15,000)	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$55,350	$0	$0	$0	$0	$0	$0
Annual Appropriation Adjustment	$0	$165,000	$0	$157,500	$0	$157,500	($157,500)
Subtotal Appropriation	$39,517,585	$41,519,000	$41,360,000	$43,699,500	$45,000,527	$2,339,500	$1,301,027
Collections	$2,814,245	$2,966,000	$2,841,000	$3,064,000	$3,174,000	$223,000	$110,000
Subtotal Budget Authority	$42,331,830	$44,485,000	$44,201,000	$46,763,500	$48,174,527	$2,562,500	$1,411,027
Reimbursements:							
Sharing & Other Reimbursements	$175,699	$284,000	$287,000	$200,000	$205,000	($87,000)	$5,000
Prior Year Recoveries	$0	$3,000	$0	$0	$0	$0	$0
Subtotal	$175,699	$287,000	$287,000	$200,000	$205,000	($87,000)	$5,000
Adjustments to Obligations:							
Unobligated Balance (SOY):							
No-Year	$869,974	$200,000	$453,747	$0	$0	($453,747)	$0
H1N1 No-Year (P.L. 111-32)	$2,534	$0	$2,402	$0	$0	($2,402)	$0
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	$7,994	$0	$1,802	$0	$0	($1,802)	$0
2-Year	$135,452	$200,000	$33,480	$0	$0	($33,480)	$0
Subtotal	$1,015,954	$400,000	$491,431	$0	$0	($491,431)	$0
Unobligated Balance (EOY):							
No-Year	($453,747)	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	($2,402)	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	($1,802)	$0	$0	$0	$0	$0	$0
2-Year	($33,480)	$0	$0	$0	$0	$0	$0
Subtotal	($491,431)	$0	$0	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$524,523	$400,000	$491,431	$0	$0	($491,431)	$0
Lapse	($417)	$0	$0	$0	$0	$0	$0
Obligations	$43,031,635	$45,172,000	$44,979,431	$46,963,500	$48,379,527	$1,984,069	$1,416,027

1/Total budget authority in this account and all tables for this account that display budget authority – does not reflect $1,409 million as shown in the President's Budget Appendix. Please see explanation as provided in footnote 1/ on page 1A-37.

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

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2015 to 2015 Increase/ Decrease
Ambulatory Care	$20,957,161	$21,820,680	$21,234,630	$21,173,525	$21,053,845	($61,105)	($119,680)
Inpatient Care	$8,251,317	$8,122,920	$8,437,864	$8,719,560	$8,934,000	$281,696	$214,440
Rehabilitation Care	$459,650	$477,407	$492,977	$534,405	$573,128	$41,428	$38,723
Mental Health Care	$4,543,202	$4,462,569	$5,025,982	$5,583,732	$6,111,404	$557,750	$527,672
Long-Term Care	$5,104,542	$5,802,978	$5,723,342	$6,521,137	$6,898,648	$797,795	$377,511
Prosthetics Care	$1,790,818	$2,586,000	$1,989,332	$2,190,576	$2,397,886	$201,244	$207,310
Dental Care	$514,731	$414,666	$541,828	$577,812	$609,212	$35,984	$31,400
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,233,041	$1,290,780	$1,339,650	$1,459,852	$1,590,480	$120,202	$130,628
Readjustment Counseling	$177,171	$194,000	$193,826	$202,901	$210,924	$9,075	$8,023
Total Obligations	$43,031,633	$45,172,000	$44,979,431	$46,963,500	$48,379,527	$1,984,069	$1,416,027

FTE by Type
Medical Services

Account	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Physicians	17,200	17,508	17,775	18,238	18,661	463	423
Dentists	972	1,045	1,037	1,063	1,087	26	24
Registered Nurses	45,589	46,335	47,074	48,302	49,422	1,228	1,120
LP Nurse/LV Nurse/Nurse Assistant	22,842	23,630	23,582	24,203	24,765	621	562
Non-Physician Providers	11,094	11,201	11,454	11,753	12,026	299	273
Health Technicians/Allied Health	56,940	58,467	60,044	62,369	63,882	2,325	1,513
Wage Board/Purchase & Hire	5,383	5,681	5,523	5,729	5,861	206	132
All Other	27,293	28,510	28,263	30,008	30,679	1,745	671
Total	187,313	192,377	194,752	201,665	206,383	6,913	4,718

Medical Services*
Employment Summary, FTE by Grade

GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
SES	0	0	0	0	0	0
Title 38	72,742	75,730	78,506	80,401	2,776	1,895
15 or higher	140	145	150	153	5	3
14	622	647	670	686	23	16
13	5,781	6,017	6,236	6,386	219	150
12	12,533	13,040	13,511	13,833	471	322
11	13,261	13,668	13,970	14,183	302	213
10	2,052	2,136	2,214	2,267	78	53
9	8,275	8,614	8,929	9,144	315	215
8	4,729	4,922	5,102	5,225	180	123
7	8,717	9,073	9,404	9,630	331	226
6	24,924	25,939	26,883	27,527	944	644
5	23,740	24,706	25,603	26,215	897	612
4	3,548	3,693	3,828	3,920	135	92
3	705	733	759	777	26	18
2	116	120	124	127	4	3
1	45	46	47	48	1	1
Wage Board	5,383	5,523	5,729	5,861	206	132
Total Number of FTE	187,313	194,752	201,665	206,383	6,913	4,718

*Field FTE

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

Description:	2013 to 2014
2013 President's Budget:	
Appropriation	$41,519,000
Collections	$2,966,000
Total 2013 President's Budget	**$44,485,000**
Adjustments:	
Adjustment for current estimate of appropriation level	($165,000)
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$21,000
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)
Adjustment to Collections	($125,000)
Total Adjustments	($284,000)
Adjusted FY 2013 Budget Estimate:	
Appropriation	$41,360,000
Collections	$2,841,000
Total Adjusted 2013 Budget Estimate = 2013 Current Estimate	**$44,201,000**
2014 Current Services Increases:	
Health Care Services	$964,463
Payraise Assumption 0.5% for 1/4 FY 2014	$44,276
Payraise Assumption 1.0% for 3/4 FY 2014	$133,139
Other Non-Pay Raise Pay Accounts	$858,285
Long-Term Care	$797,795
CHAMPVA, Spina Bifida, FMP, & CWVV	$120,202
Readjustment Counseling	$9,075
Subtotal	**$2,927,235**
2014 Total Current Services	**$47,128,235**
(% increase over 2013 adjusted)	6.6%
2014 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$8,051
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$85,000
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	($6,000)
Current Major/Supporting Initiatives:	
Activations	$8,745
DoD/VA Integrated DES Enhancement	($2,408)
Strategic Planning Major Initiatives:	
Homelessness: Zero Homelessness	$40,891
New Models of Care	($175,340)
Enhanced Veterans Experience and Access	($21,962)
Improving Veteran Mental Health	($1,645)
Improve the Quality of Health Care while Reducing Costs	($44,200)
Establish World-Class Health Informatics Capability	$0
Proposed Savings:	
Acquisition Proposals	($220,000)
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	($13,000)
Corporate Office Reduction	$0
New VISN Structure	$0
2014 Total Congressional Mandates, Initiatives, & Savings	**($341,868)**
Legislative Proposals	**($22,867)**
Appropriation	$43,699,500
Collections	$3,064,000
2014 Total Budget Authority Request (appropriation + collections)	**$46,763,500**
(% increase over 2013 adjusted)	5.8%

Budget Authority Net Change
VHA Medical Services
2015 Summary of Resource Requirements
(dollars in thousands)

Description:	2014 to 2015
2013 President's Budget, 2014 Estimate:	
Appropriation	$43,557,000
Collections	$3,051,000
Total 2013 President's Budget, 2014 Estimate	**$46,608,000**
Adjustments:	
Annual Appropriation Adjustment	$157,500
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($15,000)
Adjustment to Collections	$13,000
Total Adjustments	$155,500
Adjusted FY 2014 Budget Estimate:	
Appropriation	$43,699,500
Collections	$3,064,000
Total Adjusted 2014 Budget Estimate	**$46,763,500**
2015 Current Services Increases:	
Health Care Services	$1,311,032
Payraise Assumption 1.0% for 1/4 FY 2015	$49,987
Other Non-Pay Raise Pay Accounts	$663,913
Long-Term Care	$377,511
CHAMPVA, Spina Bifida, FMP, & CWVV	$130,628
Readjustment Counseling	$8,023
Subtotal	**$2,541,094**
2015 Total Current Services	**$49,304,594**
(% increase over 2014 adjusted)	5.4%
2015 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$8,049
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$0
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$25,000
Current Major/Supporting Initiatives:	
Activations	($487,207)
DoD/VA Integrated DES Enhancement	$0
Strategic P.L.anning Major Initiatives:	
Homelessness: Zero Homelessness	($392,742)
New Models of Care	($232,287)
Enhanced Veterans Experience and Access	($35,390)
Improving Veteran Mental Health	($11,040)
Improve the Quality of Health Care while Reducing Costs	($6,000)
Establish World-Class Health Informatics Capability	$0
Proposed Savings:	
Acquisition Proposals	$0
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	$0
Corporate Office Reduction	$0
New VISN Structure	$0
2015 Total Congressional Mandates, Initiatives, & Savings	**($1,131,617)**
Legislative Proposals	**$1,550**
Appropriation	$45,000,527
Collections	$3,174,000
2015 Total Budget Authority Request (appropriation + collections)	**$48,174,527**
(% increase over 2014 adjusted)	3.0%

Obligations by Object
Medical Services
(dollars in thousands)

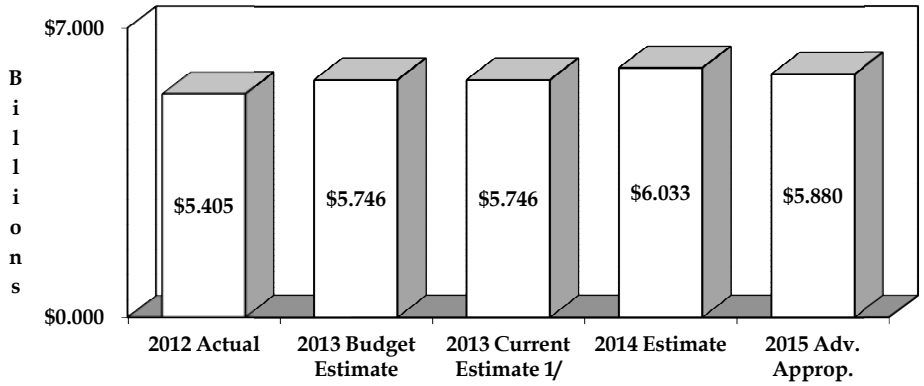
Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
10 Personal Services & Benefits:							
Physicians	$4,624,035	$4,819,200	$4,838,300	$5,049,700	$5,239,100	$211,400	$189,400
Dentists	$222,522	$244,300	$240,200	$250,500	$259,700	$10,300	$9,200
Registered Nurses	$5,282,548	$5,393,400	$5,476,900	$5,682,800	$5,847,500	$205,900	$164,700
LP Nurse/LV Nurse/Nurse Assistant	$1,465,091	$1,506,200	$1,526,600	$1,591,600	$1,646,800	$65,000	$55,200
Non-Physician Providers	$1,502,505	$1,532,700	$1,557,100	$1,615,200	$1,661,600	$58,100	$46,400
Health Technicians/Allied Health	$5,170,105	$5,342,300	$5,471,000	$5,740,600	$5,910,000	$269,600	$169,400
Wage Board/Purchase & Hire	$290,344	$308,800	$298,700	$315,800	$324,500	$17,100	$8,700
Administration	$1,760,244	$1,855,900	$1,833,800	$2,025,800	$2,089,600	$192,000	$63,800
Permanent Change of Station	$2,880	$4,400	$3,000	$3,400	$4,000	$400	$600
Employee Compensation Pay	$179,391	$211,100	$184,800	$190,700	$197,200	$5,900	$6,500
Subtotal	$20,499,664	$21,218,300	$21,430,400	$22,466,100	$23,180,000	$1,035,700	$713,900
21 Travel & Transportation of Persons:							
Employee	$52,873	$78,200	$52,800	$52,800	$52,800	$0	$0
Beneficiary	$859,735	$966,100	$903,300	$936,900	$971,000	$33,600	$34,100
Other	$24,336	$20,900	$24,300	$24,300	$24,300	$0	$0
Subtotal	$936,944	$1,065,200	$980,400	$1,014,000	$1,048,100	$33,600	$34,100
22 Transportation of Things	$10,854	$16,100	$12,300	$14,100	$15,900	$1,800	$1,800
23 Communications, Utilites & Other Rent:							
Rental of Equipment	$109,106	$104,400	$125,300	$144,100	$165,500	$18,800	$21,400
Communications	$206,736	$238,500	$227,100	$249,500	$274,100	$22,400	$24,600
Utilities	$98	$0	$0	$0	$0	$0	$0
GSA Rent	$82	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$3,288	$0	$0	$0	$0	$0	$0
Subtotal	$319,310	$342,900	$352,400	$393,600	$439,600	$41,200	$46,000
24 Printing & Reproduction:	$17,681	$27,700	$17,700	$17,700	$17,700	$0	$0
25 Other Services:							
Outpatient Dental Fees	$98,070	$115,800	$102,400	$106,900	$111,600	$4,500	$4,700
Medical & Nursing Fees	$1,603,725	$2,094,100	$1,738,000	$1,883,500	$1,958,500	$145,500	$75,000
Repairs to Furniture/Equipment	$66,499	$89,600	$71,000	$182,500	$192,300	$111,500	$9,800
Maintenance & Repair Contract Services	$8,782	$5,100	$11,200	$39,800	$44,600	$28,600	$4,800
Contract Hospital	$1,587,081	$1,919,700	$1,753,200	$1,936,800	$2,139,600	$183,600	$202,800
Community Nursing Homes	$616,511	$667,100	$662,200	$724,500	$760,900	$62,300	$36,400
Repairs to Prosthetic Appliances	$194,441	$206,600	$213,900	$235,300	$258,900	$21,400	$23,600
Home Oxygen	$156,681	$190,500	$171,400	$187,000	$202,600	$15,600	$15,600
Personal Services Contracts	$88,058	$106,900	$91,200	$94,600	$97,900	$3,400	$3,300
House Staff Disbursing Agreement	$592,663	$626,300	$636,000	$682,500	$732,400	$46,500	$49,900
Scarce Medical Specialists	$173,193	$195,300	$178,400	$183,800	$189,300	$5,400	$5,500

Obligations by Object
Medical Services
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$2,591,556	$2,637,000	$2,890,931	$2,934,500	$2,212,227	$43,569	($722,273)
Administrative Contract Services	$560,915	$749,562	$577,700	$612,300	$630,800	$34,600	$18,500
Training Contract Services	$44,238	$85,500	$45,800	$47,800	$49,500	$2,000	$1,700
CHAMPVA	$929,305	$973,100	$1,018,900	$1,112,600	$1,207,000	$93,700	$94,400
Subtotal	$9,311,718	$10,662,162	$10,162,231	$10,964,400	$10,788,127	$802,169	($176,273)
26 Supplies & Materials:							
Provisions	$111,345	$116,100	$114,900	$118,600	$122,400	$3,700	$3,800
Drugs & Medicines	$4,865,034	$4,934,600	$5,089,700	$5,349,700	$5,651,900	$260,000	$302,200
Blood & Blood Products	$73,589	$86,100	$77,000	$80,900	$85,500	$3,900	$4,600
Medical/Dental Supplies	$1,257,539	$1,468,000	$1,339,500	$1,427,700	$1,520,700	$88,200	$93,000
Operating Supplies	$136,353	$152,900	$146,200	$158,200	$169,600	$12,000	$11,400
Maintenance & Repair Supplies	$906	$0	$0	$0	$0	$0	$0
Other Supplies	$105,973	$214,538	$112,200	$118,900	$125,900	$6,700	$7,000
Prosthetic Appliances	$1,772,017	$2,081,800	$1,946,100	$2,111,300	$2,282,300	$165,200	$171,000
Home Respiratory Therapy	$40,859	$37,200	$44,800	$48,900	$53,300	$4,100	$4,400
Subtotal	$8,363,615	$9,091,238	$8,870,400	$9,414,200	$10,011,600	$543,800	$597,400
31 Equipment	$2,403,505	$1,485,600	$1,676,000	$1,077,100	$1,169,800	($598,900)	$92,700
32 Lands & Structures:							
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$6,421	$0	$0	$0	$0	$0	$0
Subtotal	$6,421	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:							
State Home	$851,942	$764,900	$975,100	$1,066,200	$1,172,600	$91,100	$106,400
Homeless Programs	$309,981	$497,900	$502,500	$536,100	$536,100	$33,600	$0
Subtotal	$1,161,923	$1,262,800	$1,477,600	$1,602,300	$1,708,700	$124,700	$106,400
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0
Total, Obligations	$43,031,635	$45,172,000	$44,979,431	$46,963,500	$48,379,527	$1,984,069	$1,416,027

Medical Support and Compliance

Medical Support and Compliance
Budgetary Resources



1/ Total budget authority for the 2013 Current Estimate – in this and all tables for this account that display budget authority – does not reflect $101 million as shown in the President's Budget Appendix, as explained in footnote 1/ on page 1A-37.

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.); $5,879,700,000, plus reimbursements, shall become available on October 1, 2014, and shall remain available until September 30, 2015: Provided, That, of the amount available under this heading, $100,000,000 shall remain available until September 30, 2016.

Appropriation Transfers

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

FY 2014 Realignment of Functions

The Budget proposes that costs of $7.989 million and 26 FTE from the VHA Office of Informatics and Analytics be funded out of the Information Technology Systems (IT) appropriation instead of the Medical Support and Compliance appropriation. VHA has determined through a detailed operational analysis that a portion of the functions of these information technology support staff are more IT in nature, and should be aligned within the Office of Information Technology. This transfer includes some funding for support contracts.

Austin Human Resources (HR) Support Services - The Budget proposes that costs of $6.346 million and 53 FTE be funded out of the Medical Support and Compliance appropriation instead of the Information Technology Systems (IT) appropriation. The Office of Information Technology (OIT) determined that the Human Resources (HR) support services staff better served VHA operations. In 2012 and 2013, the staff were supported by OIT on a reimbursable basis.

2014 Funding and 2015 Advance Appropriations Request

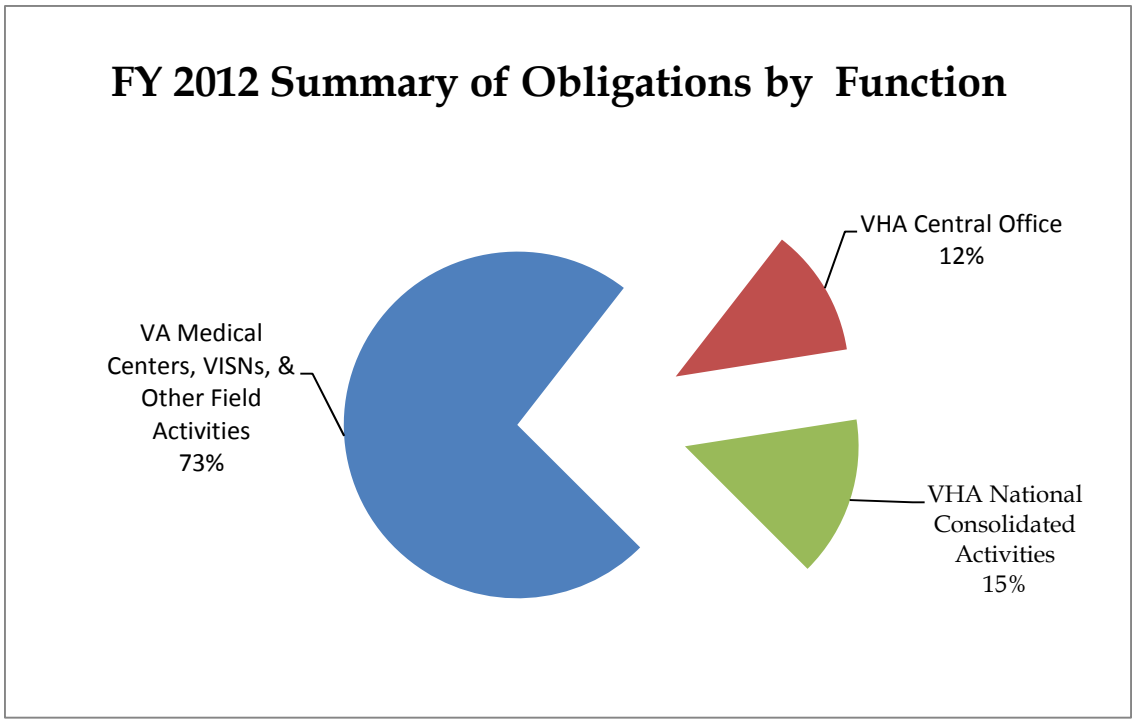
The justification for the 2014 funding and the 2015 advance appropriations request is provided in the following narrative.

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), 152 medical centers and over 1,100 clinics 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 three categories: VA Medical Centers, VISNs and Other Field Activities; VHA National Consolidated Activities; and VHA Central Office. More detailed information on each function is found below.

Below, the funding in parentheses represents the 2014 funding level and 2015 advance appropriations request on an obligation basis.

Program Resources:

- **($6.073 billion in 2014)**
- **($5.921 billion in 2015)**



VA Medical Centers, VISNs, and Other Field Activities

- **($4.433 billion in 2014)**
- **($4.433 billion in 2015)**

Medical Center Support

Provides funds for the management, operation, oversight, security, and administration of the VA's health care system located in 152 medical centers and over 1,100 clinics throughout the United States. This includes medical center management teams (Director, Chief of Staff, Chief Medical Officer, and Chief Nurse), the medical center support functions (quality of care oversight, sercurity services, legal services, billing and coding activities, acquisition, procurement, and logistics activities), human resource management, logistics and supply chain management, and financial management. Of the many functions required to operate VHA facilities, one essential function is revenue generation. This begins at the medical centers and clinics with the verification of insurance and the coding of inpatient and outpatient encounters.

Veteran Integrated Service Networks (VISN) Support

Provides funds for 21 VISN offices that deliver regional support, management and oversight to the medical centers, clinics and other field activities within their regions. This includes but is not limited to network leadership teams (Network Director, Deputy Network Director, Chief Finanical Officer, Chief Medical Officer, and Chief Information Officer) and clinical and

administrative functional 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 and integrating operations at all of the VA health care facilities within the VISN.

VHA National Consolidated Activities

- **($729 million in 2014)**
- **($686 million in 2015)**

VHA National Consolidated Activities 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 eligible dependents. The HAC provides assistance to VHA medical facilities by leading the transformation of purchased care business practices, 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
  - Foreign Medical Program

  The HAC, in partnership with the Department and the General Services Administration, is responsible for mail delivery to all VHA facilities. In addition, the HAC provides communications support, which includes translating and publishing multi-lingual documents and spearheading a comprehensive communications plan for external customers for the programs it manages. The HAC also provides 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 a Veteran's health eligibility

and facilitates the process by providing guidance to the field through training and policy development and 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 consolidated traditional revenue program functions into seven regionalized account centers. Under this model, each of the 152 VA medical centers maintains 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 (P.L. 110-387) in October 2008 which mandated national implementation of the CPAC business model by 2013. All seven centers were operational by the end of 2012, one year ahead of the date mandated by P.L. 110-387:

  Mid Atlantic CPAC — Asheville, NC (VISNs 5, 6, and 7)
  Mid South CPAC— Smyrna, TN (VISNs 9, 16, and 17)
  Florida/Caribbean CPAC — Orlando, FL (VISN 8)
  North Central CPAC — Middleton, WI (VISNs 10, 11, and 12)
  North East CPAC — Lebanon, PA (VISNs 1, 2, 3, and 4)
  Central Plains CPAC — Leavenworth, KS (VISNs 15, 19 and 23)
  West CPAC — 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 clinical, administrative, and technical employees. EES maintains accreditations with 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

- **($911 million in 2014)**
- **($802 million in 2015)**

The VHA Central Office (VHACO) provides funds for offices that provide national leadership, support, and direction to the VISNs, medical centers, clinics, other field activities, and National consolidated activities. VHACO includes the following staff offices: 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 Secretary for Health (Office for Quality, Safety and Value, Office of Nursing, Office for Workforce Services, Office of Healthcare Transformation, Office of Health Equity, and the Office of Finance), the Deputy Under Secretary for Health for Operations and Management (Office of Clinical Operations, 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 Interagency Health Affairs, the National Center for Ethics in Health Care, Office of Readjustment Counseling, Office of Health Information, and the Office of Research and Development).

Summary of Total Request, Medical Support & Compliance

(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate 1/	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2015 to 2015 Increase/ Decrease
Advanced Appropriation	$5,535,000	$5,746,000	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Transfer to North Chicago Demo. Fund, P.L. 112-74	($24,168)	$0	$0	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$0	$0	$0	$0	$0
Transfer to DOD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	($50,000)	$0	$0	$0	$0	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	($55,350)	$0	$0	$0	$0	$0	$0
Annual Appropriation Adjustment	$0	$0	$0	$0	$0	$0	$0
Subtotal Appropriation	$5,405,482	$5,746,000	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Collections	$0	$0	$0	$0	$0	$0	$0
Subtotal Budget Authority	$5,405,482	$5,746,000	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Total Budget Authority	$5,405,482	$5,746,000	$5,746,000	$6,033,000	$5,879,700	$287,000	($153,300)
Reimbursements:							
Sharing & Other Reimbursements	$37,176	$78,000	$78,000	$40,000	$41,000	($38,000)	$1,000
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Subtotal	$37,176	$78,000	$78,000	$40,000	$41,000	($38,000)	$1,000
Adjustments to Obligations:							
Unobligated Balance (SOY):							
No-Year	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	$6,378	$0	$6,114	$0	$0	($6,114)	$0
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	$2,926	$0	$1,302	$0	$0	($1,302)	$0
2-Year	$93,814	$20,000	$99,468	$0	$0	($99,468)	$0
Subtotal	$103,118	$20,000	$106,884	$0	$0	($106,884)	$0
Unobligated Balance (EOY):							
No-Year	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	($6,114)	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	($1,302)	$0	$0	$0	$0	$0	$0
2-Year	($99,468)	$0	$0	$0	$0	$0	$0
Subtotal	($106,884)	$0	$0	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	($3,766)	$20,000	$106,884	$0	$0	($106,884)	$0
Lapse	($11,487)	$0	$0	$0	$0	$0	$0
Obligations	$5,427,405	$5,844,000	$5,930,884	$6,073,000	$5,920,700	$142,116	($152,300)

1/ Total budget authority for the 2013 Current Estimate – in this and all tables for this account that display budget authority – does not reflect $101 million as shown in the President's Budget Appendix, as explained in footnote 1/on page 1A-37.

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

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2015 to 2015 Increase/ Decrease
Ambulatory Care	$2,664,938	$2,778,300	$3,149,700	$3,279,869	$3,122,975	$130,169	($156,894)
Inpatient Care	$1,054,070	$1,265,104	$1,053,899	$1,053,899	$1,054,578	$0	$679
Rehabilitation Care	$76,426	$90,301	$76,416	$76,416	$76,456	$0	$40
Mental Health Care	$720,135	$850,169	$720,000	$720,000	$720,535	$0	$535
Long-Term Care	$591,516	$666,764	$591,405	$591,405	$591,846	$0	$441
Prosthetics Care	$158,077	$0	$158,042	$158,042	$158,181	$0	$139
Dental Care	$85,251	$104,458	$85,237	$85,237	$85,294	$0	$57
CHAMPVA, Spina Bifida, FMP, & CWVV	$76,892	$88,904	$96,085	$108,034	$110,737	$11,949	$2,703
Readjustment Counseling	$100	$0	$100	$98	$98	($2)	$0
Total Obligations	$5,427,405	$5,844,000	$5,930,884	$6,073,000	$5,920,700	$142,116	($152,300)

FTE by Type
Medical Support and Compliance

Account	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Adv. Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
Physicians	604	565	620	636	651	16	15
Dentists	13	13	13	13	13	0	0
Registered Nurses	2,843	2,827	2,917	2,993	3,063	76	70
LP Nurse/LV Nurse/Nurse Assistant	204	79	209	214	219	5	5
Non-Physician Providers	84	197	86	88	90	2	2
Health Technicians/Allied Health	1,141	1,062	1,171	1,202	1,230	31	28
Wage Board/Purchase & Hire	892	900	915	939	961	24	22
All Other	41,240	40,171	42,673	43,844	44,883	1,171	1,039
Total	47,021	45,814	48,604	49,929	51,110	1,325	1,181

Medical Support & Compliance
Employment Summary, FTE by Grade
VA Medical Centers, VISNs, & Other Field Activities

GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
SES	130	135	139	143	4	4
Title 38	3,116	3,225	3,333	3,428	108	95
15 or higher	249	257	266	274	9	8
14	994	1,029	1,064	1,094	35	30
13	2,475	2,562	2,648	2,724	86	76
12	3,692	3,821	3,949	4,062	128	113
11	3,570	3,695	3,818	3,928	123	110
10	131	136	140	144	4	4
9	3,631	3,758	3,883	3,995	125	112
8	1,892	1,959	2,024	2,082	65	58
7	5,791	5,994	6,193	6,371	199	178
6	6,231	6,452	6,665	6,857	213	192
5	3,684	3,813	3,940	4,053	127	113
4	1,870	1,935	2,000	2,057	65	57
3	205	212	219	226	7	7
2	58	60	62	64	2	2
1	11	11	12	12	1	0
Wage Board	891	914	938	960	24	22
Total Number of FTE	38,621	39,968	41,293	42,474	1,325	1,181

Medical Support & Compliance
Employment Summary, FTE by Grade
VHA National Consolidated Activities

GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
SES	0	0	0	0	0	0
Title 38	329	340	340	340	0	0
15 or higher	104	107	107	107	0	0
14	318	329	329	329	0	0
13	673	695	695	695	0	0
12	513	530	530	530	0	0
11	498	515	515	515	0	0
10	5	5	5	5	0	0
9	597	617	617	617	0	0
8	236	244	244	244	0	0
7	1,748	1,806	1,806	1,806	0	0
6	1,092	1,128	1,128	1,128	0	0
5	847	875	875	875	0	0
4	118	122	122	122	0	0
3	22	23	23	23	0	0
2	0	0	0	0	0	0
1	0	0	0	0	0	0
Wage Board	0	0	0	0	0	0
Total Number of FTE	7,100	7,336	7,336	7,336	0	0

Medical Support & Compliance
Employment Summary, FTE by Grade
VHA Central Office

GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
SES	32	32	32	32	0	0
Title 38	183	183	183	183	0	0
15 or higher	118	118	118	118	0	0
14	359	359	359	359	0	0
13	272	272	272	272	0	0
12	120	120	120	120	0	0
11	103	103	103	103	0	0
10	1	1	1	1	0	0
9	52	52	52	52	0	0
8	6	6	6	6	0	0
7	37	37	37	37	0	0
6	12	12	12	12	0	0
5	4	4	4	4	0	0
4	0	0	0	0	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	1,300	1,300	1,300	1,300	0	0

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

Description:	2013 to 2014
2013 President's Budget:	
Appropriation	$5,746,000
Collections	$0
Total 2013 President's Budget	**$5,746,000**
Adjustments:	
Adjustment for current estimate of appropriation level	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	$0
Adjustment to Collections	$0
Total Adjustments	$0
Adjusted FY 2013 Budget Estimate:	
Appropriation	$5,746,000
Collections	$0
Total Adjusted 2013 Budget Estimate = 2013 Current Estimate	**$5,746,000**
2014 Current Services Increases:	
Health Care Services	$218,184
Payraise Assumption 0.5% for 1/4 FY 2014	$9,313
Payraise Assumption 1.0% for 3/4 FY 2014	$28,164
Other Non-Pay Raise Pay Accounts	$122,323
Long-Term Care	$0
CHAMPVA, Spina Bifida, FMP, & CWVV	$11,949
Readjustment Counseling	($2)
Subtotal	**$389,931**
2014 Total Current Services	**$6,135,931**
(% increase over 2013 adjusted)	6.8%
2014 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$118
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$0
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$0
Current Major/Supporting Initiatives:	
Activations	$847
DoD/VA Integrated DES Enhancement	($543)
Strategic Planning Major Initiatives:	
Homelessness: Zero Homelessness	$0
New Models of Care	($14,032)
Enhanced Veterans Experience and Access	($1,638)
Improving Veteran Mental Health	($901)
Improve the Quality of Health Care while Reducing Costs	($482)
Establish World-Class Health Informatics Capability	($37,300)
Proposed Savings:	
Acquisition Proposals	$0
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	$0
Corporate Office Reduction	($24,000)
New VISN Structure	($25,000)
2014 Total Congressional Mandates, Initiatives, & Savings	**($102,931)**
Legislative Proposals	**$0**
Appropriation	$6,033,000
Collections	$0
2014 Total Budget Authority Request (appropriation + collections)	**$6,033,000**
(% increase over 2013 adjusted)	5.0%

Budget Authority Net Change
VHA Medical Support and Compliance
2015 Summary of Resource Requirements
(dollars in thousands)

Description:	2014 to 2015
2013 President's Budget, 2014 Estimate:	
Appropriation	$6,033,000
Collections	$0
Total 2013 President's Budget, 2014 Estimate	**$6,033,000**
Adjustments:	
Annual Appropriation Adjustment	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	$0
Adjustment to Collections	$0
Total Adjustments	$0
Adjusted FY 2014 Budget Estimate:	
Appropriation	$6,033,000
Collections	$0
Total Adjusted 2014 Budget Estimate	**$6,033,000**
2015 Current Services Increases:	
Health Care Services	($209,819)
Payraise Assumption 1.0% for 1/4 FY 2015	$10,471
Other Non-Pay Raise Pay Accounts	$117,229
Long-Term Care	$441
CHAMPVA, Spina Bifida, FMP, & CWVV	$2,703
Readjustment Counseling	$0
Subtotal	**($78,975)**
2015 Total Current Services	**$5,954,025**
(% increase over 2014 adjusted)	-1.3%
2015 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$118
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$0
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$0
Current Major/Supporting Initiatives:	
Activations	($47,176)
DoD/VA Integrated DES Enhancement	$0
Strategic P.L.anning Major Initiatives:	
Homelessness: Zero Homelessness	$0
New Models of Care	($18,589)
Enhanced Veterans Experience and Access	($2,639)
Improving Veteran Mental Health	($6,039)
Improve the Quality of Health Care while Reducing Costs	$0
Establish World-Class Health Informatics Capability	$0
Proposed Savings:	
Acquisition Proposals	$0
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	$0
Corporate Office Reduction	$0
New VISN Structure	$0
2015 Total Congressional Mandates, Initiatives, & Savings	**($74,325)**
Legislative Proposals	**$0**
Appropriation	$5,879,700
Collections	$0
2015 Total Budget Authority Request (appropriation + collections)	**$5,879,700**
(% increase over 2014 adjusted)	-2.5%

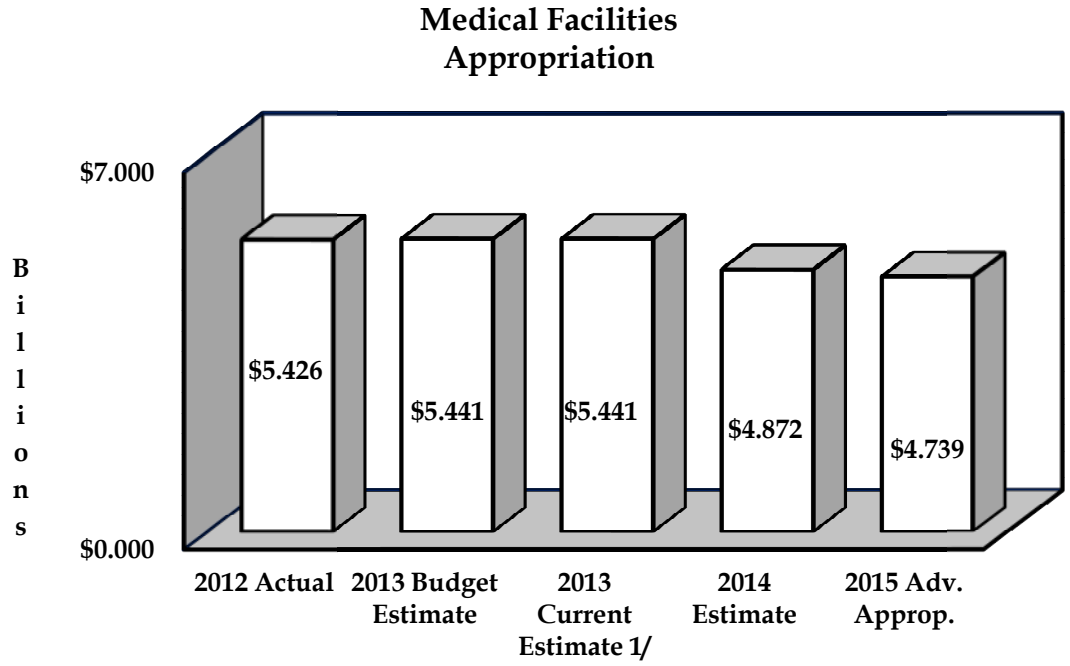
Obligations by Object
Medical Support and Compliance
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
10 Personal Services & Benefits:							
Physicians	$169,538	$170,700	$175,200	$181,800	$187,600	$6,600	$5,800
Dentists	$3,443	$3,300	$3,600	$3,800	$4,000	$200	$200
Registered Nurses	$350,286	$356,000	$361,600	$376,000	$387,900	$14,400	$11,900
LP Nurse/LV Nurse/Nurse Assistant	$4,810	$4,400	$4,800	$4,900	$4,900	$100	$0
Non-Physician Providers	$31,106	$29,900	$32,200	$33,700	$35,100	$1,500	$1,400
Health Technicians/Allied Health	$114,417	$105,900	$117,600	$121,600	$124,800	$4,000	$3,200
Wage Board/Purchase & Hire	$52,767	$53,700	$54,400	$56,500	$58,200	$2,100	$1,700
Administration	$3,227,692	$3,169,300	$3,352,300	$3,481,100	$3,582,300	$128,800	$101,200
Permanent Change of Station	$11,815	$12,900	$12,400	$13,000	$13,700	$600	$700
Employee Compensation Pay	$29,489	$34,000	$31,000	$32,500	$34,100	$1,500	$1,600
Subtotal	$3,995,363	$3,940,100	$4,145,100	$4,304,900	$4,432,600	$159,800	$127,700
21 Travel & Transportation of Persons:							
Employee	$62,847	$79,200	$62,800	$62,800	$62,800	$0	$0
Beneficiary	$80	$0	$0	$0	$0	$0	$0
Other	$4,548	$4,100	$4,600	$4,600	$4,600	$0	$0
Subtotal	$67,475	$83,300	$67,400	$67,400	$67,400	$0	$0
22 Transportation of Things	$11,329	$14,700	$11,600	$11,900	$12,200	$300	$300
23 Communications, Utilites & Other Rent:							
Rental of Equipment	$36,547	$34,100	$39,300	$42,300	$45,500	$3,000	$3,200
Communications	$80,457	$88,400	$86,100	$92,200	$98,700	$6,100	$6,500
Utilities	$3	$0	$0	$0	$0	$0	$0
GSA Rent	$481	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$1,000	$0	$0	$0	$0	$0	$0
Subtotal	$118,488	$122,500	$125,400	$134,500	$144,200	$9,100	$9,700
24 Printing & Reproduction:	$14,495	$31,607	$14,500	$14,500	$14,500	$0	$0
25 Other Services:							
Outpatient Dental Fees	$0	$0	$0	$0	$0	$0	$0
Medical & Nursing Fees	$5,357	$5,400	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$3,506	$3,400	$3,800	$4,100	$4,500	$300	$400
Maintenance & Repair Contract Services	$233	$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	$1	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$6,468	$8,400	$6,700	$6,900	$7,100	$200	$200
House Staff Disbursing Agreement	$454	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$1	$0	$0	$0	$0	$0	$0

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

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$15,951	$13,600	$17,300	$18,800	$20,400	$1,500	$1,600
Administrative Contract Services	$975,497	$1,292,939	$1,327,684	$1,295,400	$996,600	($32,284)	($298,800)
Training Contract Services	$13,952	$16,700	$14,000	$14,000	$14,000	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,021,420	$1,340,439	$1,369,484	$1,339,200	$1,042,600	($30,284)	($296,600)
26 Supplies & Materials:							
Provisions	$2,284	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$41	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$1,421	$0	$0	$0	$0	$0	$0
Operating Supplies	$32,480	$34,100	$33,500	$34,500	$35,500	$1,000	$1,000
Maintenance & Repair Supplies	$298	$0	$0	$0	$0	$0	$0
Other Supplies	$71,740	$120,854	$73,900	$76,100	$78,400	$2,200	$2,300
Prosthetic Appliances	$2	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0
Subtotal	$108,266	$154,954	$107,400	$110,600	$113,900	$3,200	$3,300
31 Equipment	$89,188	$156,400	$90,000	$90,000	$93,300	$0	$3,300
32 Lands & Structures:							
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$1,381	$0	$0	$0	$0	$0	$0
Subtotal	$1,381	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:							
State Home	$0	$0	$0	$0	$0	$0	$0
Homeless Programs	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0
Total, Obligations	$5,427,405	$5,844,000	$5,930,884	$6,073,000	$5,920,700	$142,116	($152,300)

Medical Facilities



1/Total budget authority in this account and all tables for this account that display budget authority – does not reflect $252 million as shown in the President's Budget Appendix. Please see explanation as provided in footnote 1/ on page 1A-37.

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, $4,739,000,000, plus reimbursements, shall become available on October 1, 2014, and shall remain available until September 30, 2015: Provided, That, of the amount made

available under this heading, $250,000,000 shall remain available until September 30, 2016.

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

FY 2014 Realignment of Functions

- **Biomedical Engineering Services –** As with the 2014 advance appropriation request, the 2014 President's Budget 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.

2014 Funding and 2015 Advance Appropriations Request

The justification for the 2014 funding and the 2015 advance appropriations request is provided in the following narrative.

The Medical Facilities 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.

Medical Facilities funding will support research and development 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.

VHA operates approximately 5,435 owned buildings on 15,735 acres of land and over 1,600 leases, spanning more than 1,750 locations, with over 145 million owned square feet and 14 million leased square feet in its portfolio. In total, Medical Facilities employed 23,321 FTE and obligated $5.409 billion in 2012. Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations which are covered in a separate volume.

Below, the funding in parentheses represents the 2014 fundign level and 2015 advance appropriations request on an obligation basis.

Program Resources

- **($4.897 billion in 2014)**
- **($4.765 billion in 2015)**

The programmatic needs in this section reflect VA operational changes that impact resources in 2014 and 2015. 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

- **($160 million in 2014)**
- **($26 million in 2015)**

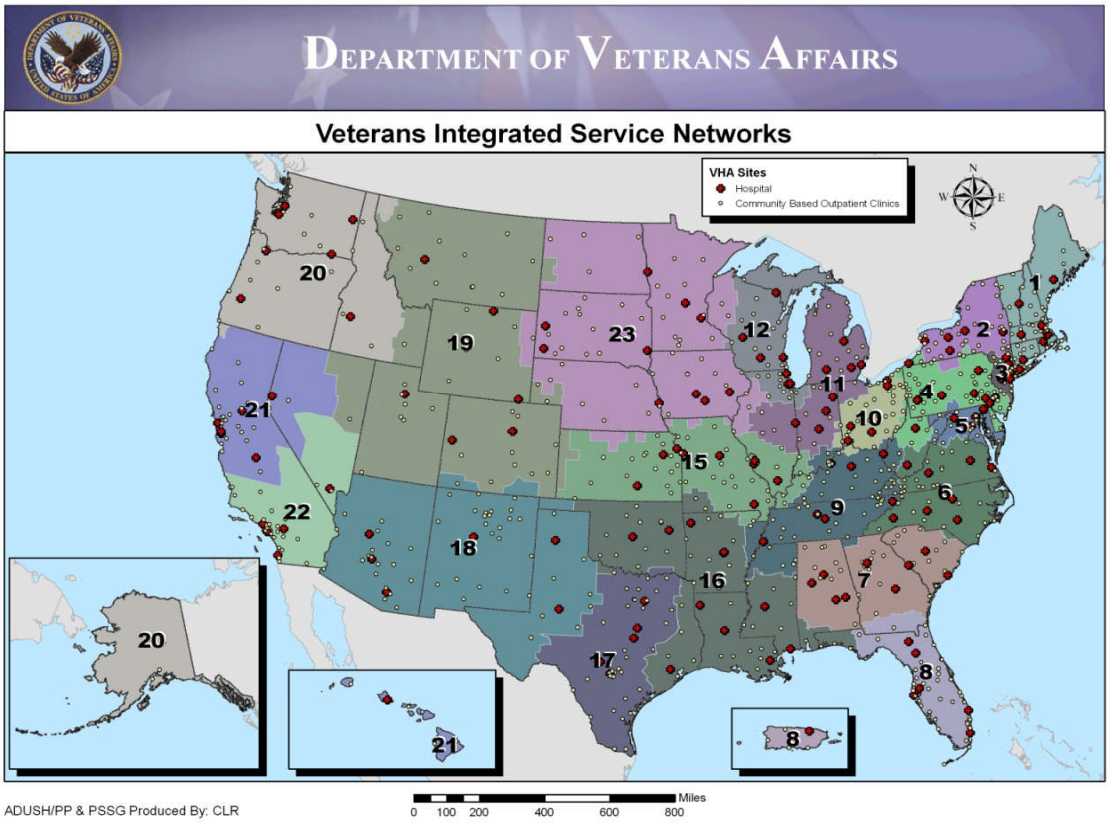
Facility activiations provide non-recurring (equipment and supplies) and recurring (additional personnel) costs associated with the activation of completed construction of new or replacement medical care facilities. Resources include assumed rates for medical equipment and furniture reuse based on the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

Zero Homelessness

- **($71 million in 2014)**
- **($71 million in 2015)**

VA, in concert with the United States Interagency Council on Homelessness, is taking decisive action toward the 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;

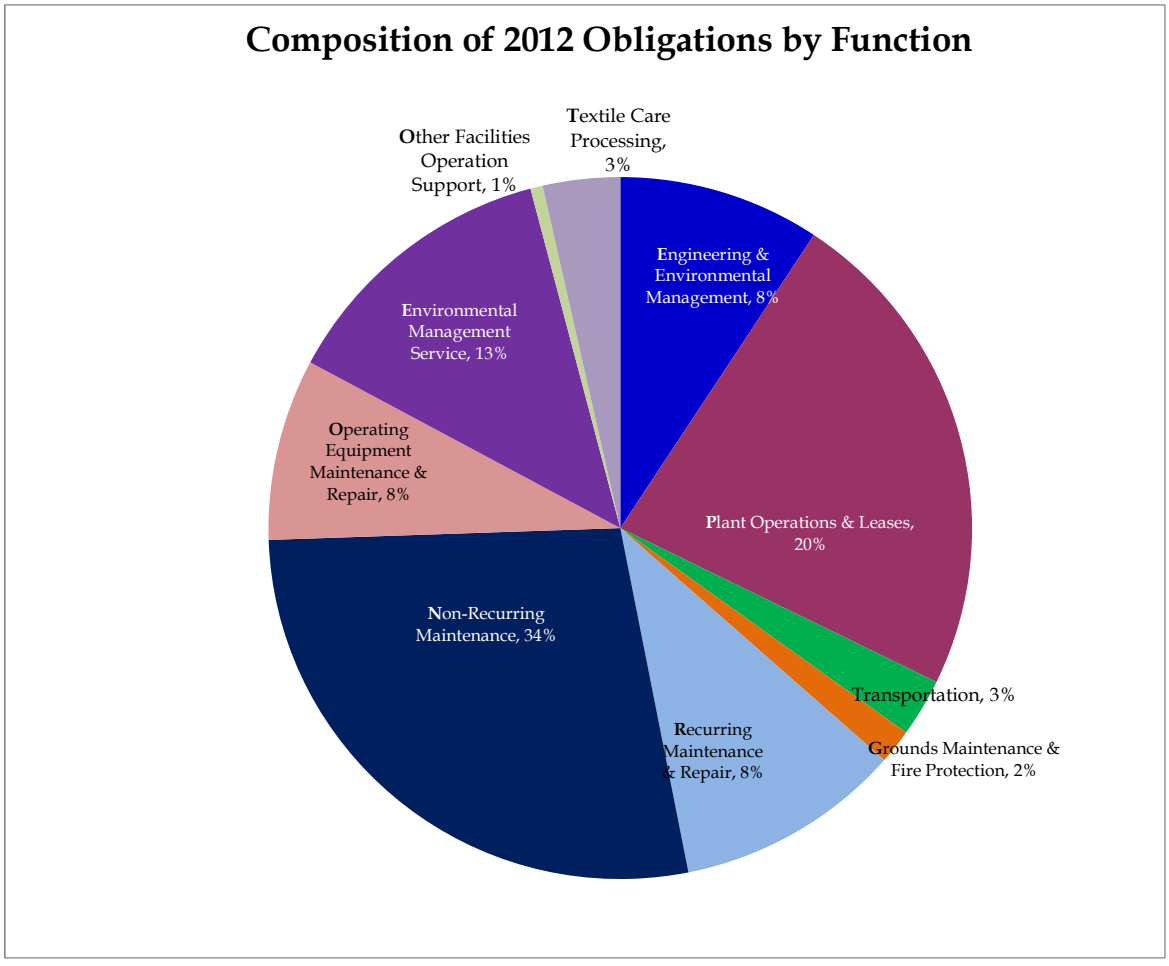
needed treatment and support services; homeless prevention services; opportunities to return to employment; and benefits assistance. The initiative of eliminating Veteran homelessness is built upon 6 strategies: Outreach/ Education, Treatment, Prevention, Housing/Supportive Services, Income/Employment/ Benefits, and Community Partnerships.



Medical Care
Number of Installations

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase / Decrease	2014 to 2015 Increase / Decrease
Veterans Integrated Service Networks	21	21	21	21	21	0	0
VA Hospitals	152	153	152	152	152	0	0
VA Community Living Centers	133	133	133	133	133	0	0
VA Domiciliary Resid. Rehab. Trt. Prgs	107	112	110	110	112	0	2
Independent Outpatient Clinics	6	6	6	6	6	0	0
Mobile Outpatient Clinics	11	11	11	11	11	0	0
Vet Centers 1/	300	300	300	300	300	0	0
Mobile Vet Centers	70	70	70	70	70	0	0
Community-Based Outpatient Clinics	821	828	840	850	851	10	1

1/ 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 3,003 FTE and resulted in $502 million in obligations in 2012.

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 2012, plant operations and leases employed 1,384 FTE and were supported by $1.242 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 2012 these activities involved 1,088 FTE and obligated a total of $144 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 2012, grounds maintenance services and the fire protection unit employed 733 FTE and obligated a total of $86 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 2012, these projects were supported by 3,313 FTE with obligations of $563 million.

Non-Recurring Maintenance (NRM)
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 1,000 square feet of new space), up to $10 million for renovations, and no upper limit for pure infrastructure projects. NRM projects improve and modernize existing facilities, demolition vacant buildings, and upgrade and replace infrastructure systems to ensure safe, state-of-the-art facilities. Examples include renovations of inpatient wards to private rooms or clinics; upgrades to safety, security, and fire alarms; improving accessibility for patients with disabilities;

improvements to the heating, ventilation, and air conditioning; and projects to improve the roads or grounds.

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.

In 2012, NRM projects were supported by 122 FTE and obligated $1.491 billion.

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 2012 was 2,010 with total obligations of $452 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 2012, these projects were supported by 936 FTE with obligations of $180 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 2012 biomedical engineering employed 1,074 FTE and obligated $272 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 2012, Environmental Management Service used 10,358 FTE and obligated $707 million.

Other Facilities Operation Support
This function obligated $31 million in 2012. 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 2012, the textile care processing and management was supported by 1,310 FTE with costs totaling $192 million.

Summary of Obligations by Functional Area
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Inc / Dec	2014 to 2015 Inc / Dec
Engineering & Environmental Management	$501,955	$530,200	$513,019	$454,410	$442,162	($58,609)	($12,248)
Plant Operations & Leases	$1,241,603	$1,788,550	$1,457,642	$1,764,070	$1,946,585	$306,428	$182,515
Transportation	$144,310	$151,400	$147,491	$130,641	$127,120	($16,850)	($3,521)
Grounds Maintenance & Fire Protection	$86,027	$92,100	$87,924	$77,879	$75,780	($10,045)	($2,099)
Recurring Maintenance & Repair	$563,098	$507,000	$575,509	$509,762	$496,021	($65,747)	($13,741)
Non-Recurring Maintenance	$1,491,107	$710,450	$1,335,300	$709,800	$460,600	($625,500)	($249,200)
Operating Equipment Maintenance & Repair	$451,824	$472,600	$461,783	$409,028	$398,002	($52,755)	($11,026)
Environmental Management Service	$707,084	$930,800	$722,670	$640,110	$622,856	($82,560)	($17,254)
Other Facilities Operation Support	$30,819	$148,100	$31,499	$27,900	$27,148	($3,599)	($752)
Textile Care Processing	$191,543	$232,800	$195,764	$173,400	$168,726	($22,364)	($4,674)
Total Obligations	$5,409,370	$5,564,000	$5,528,601	$4,897,000	$4,765,000	($631,601)	($132,000)

Medical Facilities
Program Resource Data

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

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate 1/	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase / Decrease	2014 to 2015 Increase / Decrease
Advance Appropriation	$5,426,000	$5,441,000	$5,441,000	$4,872,000	$4,739,000	($569,000)	($133,000)
Transfer to North Chicago Demo. Fund, P.L. 112-74	($37,162)	$0	$0	$0	$0	$0	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$0	$0	$6,000	$0	$0	($6,000)	$0
Transfer to DOD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	$0	$0	$0	$0	$0	$0	$0
Transfer fr Support & Compliance (1%), P.L. 112-74	$0	$0	$0	$0	$0	$0	$0
Annual Appropriation Adjustment	$0	$0	$0	$0	$0	$0	$0
Subtotal Appropriation	$5,388,838	$5,441,000	$5,447,000	$4,872,000	$4,739,000	($575,000)	($133,000)
Collections	$0	$0	$0	$0	$0	$0	$0
Total Budget Authority	$5,388,838	$5,441,000	$5,447,000	$4,872,000	$4,739,000	($575,000)	($133,000)
Reimbursements:							
Sharing & Other Reimbursements	$17,469	$43,000	$43,000	$25,000	$26,000	($18,000)	$1,000
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Subtotal	$17,469	$43,000	$43,000	$25,000	$26,000	($18,000)	$1,000
Adjustments to Obligations:							
Unobligated Balance (SOY):							
No-Year	$1,919	$0	$2,437	$0	$0	($2,437)	$0
H1N1 No-Year (P.L. 111-32)	$285	$0	$211	$0	$0	($211)	$0
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	$763	$0	$3,025	$0	$0	($3,025)	$0
2-Year	$40,502	$80,000	$32,928	$0	$0	($32,928)	$0
Subtotal	$43,469	$80,000	$38,601	$0	$0	($38,601)	$0
Unobligated Balance (EOY):							
No-Year	($2,437)	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	($211)	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental (P.L. 110-28) (No-Yr)	($3,025)	$0	$0	$0	$0	$0	$0
2-Year	($32,928)	$0	$0	$0	$0	$0	$0
Subtotal	($38,601)	$0	$0	$0	$0	$0	$0
Change in Unobligated Balance (Non-Add)	$4,868	$80,000	$38,601	$0	$0	($38,601)	$0
Lapse	($1,805)	$0	$0	$0	$0	$0	$0
Obligations	$5,409,370	$5,564,000	$5,528,601	$4,897,000	$4,765,000	($631,601)	($132,000)

1/Total budget authority in this account and all tables for this account that display budget authority – does not reflect $252 million as shown in the President's Budget Appendix. Please see explanation as provided in footnote 1/ on page 1A-37.

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

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase / Decrease	2014 to 2015 Increase / Decrease
Categories:							
Ambulatory Care	$2,569,049	$2,408,460	$2,765,441	$2,439,139	$2,443,254	($326,302)	$4,115
Inpatient Care	$1,113,384	$1,153,113	$1,081,237	$955,541	$899,422	($125,696)	($56,119)
Rehabilitation Care	$78,762	$83,292	$76,607	$68,179	$64,416	($8,428)	($3,763)
Mental Health Care	$781,396	$891,151	$758,809	$670,492	$631,061	($88,317)	($39,431)
Long-Term Care	$609,708	$751,214	$592,094	$523,222	$492,473	($68,872)	($30,749)
Prosthetics Care	$133,456	$0	$132,626	$129,382	$127,933	($3,244)	($1,449)
Dental Care	$90,488	$242,876	$87,935	$77,951	$73,494	($9,984)	($4,457)
CHAMPVA, Spina Bifida, FMP, & CWVV	$4,778	$5,894	$5,778	$6,093	$6,425	$315	$332
Readjustment Counseling	$28,349	$28,000	$28,074	$27,001	$26,522	($1,073)	($479)
Total Obligations	$5,409,370	$5,564,000	$5,528,601	$4,897,000	$4,765,000	($631,601)	($132,000)

FTE by Type
Medical Facilities

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase / Decrease	2014 to 2015 Increase / Decrease
Physicians	0	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	1	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	0	0	0	0	0	0	0
Non-Physician Providers	1	0	0	0	0	0	0
Health Technicians/Allied Health	118	126	121	119	122	(2)	3
Wage Board/Purchase & Hire	18,126	19,804	18,840	19,265	19,710	425	445
All Other	5,075	4,791	5,207	4,330	4,455	(877)	125
Total Obligations	23,321	24,721	24,168	23,714	24,287	(454)	573

Medical Facilities
Employment Summary, FTE by Grade

GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2015 Estimate	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
SES	0	0	0	0	0	0
Title 38	156	160	133	137	(27)	4
15 or higher	0	0	0	0	0	0
14	140	144	120	124	(24)	4
13	585	600	503	517	(97)	14
12	1,004	1,030	861	885	(169)	24
11	1,428	1,464	1,220	1,257	(244)	37
10	94	96	81	83	(15)	2
9	466	478	400	411	(78)	11
8	42	43	36	37	(7)	1
7	441	452	377	388	(75)	11
6	339	348	290	298	(58)	8
5	264	271	226	232	(45)	6
4	103	106	88	91	(18)	3
3	120	123	103	106	(20)	3
2	8	8	7	7	(1)	0
1	5	5	4	4	(1)	0
Wage Board	18,126	18,840	19,265	19,710	425	445
Total Number of FTE	23,321	24,168	23,714	24,287	(454)	573

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

Description:	2013 to 2014
2013 President's Budget:	
Appropriation	$5,441,000
Collections	$0
Total 2013 President's Budget	**$5,441,000**
Adjustments:	
Adjustment for current estimate of appropriation level	$0
Disaster Relief Appropriations Act, 2013 P.L. 113-2	$6,000
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	$0
Adjustment to Collections	$0
Total Adjustments	$6,000
Adjusted FY 2013 Budget Estimate:	
Appropriation	$5,447,000
Collections	$0
Total Adjusted 2013 Budget Estimate = 2013 Current Estimate	**$5,447,000**
2014 Current Services Increases:	
Health Care Services	($436,586)
Payraise Assumption 0.5% for 1/4 FY 2014	$3,774
Payraise Assumption 1.0% for 3/4 FY 2014	$11,425
Other Non-Pay Raise Pay Accounts	($79,399)
Long-Term Care	($68,872)
CHAMPVA, Spina Bifida, FMP, & CWVV	$315
Readjustment Counseling	($1,073)
Subtotal	**($570,416)**
2014 Total Current Services	**$4,876,584**
(% increase over 2013 adjusted)	-10.5%
2014 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$2
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$0
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$0
Current Major/Supporting Initiatives:	
Activations	$2,408
DoD/VA Integrated DES Enhancement	($49)
Strategic Planning Major Initiatives:	
Homelessness: Zero Homelessness	$0
New Models of Care	($5,225)
Enhanced Veterans Experience and Access	($1,224)
Improving Veteran Mental Health	($21)
Improve the Quality of Health Care while Reducing Costs	($475)
Establish World-Class Health Informatics Capability	$0
Proposed Savings:	
Acquisition Proposals	$0
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	$0
Corporate Office Reduction	$0
New VISN Structure	$0
2014 Total Congressional Mandates, Initiatives, & Savings	**($4,584)**
Legislative Proposals	**$0**
Appropriation	$4,872,000
Collections	$0
2014 Total Budget Authority Request (appropriation + collections)	**$4,872,000**
(% increase over 2013 adjusted)	-10.6%

Budget Authority Net Change
VHA Medical Facilities
2015 Summary of Resource Requirements
(dollars in thousands)

Description:	2014 to 2015
2013 President's Budget, 2014 Estimate:	
Appropriation	$4,872,000
Collections	$0
Total 2013 President's Budget, 2014 Estimate	**$4,872,000**
Adjustments:	
Annual Appropriation Adjustment	$0
Transfer to DoD-VA Hlth Care Svcs Incentive Fund, P.L. 111-84	$0
Adjustment to Collections	$0
Total Adjustments	$0
Adjusted FY 2014 Budget Estimate:	
Appropriation	$4,872,000
Collections	$0
Total Adjusted 2014 Budget Estimate	**$4,872,000**
2015 Current Services Increases:	
Health Care Services	($4,801)
Payraise Assumption 1.0% for 1/4 FY 2015	$4,270
Other Non-Pay Raise Pay Accounts	$41,630
Long-Term Care	($30,749)
CHAMPVA, Spina Bifida, FMP, & CWVV	$332
Readjustment Counseling	($479)
Subtotal	**$10,203**
2015 Total Current Services	**$4,882,203**
(% increase over 2014 adjusted)	0.2%
2015 Congressional Mandates, Initiatives, & Savings:	
Congressional Mandates:	
Caregivers & Veterans Omnibus Hlth Svcs (P.L. 111-163)	$3
Affordable Care Act (P.L. 111-148/P.L. 111-152)	$0
Indian Health Services (P.L. 111-148)	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$0
Current Major/Supporting Initiatives:	
Activations	($134,168)
DoD/VA Integrated DES Enhancement	$0
Strategic P.L.anning Major Initiatives:	
Homelessness: Zero Homelessness	$0
New Models of Care	($6,922)
Enhanced Veterans Experience and Access	($1,971)
Improving Veteran Mental Health	($145)
Improve the Quality of Health Care while Reducing Costs	$0
Establish World-Class Health Informatics Capability	$0
Proposed Savings:	
Acquisition Proposals	$0
Travel Campaign to Cut Waste	$0
Patient-Centered Community Care	$0
Corporate Office Reduction	$0
New VISN Structure	$0
2015 Total Congressional Mandates, Initiatives, & Savings	**($143,203)**
Legislative Proposals	**$0**
Appropriation	$4,739,000
Collections	$0
2015 Total Budget Authority Request (appropriation + collections)	**$4,739,000**
(% increase over 2014 adjusted)	-2.7%

Obligations by Object
Medical Facilities
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
10 Personal Services & Benefits:							
Physicians	$13	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$108	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$46	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$26	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$7,495	$8,300	$7,700	$0	$0	($7,700)	$0
Wage Board/Purchase & Hire	$1,109,897	$1,178,800	$1,161,600	$1,202,000	$1,240,400	$40,400	$38,400
Administration	$453,044	$480,500	$463,800	$366,100	$373,000	($97,700)	$6,900
Permanent Change of Station	$812	$3,900	$900	$700	$700	($200)	$0
Employee Compensation Pay	$26,396	$33,400	$27,700	$28,700	$29,300	$1,000	$600
Subtotal	$1,597,837	$1,704,900	$1,661,700	$1,597,500	$1,643,400	($64,200)	$45,900
21 Travel & Transportation of Persons:							
Employee	$6,211	$7,600	$6,000	$6,000	$6,000	$0	$0
Beneficiary	$64	$0	$0	$0	$0	$0	$0
Other	$27,299	$25,600	$27,000	$27,000	$27,000	$0	$0
Subtotal	$33,574	$33,200	$33,000	$33,000	$33,000	$0	$0
22 Transportation of Things	$14,936	$16,600	$15,500	$16,000	$16,600	$500	$600
23 Communications, Utilites & Other Rent:							
Rental of Equipment	$6,117	$6,500	$6,500	$7,000	$7,500	$500	$500
Communications	$1,454	$2,500	$1,500	$1,600	$1,700	$100	$100
Utilities	$519,243	$564,100	$527,800	$579,500	$595,000	$51,700	$15,500
GSA Rent	$25,692	$25,600	$26,700	$27,800	$28,900	$1,100	$1,100
Other Real Property Rental	$413,813	$533,800	$515,600	$598,900	$623,600	$83,300	$24,700
Subtotal	$966,319	$1,132,500	$1,078,100	$1,214,800	$1,256,700	$136,700	$41,900
24 Printing & Reproduction:	$83	$100	$100	$100	$100	$0	$0
25 Other Services:							
Outpatient Dental Fees	$7	$0	$0	$0	$0	$0	$0
Medical & Nursing Fees	$82	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$112,771	$124,400	$125,000	$12,400	$12,100	($112,600)	($300)
Maintenance & Repair Contract Services	$168,593	$181,500	$182,000	$180,600	$182,000	($1,400)	$1,400
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	$7,583	$17,500	$7,600	$7,400	$7,400	($200)	$0
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	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013 to 2014 Increase/ Decrease	2014 to 2015 Increase/ Decrease
25 Other Services (continued)							
Other Medical Contract Services	$13,723	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$348,046	$897,136	$411,401	$394,800	$418,400	($16,601)	$23,600
Training Contract Services	$1,997	$3,700	$2,000	$2,500	$2,500	$500	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0
Subtotal	$652,802	$1,224,236	$728,001	$597,700	$622,400	($130,301)	$24,700
26 Supplies & Materials:							
Provisions	$32	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$61	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$727	$0	$0	$0	$0	$0	$0
Operating Supplies	$105,847	$116,700	$110,600	$110,500	$113,700	($100)	$3,200
Maintenance & Repair Supplies	$154,340	$173,200	$163,900	$159,000	$157,900	($4,900)	($1,100)
Other Supplies	$56,867	$89,514	$59,600	$62,800	$64,800	$3,200	$2,000
Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0
Subtotal	$317,874	$379,414	$334,100	$332,300	$336,400	($1,800)	$4,100
31 Equipment	$126,840	$174,600	$135,000	$142,900	$142,900	$7,900	$0
32 Lands & Structures:							
Non-Recurring Maintenance	$1,491,107	$710,450	$1,335,300	$709,800	$460,600	($625,500)	($249,200)
All Other Lands & Structures	$207,719	$168,300	$207,800	$252,900	$252,900	$45,100	$0
Subtotal	$1,698,826	$898,450	$1,543,100	$962,700	$713,500	($580,400)	($249,200)
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	$279	$0	$0	$0	$0	$0	$0
Total, Obligations	$5,409,370	$5,564,000	$5,528,601	$4,897,000	$4,765,000	($631,601)	($132,000)

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Appropriation Transfers & Supplementals

Explanation of Appropriation Transfers in 2012:

- **$15,000,000 Transfer to the DoD–VA Health Care Sharing Incentive Fund (JIF) 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."

- **$50,000,000 Transfer to the DoD–VA Health Care Sharing Incentive Fund (JIF) from Medical Support & Compliance.** 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." This additional 2012 transfer allowed the JIF to respond to resource sharing priorities of the Secretaries of the VA and DoD, including joint projects that respond to new or ongoing health care needs of both Veterans and DoD beneficiaries such as tracking individual care for Servicemembers and their families, problem-solving training to promote psychological resilience, and other joint initiatives. New emerging initiatives include HEC (Health Executive Council) workgroups developing national initiatives to include: Deployment Health, Mental Health, Telehealth, and Credentialing Task Force.

- **$234,080,000 Transfer to Joint DoD–VA Medical Facility Demonstration Fund.** This reflected a total transfer of $234,080,000 to the Joint DoD–VA Medical Facility Demonstration Fund from Medical Services ($172,750,000), Medical Support and Compliance ($24,168,000), and Medical Facilities ($37,162,000). The authority for this transfer was provided in Public Law 112-74, section 224 the "Consolidated Appropriations Act, 2012," signed on December 23, 2011. The Demonstration Fund supports the continuing

operations of the Captain James A. Lovell Federal Health Care Center (FHCC), in North Chicago, which began operations on December 20, 2010.

- **$55,350,000 Transfer of 1 Percent from Medical Support and Compliance to Medical Services.** The purpose of this transfer was to rebalance funds between the two appropriations. The Congressional notification requirement in Public Law 112-74, section 202, was met by including this transfer in the Quarterly Status Report for the 4th Quarter 2012.

Proposed Legislation

(dollars in thousands)

Legislative Proposals	FY 2014	FY 2014 Collections
Sunset for Health Professionals Scholarship Program	$850	
VA Payment for Medical Foster Home (MFH)	($5,762)	
Waiver of 24-month Eligibility Requirement for Emergency Treatment	$1,382	
Veterans Transportation Services	($19,219)	
Smoke-Free Environment	($7,318)	
Remove Requirement VA Reimb. Certain Employees for Prof. Education	($325)	
Clarify Breach of Agreement under Employee Incentive Scholarship Prg	($38)	
Allow VA to Release Patient Info to Health Plans		$35,000
Consider VA a Participating Provider for "Purpose of Reimbursement"		$94,000
Legislative Proposals Total	**($30,430)**	**$129,000**

Sunset for Health Professionals Educational Assistance Program

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$850		$850	

Proposed Program Change in Law:

VA proposes to amend 38 USC § 7619 to extend the current sunset date for the Health Professionals Educational Assistance Program by extending authorization for the program for an additional five years to offer scholarships under this program to help meet recruitment and retention needs for critical health care providers.

Current Law or Practice:

Public Law 111-163, section 603 - the Caregivers and Veterans Omnibus Health Services Act of 2010, reestablished the Health Professionals Educational Assistance Program (HPEAP) by eliminating the previous 1998 sunset date and extending the program through December 14, 2014. The legislation, signed into law May 5, 2010, amended 38 USC 7618 to extend the sunset date and re-designated Section 7618 as Section 7619 (38 USC Part V, Chapter 76, Subchapter II, Scholarships).

Justification:

VA is actively engaged in drafting new regulations for the HPEAP and anticipates publishing final regulations in 2013. Therefore under the current sunset, this program would only be operative for less than two years. Extending the program through 2019 will enable VA to offer scholarships for more than two academic years to meet the future needs for health care professionals.

This program will help alleviate the health care workforce shortages in VA by obligating scholarship recipients to complete a service obligation at a VA health care facility after graduation and licensure/certification. Additionally, scholarships will enable students to gain academic credentials without additional debt burdens from student loans. Future benefits are gained in reduced recruitment costs as scholarship recipients will have obligated service agreements to fulfill. These types of obligations secure the graduates' services for up to three years and reduce turnover, and associated costs, typically associated with the first two years of employment.

10-Year Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....	$850	$4,110	$6,233	$6,257	$6,282	$23,732
Collections.....						
Appropriation.....	$850	$4,110	$6,233	$6,257	$6,282	$23,732

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....	$6,307	$1,584	$0	$0	$0	$31,623
Collections.....						
Appropriation.....	$6,307	$1,584	$0	$0	$0	$31,623

A Payment for Medical Foster Home (MFH)

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($5,762)		($5,762)	

Proposed Program Change in Law:

VA proposes legislation to give VA authority to pay for Veterans' care (room, board and caregiver services) in VA-approved Medical Foster Homes (MFHs). For Veterans who would otherwise need nursing home care, MFHs provide care in a private home at much lower cost than nursing home care. Medical Foster Homes have already proven to be safe, preferable to Veterans, and highly Veteran-centric, at less than half the cost to VA as care in a nursing home. Currently, all Veterans in VA's MFH program must pay for MFH, as VA does not have authority to pay.

Medical Foster Home merges traditional adult foster care with comprehensive longitudinal care provided in the home by a VA interdisciplinary team that includes a physician, nurse, social worker, rehabilitation therapist, mental health provider, dietitian and pharmacist. VA established MFHs as an alternative to traditional long-stay nursing home care in 2000. So far, MFHs have demonstrated significant success in 35 states and are in development in another ten states. Presently, over 400 VA-approved caregivers provide MFH care in their homes to over 500 Veterans daily nation-wide, albeit paid by the Veterans themselves. For all current Veterans served in MFHs, their care needs are fundamentally no different whether they reside in a MFH or in a nursing home; however, their care needs can be met at substantially lower costs in a MFH than in a long-stay nursing home. MFH is a proven alternative in the community that allows Veterans who are referred for or currently reside in nursing homes to receive this care in a community MFH. Many more service-connected Veterans referred to or residing in nursing homes would choose MFH if VA paid the costs for MFH. Instead, they presently defer to nursing home care due to VA having payment authority to cover nursing home but not the authority to pay for Veterans' care in a MFH. As a result of this gap in authority, VA pays more than twice as much for the long-term nursing home care for many Veterans than if VA had the proposed authority to pay for MFH care.

Under this proposal, VA payment for MFH would be exclusively for Veterans who would otherwise need nursing home care, while assisted living by most definitions and in most states routinely excludes individuals who would otherwise need nursing home level of care. This proposal is limited in scope and is intended to cover only VA-approved MFH caregivers serving three Veterans or

fewer per home. This proposal does not create general authority to cover Veterans who reside in assisted living facilities.

Current Law or Practice:

VA does not presently have the authority to pay for nursing home level of care in non-nursing home settings. VA does not have authority to pay for general assistive living facilities, and this proposal will not amend that restriction. VA currently has authority to pay for nursing home level of care only in a nursing home (either VA or community-based), and provides nursing home care to over 17,000 Veterans every day at an annual cost to VA of $3.6 billion per year. VA has a responsibility to reduce its mounting expenditures for nursing home care, especially where safe and proven home-based alternatives are available as identified in this proposal.

Justification:

Authorizing VA to pay for certain MFH care would result in more Veterans receiving long-term care in a preferred setting, with substantial reductions in costs to VA.

10-Year Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....	($5,762)	($6,825)	($8,084)	($9,576)	($11,342)	($41,589)
Collections.....						
Appropriation.....	($5,762)	($6,825)	($8,084)	($9,576)	($11,342)	($41,589)

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....	($13,435)	($15,914)	($18,850)	($22,328)	($26,447)	($138,563)
Collections.....						
Appropriation.....	($13,435)	($15,914)	($18,850)	($22,328)	($26,447)	($138,563)

Waiver of 24-Month Eligibility Requirement for Emergency Treatment

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$1,382		$1,382	

Proposed Program Change in Law:

VA proposes to add subsection "(C)" to §1725(b)(2) to provide an exception to the 24-month requirement in §1725(b)(2)(B) of title 38, U.S.C., for Veterans who have recently enrolled in the VA health care system but have not received care or services under chapter 17 due to wait times associated with their initial appointment at a VA medical facility.

Current Law or Practice:

38 U.S.C 1725(b)(2)(B), as currently written, imposes a requirement that Veterans must have received VA care within the preceding 24 months in order to be eligible for emergency treatment. VA proposes this section be amended by adding subparagraph (C) to waive the 24-month requirement for a certain population of Veterans.

Justification:

Currently, Veterans who are enrolled in the VA health care system, but have not received care or services from VA under chapter 17 lack eligibility for payment or reimbursement for non-VA emergency treatment under § 1725. Under the current statute, payment for such treatment would be administratively denied because the Veteran had not received care or services in the last 24 months from VA under chapter 17, even if the Veteran had requested and was scheduled for a new patient examination.

If adopted, this proposed change would address the restrictive nature of the 24-month requirement included in §1725(b)(2)(B) and provide otherwise eligible recently enrolled Veterans with the "safety net" of non-VA emergency coverage.

10-Year Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....	$1,382	$1,513	$1,657	$1,818	$1,993	$8,363
Collections.....						
Appropriation....	$1,382	$1,513	$1,657	$1,818	$1,993	$8,363

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....	$2,186	$2,397	$2,630	$2,884	$3,164	$21,624
Collections.....						
Appropriation....	$2,186	$2,397	$2,630	$2,884	$3,164	$21,624

Transportation of Individual to and from Facilities of the Department of Veterans Affairs (VA)

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($19,219)		($19,219)	

Proposed Program Change in Law:

VA proposes legislation to extend a recently enacted provision, , 38 USC § 111A that authorized VA to transport any person to or from a VA facility or other place in connection with vocational rehabilitationor counseling required by the Secretary pursuant to chapter 34 or 35 of Title 38, or for the purpose of examination, treatment, or care. This authority was enacted in January 2013 under Public Law 112-260, Section 202, of the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012 and expires one year after the data of enactment. This proposal would extend the authority for an additional five years.

Current Law or Practice:

Under 38 USC 111A, the Secretary has the authority to transport any Veteran to or from a VA facility or other place in connection with vocational rehablilitation, counseling, or for the purpose of examination, treatment, or care. Public Law 112-260, section 202, revised VA's transportation authorities providing VA the authority to supplement volunteer drivers with VA staff to drive VTS vehicles. The clarifying authority established under P.L. 112-260 expires on January 10, 2014.

Justification:

VA launched a Veterans Transportation Service (VTS) initiative in 2010 to enhance, support, and organize transportation efforts for Veterans by VA health care facilities.

Through the VTS program, VA provided funding to local VA facilities for mobility managers, transportation coordinators and vehicles to complement the existing access to care that volunteers already provide. The service provides Veterans with the ability to be transported to and from their VA health care appointments. Between October 2011 and May 2012, VTS transported more than 43,000 Veterans door to door, making more than 50,000 trips that totaled more than 2.1 million miles. The average length of a trip is almost 60 miles—a

considerable distance in some rural communities, and a prohibitive distance for those with poor health if transportation was not available.

However, with increasing numbers of transportation-disadvantaged Veterans, there simply are not enough volunteers in all regions of the country to sustain the current level of service. Furthermore, volunteer drivers generally do not transport Veterans who are not ambulatory, require portable oxygen, have undergone a procedure involving sedation, or have other clinical issues. Additionally, some volunteers, for valid reasons, are reluctant to transport non-ambulatory or very ill Veterans. Section 111A allows VA to supplement volunteer drivers with VA staff to drive the VTS vehicles for one year. Without the proposed extension, it is possible that VTS will need to be significantly reduced or curtailed in January 2014, particularly in rural areas of the country.

10-Year Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....	($19,219)	($19,875)	($20,544)	($21,205)	($21,855)	($102,698)
Collections.....						
Appropriation....	($19,219)	($19,875)	($20,544)	($21,205)	($21,855)	($102,698)

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....	$0	$0	$0	$0	$0	($102,698)
Collections.....						
Appropriation....	$0	$0	$0	$0	$0	($102,698)

Smoke-Free Environment

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($7,318)		($7,318)	

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 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, 2013 there are 3,750 local and/or state/territory/commonwealth hospitals, healthcare systems and clinics and four national healthcare 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, 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 healthcare, 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 102-585 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. 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 healthcare 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 Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....	($7,318)	($7,440)	($7,566)	($7,697)	($7,833)	($37,854)
Collections.....						
Appropriation.....	($7,318)	($7,440)	($7,566)	($7,697)	($7,833)	($37,854)

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....	($7,974)	($8,118)	($8,264)	($8,412)	($8,564)	($79,186)
Collections.....						
Appropriation.....	($7,974)	($8,118)	($8,264)	($8,412)	($8,564)	($79,186)

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:

This proposal would eliminate Title 38 USC § 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:

Public Law 102-40, the Department of Veterans Affairs Health-Care Personnel Act of 1991, added Section 7411 to title 38 and increased the special pay available for physicians and dentists. This provision, which was not part of a VA legislative initiative, created an entitlement to reimbursement for physicians and dentists. No other occupations in VHA are entitled to reimbursement for continuing medical education expenses.

Justification:

VHA has a long history of providing educational and training support to all clinical and administrative staff. 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 5-year cost would be approximately $1.63 million.

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

10-Year Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....	($325)	($325)	($325)	($325)	($325)	($1,625)
Collections.....						
Appropriation.....	($325)	($325)	($325)	($325)	($325)	($1,625)

$ in thousands	2019	2020	2021	2022	2023	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 38 USC § 7675, subchapter VI, to provide that full-time student participants in the Employee Incentive Scholarship Program (EISP) would have the same liability as part-time students for breaching an agreement by leaving VA employment.

Current Law or Practice:

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

Justification:

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

As reflected below, the proposal does not result in costs to the Department. There are direct cost savings for VHA related to the recovery of funds from scholarship participants who leave VA employment prior to completion of their education program. There are 13,556 EISP participants (cumulative 1999 – February 2013). 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 Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....	($38)	($38)	($39)	$0	$0	($115)
Collections.....						
Appropriation....	($38)	($38)	($39)	$0	$0	($115)

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....	$0	$0	$0	$0	$0	($115)
Collections.....						
Appropriation....	$0	$0	$0	$0	$0	($115)

Allow VA to Release Patient Information to Health Plans

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$0	$35,000	$0	

Proposed Program Change in Law:

To amend 38 USC § 7332(b) to include a provision for the disclosure of VA records of the identity, diagnosis, prognosis or treatment of a patient relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV) or sickle cell anemia to health plans for the purpose of VA obtaining reimbursement for nonservice-connected 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 USC 7332(b). The term "consent" is used in the same context as the term "authorization" in the Department of Health and Human Services (HHS) Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, 45 CFR Parts 160 and 164. The Veterans Health Administration (VHA) is prohibited from disclosing information identifying a 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 USC 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 USC 1729, VA has authority to recover from health plans or health insurance carriers the reasonable charges for treatment of a Veteran's nonservice-connected disabilities. To recover reasonable charges and obtain reimbursement for care, VA must submit bills or claims containing diagnostic code information to the health plan or health insurance carrier for the admission or episode of care. If during the admission or episode of care the Veteran was diagnosed and treated for drug abuse, alcoholism or alcohol abuse, infection with HIV or sickle cell anemia, this information is communicated via the diagnostic codes on the bill or claim to the health plan or health insurance carrier.

VA is given authority to disclose any health information to health plans required for payment of care and services provided to the patient under the HHS HIPAA privacy regulations, 45 CFR 164.506(c). In addition, under the Privacy Act, the agency has promulgated a routine use in the billing and collection system of records authorizing disclosure of health information to health plans for reimbursement for care provided to the patient. There is no such authority under 38 USC 7332; therefore, 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 USC 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 P.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 $1 billion 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 USC 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. If the proposed amendment to 38 USC 7332(b) is passed, VHA Handbook 1605.1 would need to be updated to reflect the inclusion of the 7332-protected diagnoses as a category of information that Veterans can request withheld from disclosure. The currently protected diagnoses would then be governed by the same regulations governing treatment of all other conditions.

10-Year Cost Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....						
Collections.....	$35,000	$37,000	$37,920	$39,361	$40,857	$190,138
Appropriation.....	($35,000)	($37,000)	($37,920)	($39,361)	($40,857)	($190,138)

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....						
Collections.....	$42,409	$44,021	$45,693	$47,430	$49,232	$418,923
Appropriation.....	($42,409)	($44,021)	($45,693)	($47,430)	($49,232)	($418,923)

Consider VA a Participating Provider for "Purposes of Reimbursement"

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$94,000			

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 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, codified at 38 U.S.C. 1729A, established the current Medical Care Collections Fund (MCCF). With the enactment of the Balanced Budget Act of 1997, VA is authorized to retain collections from third-party payers and certain co-payments. VA can use these collections to fund medical care to Veterans and to pay for its medical care collection expenses. This law also authorized VA to collect reasonable charges versus reasonable costs for care. Reasonable charges are based on the amounts that health insurers would pay for the same care provided by non-government health care providers in the same geographic area.

VA has authority under 38 USC 1729 to recover from health insurers the reasonable charges for treatment of a Veteran's non service-connected disabilities.

Justification:

This proposal would prevent a health insurer from denying or reducing payment on the grounds that VA is not a participating provider.

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

NOTE: DoD, by statute as codified under 10 USC 1095, contains authority for these business practices

10-Year Costs Table:

$ in thousands	2014	2015	2016	2017	2018	5 Year
Obligations.....						
Collections.....	$94,000	$98,000	$101,468	$105,324	$109,326	$508,118
Appropriation.....	($94,000)	($98,000)	($101,468)	($105,324)	($109,326)	($508,118)

$ in thousands	2019	2020	2021	2022	2023	10 Year
Obligations.....						
Collections.....	$113,480	$117,793	$122,269	$126,915	$131,000	$1,119,575
Appropriation.....	($113,480)	($117,793)	($122,269)	($126,915)	($131,000)	($1,119,575)

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:

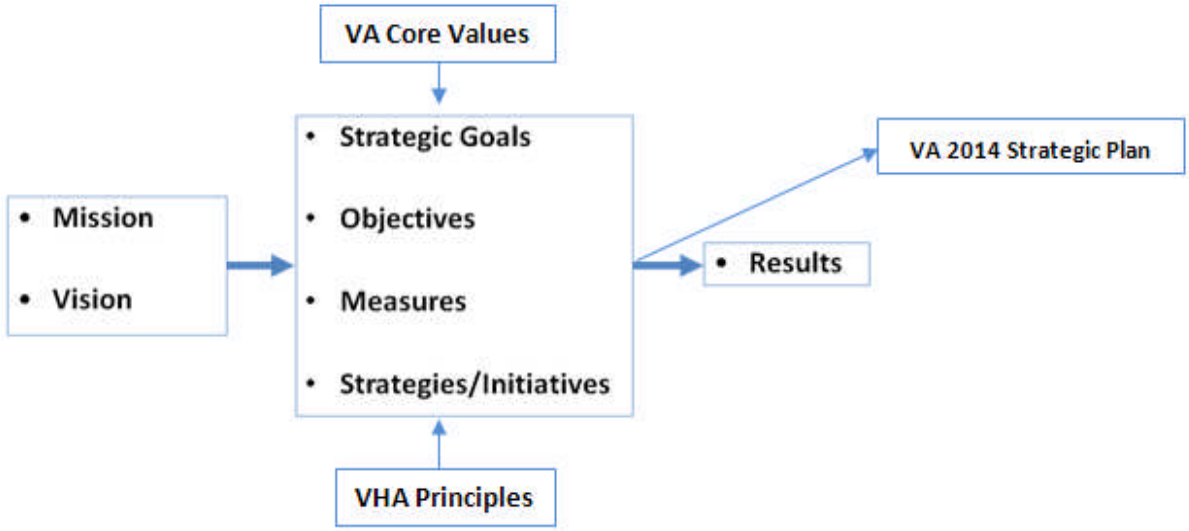
Veterans and their families	Academic affiliates
The Administration and Congress	Health care professional trainees
DoD and other Federal Agencies	Researchers
Veteran Service Organizations	Contract providers
State/County Veterans offices	VA employees
State Veterans homes	Public-at-large
Local communities	

VHA Strategic Framework

Overview
VHA's National Leadership Council (NLC) developed a strategic planning framework to accomplish its mission and achieve VHA's vision, as cited above.

Strategic Framework
The VHA Strategic Framework shown below guides planning and decision-making to enable VA to provide Veterans with health care that is personalized, proactive, and patient-drive. The framework is informed by VA's Core Values of **I**ntegrity, **C**ommitment, **A**dvocacy, **R**espect, and **E**xcellence (ICARE). The framework also utilizes VHA's Principles of being Patient-Centered, Team-Based, Data-Driven/Evidence-Based and focusing on Prevention/Population Health, Providing Value, and Continuously Improving.

VHA STRATEGIC FRAMEWORK
2013-2018



Goals

VHA is charting a deliberate course to guide strategic change to assure a health care system that will define excellence in the 21st Century. The following VHA Strategic Goals represent VHA's strategy over the next five years to focus on personalized health care which will deliver sustained value to Veterans.

Strategic Goal #1: PROVIDE VETERANS PERSONALIZED[1], PROACTIVE[2], PATIENT-DRIVEN[3] HEALTH[4] CARE.

Strategic Goal #2: ACHIEVE MEASURABLE IMPROVEMENTS IN HEALTH OUTCOMES.

Strategic Goal #3: ALIGN RESOURCES TO DELIVER SUSTAINED VALUE TO VETERANS.

Performance Measures

VHA's performance measurement system is the final component of the strategic planning framework. Eighteen performance measures have been identified that meet the strategic intent of VHA's mission and vision. Eight of these measures are identified as "key measures" while two of these measures support Agency Priority Goals. The performance measures cover a range of clinical, administrative and financial actions required to support VHA's Strategic Framework cited above.

To be included, the measure must meet the mandatory criteria of:

1. being of specific interest to the public
   AND
2. the measures collectively cover a substantial portion of the organization's budget request.

The performance measures contained in the 2014 VHA Performance Plan have been screened and determined to satisfy the below criteria and are an appropriate platform for assessing VHA health care services and programs.

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[1] **Personalized** – a dynamic adaptation or customization of recommended education, prevention and treatment that is specifically relevant to the individual user, based on the user's history, clinical presentation, lifestyle, behavior and preferences.

[2] **Proactive** – acting in advance of a likely future situation, rather than just reacting; taking initiative to make things happen rather than just adjusting to a situation or waiting for something to happen.

[3] **Patient-Driven** – an engagement between a patient and a health care system where the patient is the source of control such that their health care is based in their needs, values, and how the patient wants to live

[4] **Health** – a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (*World Health Organization)*

Veterans Health Administration
Table 1: Performance Summary Table

Categories (See Note at the bottom of this spreadsheet for a list of categories)	Performance Measures Data								
	Measure (Key Measures in Bold)	Results History				Future Targets			Strategic Target
		2009	2010	2011	2012 (Final)	2013 (Final)	2014 (Requested Funding)	2015 (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	**Prevention Index V**[5]	89%	91%	92%	94%	93%	94%	94%	95%
(A) Services for Veterans and Eligible Beneficiaries	**Clinical Practice Guidelines Index IV**[6]	91%	92%	91%	94%	92%	93%	93%	94%

[5] The 2009-2011 results are PI IV. The 2012-2014 targets are PI V.
[6] The 2009-2011 results are CPGI III. The 2012-2014 targets are CPGI IV.

Categories (See Note at the bottom of this spreadsheet for a list of categories)	**Performance Measures Data**								
	Measure (Key Measures in Bold)	**Results History**				**Future Targets**			**Strategic Target**
		2009	**2010**	**2011**	**2012** (Final)	**2013** (Final)	**2014** (Requested Funding)	**2015** (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	Percentage of total HUD-VASH vouchers that resulted in a Veteran achieving resident status **(Supports Agency Priority Goal)**	N/Av	88%	100%	92%	88%	90%	90%	90%

Categories (See Note at the bottom of this spreadsheet for a list of categories)	**Performance Measures Data**								
	Measure (Key Measures in Bold)	**Results History**				**Future Targets**			**Strategic Target**
		2009	**2010**	**2011**	**2012** (Final)	**2013** (Final)	**2014** (Requested Funding)	**2015** (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	**Number of Homeless Veterans (on a single night) (Supports Agency Priority Goal)** (Joint VHA-OPIA Measure) (Based on January Point-in-Time (PIT) count results) This APG should be measured by the PIT count following the end of the fiscal year to ensure the efforts and investments of the full year are reflected.	75,609	76,329	67,495	62,619	47,000	35,000	TBD	TBD

Categories (See Note at the bottom of this spreadsheet for a list of categories)	Performance Measures Data								
	Measure (Key Measures in Bold)	Results History				Future Targets			Strategic Target
		2009	2010	2011	2012 (Final)	2013 (Final)	2014 (Requested Funding)	2015 (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	Percent of targeted population of OEF/OIF Veterans with a primary diagnosis of PTSD who receive a minimum of 8 psychotherapy sessions within a 14-week period[7]	N/Av	11%	15%	15%	67%	83%	90%	97%
(A) Services for Veterans and Eligible Beneficiaries	The percent of Veterans being discharged from an inpatient Mental Health unit who receive outpatient mental health follow-up care within 7 days of discharge.[8]	N/Av	N/Av	N/Av	N/Av	68%	75%	80%	85%

[7] The targeted number of Veterans remains unchanged, but the manner in which the information is displayed within the Future and Strategic Targets beginning in FY 2013 has been improved to reflect more directly the percent of Veterans who would be realistically expected to agree to participate in this psychotherapy, rather than assuming all OEF/OIF/OND Veterans would participate.

[8] The description of this measure has been changed in 2013 to more accurately reflect how this is measured.

Categories (See Note at the bottom of this spreadsheet for a list of categories)	Performance Measures Data								
	Measure (Key Measures in Bold)	Results History				Future Targets			Strategic Target
		2009	2010	2011	2012 (Final)	2013 (Final)	2014 (Requested Funding)	2015 (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	Percent of new mental health appointments completed within 14 days of the create date for the appointment[9] **(New)**	N/Av	N/Av	N/Av	N/Av	TBD (Baseline)	TBD	TBD	TBD
(A) Services for Veterans and Eligible Beneficiaries	Percent of established mental health patients with a scheduled appointment within 14 days of the desired date for the appointment[10] **(New)**	N/Av	N/Av	N/Av	N/Av	TBD (Baseline)	TBD	TBD	TBD

[9] In 2013, VHA updated the methodology to measure wait times for new patient appointments to improve reliability and consistency. Appointments for new patients will use the create date, defined as when the appointment was made and automatically captured by the scheduling system. Therefore, no targets are set in 2013 and 2014 so baseline performance can be established.
[10] In 2013, VHA updated the methodology to measure wait times for established patient appointments to improve
reliability and consistency. Appointments for established patients will use the desired date, defined as the agreed upon date determined together by provider and patient. Desired date is measured prospectively to better represent patient satisfaction. Therefore, no targets are set in 2013 and 2014 so baseline performance can be established.

Categories (See Note at the bottom of this spreadsheet for a list of categories)	Performance Measures Data								
	Measure (Key Measures in Bold)	Results History				Future Targets			Strategic Target
		2009	2010	2011	2012 (Final)	2013 (Final)	2014 (Requested Funding)	2015 (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	**Percent of new primary care appointments completed within 14 days of the create date for the appointment[9] (New)**	N/Av	N/Av	N/Av	N/Av	TBD (Baseline)	TBD	TBD	TBD
(A) Services for Veterans and Eligible Beneficiaries	**Percent of established primary care patients with a scheduled appointment within 14 days of the desired date for the appointment [10] (New)**	N/Av	N/Av	N/Av	N/Av	TBD (Baseline)	TBD	TBD	TBD
(A) Services for Veterans and Eligible Beneficiaries	**Percent of new specialty care appointments completed within 14 days of the create date for the appointment[9] (New)**	N/Av	N/Av	N/Av	N/Av	TBD (Baseline)	TBD	TBD	TBD

Categories (See Note at the bottom of this spreadsheet for a list of categories)	Performance Measures Data								
	Measure (Key Measures in Bold)	Results History				Future Targets			Strategic Target
		2009	2010	2011	2012 (Final)	2013 (Final)	2014 (Requested Funding)	2015 (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	**Percent of established specialty care patients with a scheduled appointment within 14 days of the desired date for the appointment** [10] **(New)**	N/Av	N/Av	N/Av	N/Av	TBD (Baseline)	TBD	TBD	TBD
(A) Services for Veterans and Eligible Beneficiaries	**Percentage of patients rating VA health care as a 9 or 10 (on a scale from 0 to 10)**[11]								
(A) Services for Veterans and Eligible Beneficiaries	Inpatient	63% (Baseline)	64%	64%	64%	66%	67%	67%	75%
(A) Services for Veterans and Eligible Beneficiaries	Outpatient	57% (Baseline)	55%	55%	55%	58%	59%	59%	70%

[11] 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.

Categories (See Note at the bottom of this spreadsheet for a list of categories)	Performance Measures Data								
	Measure (Key Measures in Bold)	Results History				Future Targets			Strategic Target
		2009	2010	2011	2012 (Final)	2013 (Final)	2014 (Requested Funding)	2015 (Advanced Approp. Request)	
(A) Services for Veterans and Eligible Beneficiaries	Percent of Veterans who report "yes" to the Shared Decision-making questions in the Inpatient Surveys of the Health Experiences of Patients (SHEP)[12]	N/Av	71%	72% (Baseline)	72%	72%	73%	73%	75%
(A) Services for Veterans and Eligible Beneficiaries	The average proportion of patients responding "Always" to receiving timely appointments, care and information **(New)**	N/Av	N/Av	N/Av	N/Av	TBD (Baseline)	TBD	TBD	TBD
(A) Services for Veterans and Eligible Beneficiaries	Percent of Veterans participating in telehealth[13]	N/Av	N/Av	N/Av	9%	15%	16%	16%	TBD
(B) Support Delivery of Services	Percent of Non-VA Claims Paid in 30 Days	N/Av	N/Av	79%	80%	90%	90%	90%	90%

[12] 2011 was a re-baseline year after measure validation was completed in 2010.

[13] The description of this measure was changed in 2012 to reflect a more patient centric assessment of telehealth growth. Telehealth programs that are included in the Monthly Performance Review metric = Clinical Video Telehealth (CVT), Home Telehealth (HT) and Store and Forward Telehealth (SFT). The denominator is the number of unique patients in the most recent fiscal year, excluding: Non-Veterans, Active Duty Service members, Caregivers, and Veterans receiving Pharmacy services only. The FY 2012 denominator was 5,455,769 Veterans.

Note: *Categories are as follows:(A) Services for Veterans and Eligible Beneficiaries, (B) Support Delivery of Services, and (C) Management of Government Resources*

Table 2: Performance Measure Supporting Information

<u>Prevention Index V</u> (Key Measure)

a) Means and Strategies:
- The index is a 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) Crosscutting 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 2009-2011 results are PI IV. The 2012-2014 targets are PI V.

h) Link to a Category, Capability and to one or more secondary Criteria:
- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA.

Table 2: Performance Measure Supporting Information

<u>Clinical Practice Guidelines Index IV</u> (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) Crosscutting Activities:
- Ongoing work with DoD to implement and refine Clinical Practice Guidelines which serve as a basis and reference 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 2009-2011 results are CPGI III. The 2012-2014 targets are CPGI IV.

h) Link to a Category, Capability and to one or more secondary Criteria:
- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA.

Table 2: Performance Measure Supporting Information

<u>Percentage of total HUD-VASH vouchers issued to homeless Veterans that resulted in permanent housing</u> (Supports Agency Priority Goal)

a) Means and Strategies:

- The Department of Housing and Urban Development (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:

- The *Veteran Homelessness: A Supplemental Report to the 2011 Annual Homeless Assessment Report* (AHAR) to Congress estimates that there were 67,495 homeless Veterans on a single night in January 2012. Additionally, based on this report, homeless Veterans make up approximately 14% 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) Crosscutting 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 a Category, Capability and to one or more secondary Criteria:

- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Number of Homeless Veterans (on a single night)</u> (Supports Agency Priority Goal)

a) Means and Strategies:

- HUD's AHAR provides 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:
  - An annual Point-in-Time (PIT) count conducted by thousands of volunteers and staff across the country working with local HUD Continuums of Care (CoC).
  - HUD's 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.
  - VA reports 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.

d) Measure Validation:

- Involvement of providers, homeless 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 homeless Veterans and engaging them in participation. HUD works closely with the community, training local CoCs to conduct PITs. HUD also maintains HMIS, working closely with CoCs to ensure technical support and accurate data entry. VA and HUD's collaborative approach in this process will ensure 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 to yield the count of homeless Veterans on a single night.

e) Crosscutting 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:

Opening Doors Population Goals: Incremental Targets						
	2010 Investment (2011 PIT)	**2011 Investment (2012 PIT)**	**2012 Investment (2013 PIT)**	**2013 Investment (2014 PIT)**	**2014 Investment (2015 PIT)**	**2015 Investment (2016 PIT)**
Veterans (Persons)	**67,495**	**59,000**	**47,000**	**35,000**	**TBD**	**TBD**

The APG should be measured by the PIT count *following* the end of the fiscal year to ensure the efforts and investments of the full year are reflected. Targets for 2014 and 2015 will be determined after the January 2013 PIT results are released, in consultation with HUD and USICH.

h) Link to a Category, Capability and to one or more secondary Criteria:

- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Percent of new mental health appointments completed within 14 days of the create date for the appointment</u> (Key Measure) (NEW)

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.
- Leadership teams and clinical/administrative services at all levels of the organization examine wait times for completed appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each Veteran.

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. Staff have the option to drill down to SSN numbers to validate VHA Service Support Center (VSSC) reports.

d) Measure Validation:
- This measure was designed to capture the timeliness of new mental health appointment scheduling from the perspective of the Veteran.
- Access will be tracked based on the wait time between the date the appointment is created and the date the appointment is completed. Create Date is automatically captured by the scheduling package which ensures data validity. The information is used to guide VHA actions in balancing supply and demand.

e) Crosscutting Activities:
- None

f) External Factors:
- None

g) Other Supporting Information:
- None

h) Link to a Category, Capability and to one or more secondary Criteria:
- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Percent of established mental health patients with a scheduled appointment within 14 days of the desired date</u> (Key Measure) (NEW)

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.
- Leadership teams and clinical/administrative services at all levels of the organization examine wait times for scheduled appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each Veteran.

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 in the previous 24 months at the facility the appointment is being scheduled.

c) Data Verification:
- This data is available on a monthly basis. Staff have the option to drill down to SSN numbers to validate VSSC reports.

d) Measure Validation:
- This measure was designed to capture the timeliness of established mental health appointment scheduling from the perspective of the Veteran.
- This is a prospective measure of wait time for an established patient. Knowing the gap between desired date and scheduled appointment date has been shown to predict patient satisfaction and outcomes. The information is used to guide VHA actions in balancing supply and demand.
- For internal demand, desired date will be the same as the Agreed Upon Date (AUD) determined together by provider and patient. Audits will be conducted to ensure that schedulers use the AUD as the desired date. For external demand accuracy of scheduler's entry of desired date will be audited.

e) Crosscutting Activities:
- None

f) External Factors:
- None

g) Other Supporting Information:
- None

h) Link to a Category, Capability and to one or more secondary Criteria:
- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Percent of new primary care appointments completed within 14 days of the create date for the appointment</u> (Key Measure) (NEW)

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.
- Leadership teams and clinical/administrative services at all levels of the organization examine wait times for completed appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each Veteran.

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. Staff have the option to drill down to SSN numbers to validate VSSC reports.

d) Measure Validation:

- This measure was designed to capture the timeliness of new primary care appointment scheduling from the perspective of the Veteran.
- Access will be tracked based on the wait time between the date the appointment is created and the date the appointment is completed. Create Date is automatically captured by the scheduling package which ensures data validity. The information is used to guide VHA actions in balancing supply and demand.

e) Crosscutting Activities:

- None

f) External Factors:

- None

g) Other Supporting Information:

- In 2013, VHA updated the methodology to improve reliability and consistency, using new baseline data to establish targets. Appointments for new patients will use the create date, defined as when the appointment was made and automatically captured by the scheduling system. Therefore, no targets are set in 2013 and 2014 so baseline performance can be established.

h) Link to a Category, Capability and to one or more secondary Criteria:

- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Percent of established primary care patients with a scheduled appointment within 14 days of the desired date</u> (Key Measure) (NEW)

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.
- Leadership teams and clinical/administrative services at all levels of the organization examine wait times for scheduled appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each Veteran.

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 in the previous 24 months at the facility the appointment is being scheduled.

c) Data Verification:
- This data is available on a monthly basis. Staff have the option to drill down to SSN numbers to validate VSSC reports.

d) Measure Validation:
- This measure was designed to capture the timeliness of established primary care appointment scheduling from the perspective of the Veteran.
- This is a prospective measure of wait time for an established Primary Care patient. Knowing the gap between desired date and scheduled appointment date has been shown to predict patient satisfaction and outcomes. The information is used to guide VHA actions in balancing supply and demand.
- For internal demand, desired date will be the same as the Agreed Upon Date (AUD) determined together by provider and patient. Audits will be conducted to ensure that schedulers use the AUD as the desired date. For external demand accuracy of scheduler's entry of desired date will be audited.

e) Crosscutting Activities:
- None

f) External Factors:
- None

g) Other Supporting Information:
- In 2013, VHA will implement methodology changes intended to improve the reliability and consistency of the established patient wait time measures. Visits planned with providers will use agreed upon date (which are named desired date in the system). All other visits will be measured by desired date. Desired date will be measured prospectively to better represent patient satisfaction. Therefore, no targets are set in 2013 so baseline performance may be established.

h) Link to a Category, Capability and to one or more secondary Criteria:
- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Percent of new specialty care appointments completed within 14 days of the create date for the appointment</u> (Key Measure) (NEW)

a) Means and Strategies:

- VHA fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process by predicting and anticipating patient needs at the time of their appointment and taking steps to:
  - 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
- Leadership teams and clinical/administrative services at all levels of the organization examine wait times for completed appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each Veteran.

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. Staff have the option to drill down to SSN numbers to validate VSSC reports.

d) Measure Validation:

- This measure was designed to capture the timeliness of new specialty care appointment scheduling from the perspective of the Veteran.
- Access will be tracked based on the wait time between the date the appointment is created and the date the appointment is completed. Create Date is automatically captured by the scheduling package which ensures data validity. The information is used to guide VHA actions in balancing supply and demand.

e) Crosscutting Activities:

- None

f) External Factors:

- None

g) Other Supporting Information:

- In 2013, VHA updated the methodology to improve reliability and consistency, using new baseline data to establish targets. Appointments for new patients will use the create date, defined as when the appointment was made and automatically captured by the scheduling system. Therefore, no targets are set in 2013 and 2014 so baseline performance can be established.

h) Link to a Category, Capability and to one or more secondary Criteria:

- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Percent of established specialty care patients with a scheduled appointment within 14 days of the desired date</u> (Key Measure) (NEW)

a) Means and Strategies:

- VHA fully implemented Advanced Clinic Access (ACA), an initiative that promotes the smooth flow of patients through the clinic process by predicting and anticipating patient needs at the time of their appointment and taking steps to:
  - 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
- Leadership teams and clinical/administrative services at all levels of the organization examine wait times for scheduled appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each Veteran.

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 in the previous 24 months at the facility the appointment is being scheduled.

c) Data Verification:

- This data is available on a monthly basis. Staff have the option to drill down to SSN numbers to validate VSSC reports.

d) Measure Validation:

- This measure was designed to capture the timeliness of established specialty care appointment scheduling from the perspective of the Veteran.
- This is a prospective measure of wait time for an established Primary Care patient. Knowing the gap between desired date and scheduled appointment date has been shown to predict patient satisfaction and outcomes. The information is used to guide VHA actions in balancing supply and demand.
- For internal demand, desired date will be the same as the Agreed Upon Date (AUD) determined together by provider and patient. Audits will be conducted to ensure that schedulers use the AUD as the desired date. For external demand accuracy of scheduler's entry of desired date will be audited.

e) Crosscutting Activities:

- None

f) External Factors:

- None

g) Other Supporting Information:

- In 2013, VHA will implement methodology changes intended to improve the reliability and consistency of the established patient wait time measures. Visits planned with providers will use agreed upon date (which are named desired date in the system). All other visits will be measured by desired date. Desired date will be measured prospectively to better represent patient satisfaction. Therefore, no targets are set in 2013 so baseline performance may be established.

h) Link to a Category, Capability and to one or more secondary Criteria:

- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

<u>Percentage of patients rating VA health care as a 9 or 10 (on a scale from 0 to 10)</u> (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) Crosscutting 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 a Category, Capability and to one or more secondary Criteria:
- This measure links to the Health Capability under the category of Services for Veterans and Eligible Beneficiaries.
- This measure is identified with the core missions of VA and is of demonstrated high-visibility to our stakeholders.

Selected Program Highlights

Introduction

This section provides narrative descriptions of the selected programs supported by the Veterans Health Administration (VHA). The funding levels presented in this chapter highlight these programs to provide a better understanding of programmatic services provided to Veterans. However, some programs overlap and therefore cannot be added together to determine the overall funding amount. Such overlapping programs include, but are not limited to, the services provided as part of mental health care, long-term care, as well as services offered to homeless Veterans.

Selected Program Highlights

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)							
AIDS	$948,986	$990,000	$1,025,200	$1,105,200	$1,189,100	$80,000	$83,900
Blind Rehabilitation Service	$124,296	$134,000	$132,700	$141,200	$149,700	$8,500	$8,500
CHAMPVA/FMP/Spina Bifida/CWVV	$1,314,711	$1,385,578	$1,441,513	$1,573,979	$1,707,642	$132,466	$133,663
Education and Training	$1,661,649	$1,745,880	$1,745,880	$1,839,216	$1,953,498	$93,336	$114,282
Emergency Care	$417,925	$570,000	$465,305	$518,980	$580,232	$53,675	$61,252
Energy / Green Management	$145,300	$181,300	$181,300	$186,200	$189,900	$4,900	$3,700
Enh. of Comp. Emerg. Mgmt. Prog. (CEMP)	$155,331	$156,095	$156,095	$164,385	$174,395	$8,290	$10,009
Gulf War Programs	$1,784,281	$1,941,000	$1,981,500	$2,189,800	$2,412,700	$208,300	$222,900
Health Care Sharing:							
Services Purchased by VA	$1,115,470	$1,092,003	$1,160,089	$1,206,492	$1,254,752	$46,403	$48,260
Services Provided by VA	$48,953	$42,310	$50,912	$52,948	$55,066	$2,036	$2,118
VA/DoD Sharing:							
Services Purchased from DoD	$94,025	$86,419	$86,419	$88,147	$89,910	$1,728	$1,763
Serivces Provided by VA	$157,396	$191,041	$191,041	$194,861	$198,758	$3,820	$3,897
Health Professional Educ. Asst. Prog	$43,711	$69,361	$47,622	$59,578	$66,136	$11,956	$6,558
Homeless Veterans Programs:							
Homeless Veterans Treatment Costs	$4,018,916	$4,410,369	$4,447,145	$4,827,583	$5,216,555	$380,438	$388,972
Programs to Assist Homeless Veterans	$1,023,271	$1,351,851	$1,351,851	$1,392,742	$1,000,000	$40,891	($392,742)
Income Verification Match (IVM)	$15,865	$18,759	$16,770	$16,770	$16,770	$0	$0
Long-Term Care	$6,305,766	$7,220,956	$6,906,841	$7,635,764	$7,982,967	$728,923	$347,203
Mental Health	$6,044,733	$6,184,098	$6,504,791	$6,974,224	$7,463,000	$469,433	$488,776
National Center for Post-Traumatic Stress Disorder	$16,307	$16,664	$16,666	$17,288	$17,919	$622	$631
Non-Recurring Maint. & Leases	$1,935,463	$1,269,850	$1,877,600	$1,336,500	$1,113,100	($541,100)	($223,400)
OEF/OIF/OND	$2,924,868	$3,279,147	$3,566,000	$4,059,200	$4,552,400	$493,200	$493,200
Pharmacy	$5,775,545	$6,071,280	$6,042,234	$6,350,895	$6,709,726	$308,661	$358,831
Prosthetics	$2,082,351	$2,586,000	$2,280,000	$2,478,000	$2,684,000	$198,000	$206,000
Readjustment Counseling	$205,620	$222,000	$222,000	$230,000	$237,500	$8,000	$7,500
Rural Health	$248,040	$250,000	$250,000	$250,000	$250,000	$0	$0
Spinal Cord Injury	$525,298	$583,000	$561,800	$601,400	$643,500	$39,600	$42,100
Traumatic Brain Injury (TBI)-All Vets	$231,333	$280,139	$239,800	$245,600	$246,200	$5,800	$600
Traumatic Brain Injury (TBI)-OEF/OIF/OND	$51,013	$60,401	$53,000	$50,600	$48,100	($2,400)	($2,500)
Women Veterans Health Care:							
Gender Specific Health Care	$326,074	$403,000	$370,800	$421,900	$476,500	$51,100	$54,600
Total Care	$4,110,659	$3,467,400	$4,485,700	$4,879,100	$5,291,800	$393,400	$412,700

AIDS

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$948,986	$990,000	$1,025,200	$1,105,200	$1,189,100	$80,000	$83,900

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 preventive 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 1: 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 National HIV Program Office, in the VHA Office of Public Health, will intensify HIV testing to identify those who are positive and link them to care. This effort will be applied to all Veterans but concentrated in communities where HIV is most prevalent.

VA will also promote HIV prevention by making both male and female condoms available to all Veterans in care, by ensuring that pre-exposure prophylaxis is available to Veterans who are at high risk of acquiring HIV and meet certain criteria, and by disseminating comprehensive evidence-based HIV prevention strategies among HIV–negative Veterans to ensure that they remain uninfected and 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 ensure that all Veterans diagnosed with HIV in VA are linked to an appropriate provider in a timely manner. 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 high quality of care. All Food and Drug Administration (FDA) approved anti-retroviral medications will be made available to Veterans with HIV.

Veterans with HIV suffer from high rates of co-morbidities, which may include mental health disorders, cardiovascular disease, renal dysfunction, metabolic disorders, and substance abuse. VA will ensure that all Veterans with HIV receive the care they need for these conditions and that health outcomes for Veterans with HIV are equitable or exceed the standard of care in the community. The Program Office will also ensure that educational opportunities about managing and treating HIV and its co-morbidities are made available to all VA providers. Providers and facility leaders will be held accountable to these standards and annual reports produced by VHA's Office of Public Health on the quality of care HIV-positive Veterans receive. The National HIV Program Office will provide feedback to VA providers, leadership, and the public on quality indicators of HIV/AIDS care delivered to Veterans through these annual reports.

Goal 3: Reduce HIV-related health disparities.

All HIV-positive Veterans will have equal access to highly active anti-retroviral 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 National 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 National HIV Program Office is 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.

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

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$124,296	$134,000	$132,700	$141,200	$149,700	$8,500	$8,500

The mission of Blind Rehabilitation Service (BRS) is to assist eligible blind and visually impaired Veterans and Servicemembers in developing the skills needed for personal independence and successful reintegration into the community and family environment.

BRS is an integrated system of care that includes:

- 13 inpatient blind rehabilitation centers ;
- 11 outpatient blind rehabilitation clinics;
- 43 low vision clinics;
- 157 blindness case managers (called Visual Impairment Services Team (VIST) Coordinators) for the most severely disabled blind Veterans; and
- 78 Blind Rehabilitation Outpatient Specialists (BROS) who provide care in Veterans' homes. BROS are also assigned to Polytrauma Centers and Sites to partner for the care of Servicemembers and Veterans whose polytrauma includes vision loss.

Rehabilitation in BRS is interdisciplinary and patient-centered, using integrated plans of care that address the Veterans' needs and goals to guide service delivery. Family members, included as members of the team, are provided with education and training that allow them to understand visual impairment and provide support for goals. The specialized blind rehabilitation database provides a mechanism for coordinated system-wide care, management and data analysis. BRS personnel evaluate and determine best practices for cutting-edge technology that provides blind Veterans and Servicemembers with peak performance.

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

<u>Intermediate and Advanced Low-Vision Clinics</u>
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 ensure 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 intense, short-term (about 2 weeks) outpatient blind rehabilitation. They provide comfortable overnight accommodations for distant 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, adjustment counseling and education for severely visually impaired Veterans and active duty Servicemembers and their families. Every VA Medical Center is required to provide a Visual Impairment Service Team to assure that severely disabled blind Veterans are providing all benefits to which they are entitled.

Blind Rehabilitation Outpatient Specialists (BROS)
BROS are multi-skilled professionals who provide direct blind and vision 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 (BRC)
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 that includes not only blindness professions, but also nursing, social work, psychology and optometry. 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.

VA continually improves access to specialized rehabilitation services for Veterans with visual impairment and blindness. Programs include:

- Low vision services to maximize remaining vision – these programs include access to optical and electronic devices that enhance vision.
- Orientation and mobility training to assure that Veterans are able to move safely in their environments, are able to wayfind using orientation

techniques and small mobile global positioning systems, are able to travel safely on public transportation.

- Enhanced activities of daily living training to assure that Veterans are able to clean and organize their homes, manage medication and healthcare regimens, manage time effectively, shop, cook, dress, manage finances, and provide care for other family members.
- Cutting edge technology assessment and training for the use of personal computers, tablets and smartphones and their applications, global positioning systems, Braille, speech-output devices, etc.
- Manual skills training that leads to successful abilities to resume leisure activities, home maintenance, carpentry, car repair and maintenance, etc.
- Inpatient transitional rehabilitation programs, focusing on independent living and community re-integration.
- Telehealth assessment, treatment, and monitoring options for Veterans with visual impairment.
- Partnerships with Recreational Therapy so that Veterans may participate in leisure sports and games, as well as competitive sports.
- Partnership with Care Management and Social Work Service to assure that PACT social workers identify, counsel and refer Veterans with visual impairment appropriately.
- Partnerships with Optometry and Ophthalmology to assure that Veterans, whose visual impairment cannot be managed with basic low vision care, are identified and referred for care in BRS programs.
- Partnerships with other programs in VA's Rehabilitation and Prosthetics Services to assure standardization in workload capture, guidance on best practices; devising appropriate medical coding practices, and prosthetics and sensory aids guidelines for emerging technology.

BRS also partners with external agencies to ensure that VA provides world-class care for Veterans visual impairment and blindness:

- VA blind and vision rehabilitation programs are accredited 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 BRS inpatient centers and outpatient clinics.
- In collaboration with the DoD Vision Center of Excellence, BRS staff partner to provide early identification and support case managers to coordinate vision and rehabilitation care services for active duty Servicemembers;

assess technology gaps for Servicemembers and Veterans with visual impairments and perform a gap analysis for assistive technology.

- BRS staff members serve on a workgroup for the Academy for Certification of Vision Rehabilitiation & Education Professionals (ACVREP) to develop and deploy a certification in Blindness Assistive Technology.

- BRS and Prosthetics and Sensory Aids Service (PSAS) partner with guide dog training schools to ensure that Veterans who are interested in working with a guide dog are assessed for appropriateness, understand the responsibilities in acquiring and working with a guide dog, and are referred to schools that meet the highest international standards. After referral and procurement, PSAS supports the health and equipment costs of working dog partners.

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

		2013			2015	2013-2014	2014-2015
	2012	Budget	Current	2014	Advance	Increase /	Increase /
	Actual	Estimate	Estimate	Estimate	Approp.	Decrease	Decrease
Obligations ($000)							
CHAMPVA	$1,181,775	$1,229,808	$1,287,000	$1,404,164	$1,531,000	$117,164	$126,836
Foreign Medical Program (includes Foreign C&P Exams).	$26,364	$25,759	$25,759	$27,587	$30,116	$1,828	$2,529
Spina Bifida Program	$25,256	$26,691	$26,691	$27,901	$29,164	$1,210	$1,263
Children of Women Vietnam Vets	$0	$200	$200	$200	$200	$0	$0
Subtotal	$1,233,395	$1,282,458	$1,339,650	$1,459,852	$1,590,480	$120,202	$130,628
Operating Expense:							
Administrative	$76,545	$97,342	$96,085	$108,034	$110,737	$11,949	$2,703
Facilities	$4,771	$5,778	$5,778	$6,093	$6,425	$315	$332
Total	$1,314,711	$1,385,578	$1,441,513	$1,573,979	$1,707,642	$132,466	$133,663

The Veterans Health Care Expansion Act of 1973, P.L. 93-82, authorized VA to provide a health benefits program which shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001, P.L. 107-14, extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65. 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; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense (DoD) TRICARE Program. CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for

Medicaid, Indian Health Service, and State Victims of Crime Compensation Programs.

The Veterans Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163, section 102, further expanded CHAMPVA to include primary family caregivers of certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through the existing CHAMPVA Program when the primary family caregiver has no other health care coverage (including Medicare and Medicaid).

CHAMPVA programs also include Foreign Medical Program (FMP), Spina Bifida Health Care Program, and Children of Women Vietnam Veterans Health Care Program (CWVV).

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 where the VA Outpatient Clinic has jurisdiction of the health care services. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions.

Spina Bifida Health Care Program - Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, P.L. 104-204, section 421, VA administers the Spina Bifida Health Care Program for birth children of Vietname Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003, P.L. 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 only for medical services associated with spina bifida; under the Veterans' Mental Health and Other Care Improvements Act of 2008, P.L. 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, P.L. 106-419, section 401, VA administers the CWVV program for children with certain birth defects born to women Vietnam Veterans. The CWVV Program provides reimbursement only for covered birth defects.

Education and Training - Health Care Professionals

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)							
Education and Training Support[1]	$845,843	$890,029	$890,029	$934,530	$990,601	$44,501	$56,071
Trainees[2]	$815,806	$855,851	$855,851	$904,686	$962,897	$48,835	$58,211
Total	$1,661,649	$1,745,880	$1,745,880	$1,839,216	$1,953,498	$93,336	$114,282
Health Profs. Individuals Rotating thru VA							
Physician Residents & Fellows	36,745	36,019	36,019	36,222	36,425	203	203
Medical Students	20,516	23,367	23,367	23,995	24,100	628	105
Nursing Students	26,339	32,180	32,180	32,440	32,700	260	260
Associated Health Residents & Students	31,700	24,916	24,916	25,316	25,716	400	400
Total	115,300	116,482	116,482	117,973	118,941	1,491	968

[1] Educational supplement to the Veterans Equitable Resource Allocation (VERA) model in support of the indirect costs of VA medical centers that have clinical training programs. These funds help offset costs such as faculty time, education office staffing, accreditation costs, and space and equipment needs.

[2] Special Purpose funds that are allocated in the President's Budget to directly fund the stipends and benefits of VA clinical trainees who rotate through VA medical centers during the year.

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. The critical areas of need are based on the VA and VHA strategic plans and VA Secretary's priorities.

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. There are 124 VA medical centers and three independent outpatient clinics that maintain affiliations with 126 of 141 allopathic medical schools and 15 of 26 osteopathic medical schools. 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 Nation's health care system evolves, VA represents the leading edge of innovative educational and clinical training programs that benefit Veterans and all Americans.

Emergency Care

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$417,925	$570,000	$465,305	$518,980	$580,232	$53,675	$61,252

Under the Veteran's Millennium Health Care Act, P.L. 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, or 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

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$140,837	$181,300	$181,300	$186,200	$189,900	$4,900	$3,700

The Green Management Program, residing in VA's Office of Management, integrates energy, environmental, vehicle fleet, and sustainable (green) building management challenges at the Department level. The program's scope and policies cover all VA administrations and staff offices. The main program resource is non-NRM Medical Facilities funding. Key requirements for Federal agencies to achieve a variety of green management performance benchmarks are contained in: the Energy Policy Act of 2005; Executive Order (EO) 13423 (January 2007); the Energy Independence and Security Act of 2007; EO 13514 (October 2009); Presidential Memorandum – Implementation of Energy Projects and Performance-Based Contracting for Energy Savings (December 2011); and Presidential Memorandum - Driving Innovation and Creating Jobs in Rural America through Biobased and Sustainable Product Procurement (February 2012). These mandates include 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, among others. To meet these requirements, VA maintains Department-level task forces that develop, update and coordinate implementation of multi-year action plans for energy management, environmental stewardship, vehicle fleet management, sustainable building, and greenhouse gas emissions reduction. Each action plan and task

force includes representation from, and actions for, all VA administrations and relevant staff offices.

In 2012, VA successfully carried out an ambitious green management program. Among other accomplishments, VA: 1) created additional environmental management systems; 2) reached sustainable building certification totaling over 20% by square footage and 9.2% by number of buildings, and started the certification process on 50 additional buildings; 3) reached completion of 99% of meter installations for steam, water and natural gas at VA-owned facilities nationwide; 4) awarded over 47 energy projects including solar, geothermal, renewably fueled combined heat and power plants, energy and water conservation implementation, and building retro-commissioning; and 5) undertook 45 detailed feasibility studies evaluating potential additional renewably fueled on-site energy projects. The Green Management Program also continued funding facility and regional level energy and environmental manager positions.

In 2013 and 2014, VA plans to implement additional solar, geothermal, and combined heat and power energy projects. Other planned initiatives include:

1) implementation of Energy Saving Performance Contracts (ESPCs) and Utility Energy Savings Contracts (UESCs) to total $160 million in investment;
2) constructing up to 11 combined heat and power projects (renewably fueled where viable);
3) completion of retro-commissioning for 50% of VA facilities;
4) energy assessments of up to 40 facilities;
5) improvements to the functionality of VA's national utility metering data collection and analysis system;
6) obtaining green building certification for up to 200 existing buildings;
7) renewable energy feasibility studies at up to 50 sites; and
8) continued funding of facility and regional level energy managers and environmental coordinators.

See Chapter 9.2, Green Management Program, in Volume 4, for additional program information.

Comprehensive Emergency Management Program (CEMP)

	2012	2013		2014	2015	2013-2014	2014-2015
		Budget	Current		Advance	Increase /	Increase /
	Actual	Estimate	Estimate	Estimate	Approp.	Decrease	Decrease
Obligations ($000)	$155,331	$156,095	$156,095	$164,385	$174,395	$8,290	$10,009

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 DoD 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 Veterans Integrated Service Networks (VISN)-based patient evacuation capabilities, a federal emergency regional coordination program, field evaluation, and contingency support for CEMP.

Gulf War Programs

		2013			2015	2013-2014	2014-2015
	2012 Actual	Budget Estimate	Current Estimate	2014 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)	$1,784,281	$1,941,000	$1,981,500	$2,189,800	$2,412,700	$208,300	$222,900

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 and diagnostic evaluations for 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; conducting surveys of Gulf War Veterans to determine if they have any adverse health effects related to their deployment; and, developing effective outreach and educational tools for Gulf War Veterans with health concerns related to potential environmental exposures and their deployment.

Health Care Sharing

		2013			2015	2013-2014	2014-2015
	2012 Actual	Budget Estimate	Current Estimate	2014 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Services Purchased by VA:							
Obligations ($000)	$1,115,470	$1,092,003	$1,160,089	$1,206,492	$1,254,752	$46,403	$48,260
Services Provided by VA:							
Reimbursements ($000)	$48,953	$42,310	$50,912	$52,948	$55,066	$2,036	$2,118

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, P.L. 104-262. VA also procures health care resources using Federal Supply Schedules. These authorities are the contracting mechanism of choice for VHA and non- 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 medical schools, medical practice groups, and academic institutions, allow quality service and support VHA 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

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
VA Services Purchased from DoD:							
Obligations ($000)	$94,025	$86,419	$86,419	$88,147	$89,910	$1,728	$1,763
VA/DoD Sharings Svcs, VA Provided:							
Reimbursements ($000)	$157,396	$191,041	$191,041	$194,861	$198,758	$3,820	$3,897

Section 721 of the 2003 National Defense Authorization Act (NDAA), P.L. 107-314, required DoD and VA to establish a joint incentive program to identify, implement, fund, and evaluate creative coordination and sharing initiatives at the facility, intraregional, and national levels. Title 38 U.S.C., Section 8111 authorizes VA and DoD to enter into sharing agreements for the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both Departments.

Health Professionals Educational Assistance Program (HPEAP)

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)							
Education Debt Reduction Program (EDRP)	$19,208	$31,333	$18,000	$22,000	$26,000	$4,000	$4,000
Employee Incentive Scholarship Program (EISP)	$1,801	$2,000	$2,000	$2,000	$2,000	$0	$0
VA Nursing Education for Employees Program (VANEEP)	$7,641	$14,573	$10,573	$14,573	$14,573	$4,000	$0
Nat'l Nursing Education Initiative (NNEI)	$15,061	$17,049	$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	$900	$0	$450	$900	$450	$450
Total	$43,711	$69,361	$47,622	$59,578	$66,136	$11,956	$6,558

The Education Debt Reduction Program (EDRP) was authorized by the Veterans Programs Enhancement Act of 1998 (P.L. 105-368) and implemented in 2002. The statute was amended by the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135) and the Caregivers and Veterans Omnibus Health Service Act of 2010 (P.L. 111-163). The program serves as both a recruitment and retention tool. Legislation authorizes VHA to offer education debt reduction reimbursements to employees 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 when recruitment and retention of qualified personnel is difficult. In addition to being in positions difficult to recruit and retain, the employees must have qualifying loans.

The law allows EDRP participants who are full-time employees to receive education debt reduction payments up to a maximum of $60,000. Award reimbursements are made annually for one to five years. Under P.L. 111-163 , there is allowance for the Secretary to grant waivers to the $60,000 cap for certain critical hires. 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 FY 2002 through March 18, 2013, 9,820 VHA employees have been approved for EDRP as a recruitment or retention incentive. A total of $180 million has been reimbursed or will be reimbursed to these EDRP recipients through FY 2018. Traditionally across VHA, many VISNs have identified physicians, registered nurses, and pharmacists as their most difficult positions to recruit and retain. These occupations are identified and analyzed on an annual basis as part of the workforce succession planning process, where initiatives and strategies to compete for these practitioners in the health care market are outlined.

In spite of more than 20% growth in the Title 38 and Hybrid Title 38 workforce, the EDRP program has not grown as quickly as initially anticipated after passage of P.L. 111-163. Low utilization of EDRP may be due to participants defaulting on loans and consequently being terminated from the program and employees vacating the qualifying EDRP position. However, VHA projects ~~slightly~~ increased utilization of EDRP for 2014 based on the following factors:

- Increased award amounts from the previous VA cap of $48,000 to the legislative cap of ~~up to~~ $60,000;
- Expanded use of EDRP as a recruitment incentive for the current Mental Health Hiring Initiative; and,

- Additional hiring associated with the activation of new VHA medical centers.

The Employee Incentive Scholarship Program (EISP) was established by Title VIII of Public Law 105-368, Department of Veterans Affairs Health Care Personnel Incentive Act of 1998, and codified in sections 7671-7675 of Title 38, United States Code (U.S.C.). The statute was amended by Public Law 107-135, the Department of Veterans Health Care Programs Enhancement Act of 2001, Public Law 108-170, the Veterans Health Care, Capital Asset, And Business Improvement Act of 2003, and Public Law 108-422, the Veterans Health Programs Improvement Act of 2004. 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.

The reduced 2012 actual expenditures for the EISP, NNEI, and VANEEP reflect a cumulative effect of program changes. Participants in EISP, NNEI, and VANEEP receive multi-year scholarships. To address rising out-year costs and increasing attrition rates in these programs, VHA has implemented changes to these programs over the past two years. These changes include implementing NNEI funding distribution allocations for each medical facility and requiring Facility Director endorsements, justifications, and commitments to hire in new occupations after completion of programs. The cumulative effect of these changes has been a reduced number of applications due to revised selection criteria, decreased immediate funding requirements, and reduced out-year funding obligations. However, as a result of various initiatives to increase the number of mental health professionals and the number of clinical nurse leaders, VHA projects increased use of NNEI and VANEEP in 2014.

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. Title 38 U.S.C. section 7631 allows for periodic adjustments in the amount of assistance whenever there is a general Federal pay increase. As of September 2012, VA has awarded 13,036 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 P.L. 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 projected that the regulatory process for the new scholarship programs will be completed in 2014. The first scholarship awards are anticipated to occur in the first quarter of fiscal year 2015.

Homeless Veterans Programs

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)							
Homeless Veterans Treatment Costs	$4,018,916	$4,410,369	$4,447,145	$4,827,583	$5,216,555	$380,438	$388,972
Programs to Assist Homeless Veterans[1]							
Permanent Housing/Supportive Services							
HUD-VASH case management	$169,873	$244,602	$244,602	$278,183	$78,183	$33,581	($200,000)
Subtotal	**$169,873**	**$244,602**	**$244,602**	**$278,183**	**$78,183**	**$33,581**	**($200,000)**
Transitional Housing							
Grant & Per Diem	$208,046	$202,468	$202,468	$214,990	$214,990	$12,522	$0
Grant & Per Diem Liaisons	$26,400	$32,857	$32,857	$35,010	$35,010	$2,153	$0
Other - Sustainment	$34,892	$14,885	$38,370	$44,203	$17,726	$5,833	($26,477)
Health Care for Homeless Vets (HCHV)	$118,889	$195,577	$137,013	$137,013	$97,013	$0	($40,000)
Subtotal	**$388,227**	**$445,787**	**$410,708**	**$431,216**	**$364,739**	**$20,508**	**($66,477)**
Prevention Services							
Supportive Services Low Income Vets & Families	$99,974	$300,000	$300,000	$300,000	$300,000	$0	$0
National Call Center for Homeless Veterans (NCCHV)	$3,882	$3,200	$3,200	$3,853	$3,853	$653	$0
Justice Outreach Homelessness Prevention Initiative	$18,338	$20,850	$20,850	$33,751	$33,751	$12,901	$0
HUD-VA Pilots (VHPD)	$1,393	$3,412	$3,412	$0	$0	($3,412)	$0
Subtotal	**$123,587**	**$327,462**	**$327,462**	**$337,604**	**$337,604**	**$10,142**	**$0**
Treatment							
Domiciliary Care for Homeless Vets - Sustainment	$198,987	$183,192	$202,423	$218,974	$218,974	$16,551	$0
Domiciliary Care for Homeless Vets - Initiative	$19,975	$31,560	$31,560	$0	$0	($31,560)	$0
Substance Abuse/Mental Health Enhancement	$3,534	$6,800	$6,800	$0	$0	($6,800)	$0
Expansion of Homeless Dental Initiative	$10,307	$10,342	$10,342	$0	$0	($10,342)	$0
Subtotal	**$232,803**	**$231,894**	**$251,125**	**$218,974**	**$218,974**	**($32,151)**	**$0**
Employment/Job Training							
Homeless Veterans Supported Employment Program (HVSEP)	$25,196	$33,822	$33,822	$35,513	$0	$1,691	($35,513)
Homeless Ther. Empl, CWT & CWT/TR - Sustainment	$73,067	$62,402	$78,250	$85,328	$0	$7,078	($85,328)
Subtotal	**$98,263**	**$96,224**	**$112,072**	**$120,841**	**$0**	**$8,769**	**($120,841)**
Administrative							
Getting to Zero	$3,340	$3,466	$3,466	$3,466	$0	$0	($3,466)
National Homeless Registry	$7,178	$2,416	$2,416	$2,458	$500	$42	($1,958)
Subtotal	**$10,518**	**$5,882**	**$5,882**	**$5,924**	**$500**	$42	($5,424)
VA Require Total							
Grand Total	**$1,023,271**	**$1,351,851**	**$1,351,851**	**$1,392,742**	**$1,000,000**	**$40,891**	**($392,742)**

[1]As with all VA Medical Care initiatives, in 2014, funding shown reflects the total estimated costs of these programs. Final 2015 funding levels for these programs will be determined during the 2015 budget process.

On a single night in January 2012, 62,619 Veterans were homeless; however, it is estimated that over the course of the year, approximately 144,842 Veterans experienced homelessness.[1] VA is committed to preventing and ending homelessness among Veterans, and is poised to assist homeless and at-risk Veterans through the provision of a comprehensive continuum of care that includes Outreach/Education, Prevention, Treatment, Income/Employment/Benefits, and Housing/Supportive Services provided in collaboration with Federal, state, local governments and community partners.
The VA Plan to End Homelessness among Veterans became a primary initiative of the Department and was incorporated into VA's Transformational Initiatives,

[1] **U.S. Department of Housing and Urban Development.** ***The 2012 Point-in-Time Estimates of Homelessness: Volume I of the 2012 Annual Homeless Assessment Report to Congress.***

where it is referred to as Eliminate Veteran Homelessness (EVH). The efforts are integrated Department-wide and include the support of the National Cemetery Administration (NCA) and the Veterans Benefits Administration (VBA). The Office of Public and Intergovernmental Affairs (OPIA) Homeless Veterans Initiatives Office (HVIO) is the lead organization for this initiative. HVIO has primary responsibility for the initiative's internal and external communication strategies, federal and state level interagency collaborations and national policy development. The administration of VA's clinical homeless programs are aligned within the Veterans Health Administration (VHA), Office of the Deputy Under Secretary for Operations and Management, which is accountable for the budget execution of VHA's Homeless Veterans Programs, and for the provision of clinical intervention and treatment services for homeless and at-risk Veterans. The VBA, NCA, and the Office of Asset Enterprise Management (OAEM) are collaborative partners in the EVH initiative that operate within their respective budgets -- separate from VHA's Homeless Veteran Programs -- and are accountable to their own leadership for their performance.

VA is positioned to assist homeless and at-risk Veterans in achieving their optimal level of functioning and quality of life through the provision of a comprehensive continuum of care that address the psychosocial factors surrounding homelessness while building the capacity of available residential, rehabilitative, transitional, and permanent housing supply. The continuum includes both prevention and treatment services. These services include but are not limited to: primary and specialty medical care, mental health and substance use disorder treatment, case management, outreach, vocational rehabilitation/employment services, housing, and coordination of related services with VBA and NCA. This continuum includes VA Medical Centers (VAMCs), Public Housing Authorities (PHAs), and Continuums of Care (CoCs), as well as a range of public and private nonprofit providers. The intent is for every eligible Veteran to have access to a safe, stable environment, and that there will be sufficient capacity so that all Veterans willing to accept services will be able to leave the streets and enter shelter/housing in order to stabilize and begin rebuilding their lives.

Since the inception of the EVH transformational initiative, VA has not only expanded existing programs and developed new programs, but has increased efforts to: develop partnerships with federal and state agencies, Veterans Service Organizations, national advocacy groups, and community-based providers; enhance outreach efforts to agencies as well as to individual Veterans; increase data collection and reporting methods including by working closely with federal agencies and local continuums of care; and develop new methods to explore evidence-based research and test best practice models.

Additionally, VA has made unprecedented efforts to promote the services available to Veterans who are homeless or might become homeless through its comprehensive approach to outreach (media and 'boots on the ground'), the implementation of an at-risk clinical reminder in VAMC out-patient settings and continued interaction and collaboration with public and private sector partners. The total number of Veterans served in VHA's specialized programs for homeless or at-risk Veterans in 2012 was 200,094, an increase of 27% from 2011. VA has also increased its capacity to provide services for Veterans in need. These increases, combined with the new programs and outreach VA has launched in the past year, make VA optimistic that the number of homeless Veterans will continue to decline.

Recent Enhancements:

Housing First: In FY 2012, VHA expanded implementation of the evidence-based practice, Housing First. The Housing First model prioritizes housing and then assists the Veteran with access to healthcare and other supports that promote housing stabilization and improved quality of life. What differentiates a Housing First approach from other strategies to end homelessness is that there is an immediate and primary focus on helping the homeless Veteran quickly access and sustain permanent housing. Housing First is a model that promotes rapid access and dispenses with trying to determine who is "housing ready" or demanding treatment prior to housing. Treatment and other support services are wrapped around the Veteran as they obtain and maintain permanent housing. Housing First must target and place the most needy, most vulnerable Veterans into permanent housing directly from streets, shelters and emergency housing unless there is a need for acute medical intervention. VA medical centers (VAMC) in 14 high-priority, high-volume communities implemented the Housing First model for chronically homeless Veterans, targeting street homeless. Through this initiative 450 Veterans have exited homelessness and are now living in permanent supportive housing. Lessons learned from this initiative informed VA to include and promote a larger systems transformation within VA to include a Housing First modality as policy. The implementation and dissemination model utilized by VA is also serving as a prototype for the Department of Housing and Urban Development (HUD) and VA to promote larger community adoption of Housing First.

Homeless Veteran Patient Aligned Care Teams (H-PACT)**:** This initiative was implemented in each of the 25 targeted United States Interagency Council on Homelessness (USICH) high priority cities within the United States with the intention to provide integrated, coordinated and comprehensive clinical and primary care in conjunction with homeless services. These 25 cities, and the VA facilities within them, have approximately 70% of all homeless Veterans

nationally, and it is expected that this initiative will substantially reduce emergency department and inpatient-level care while facilitating earlier exits from homelessness. In 2012, 3,402 Veterans were enrolled in one of 31 H-PACTs located in 28 facilities. Veterans enrolled in H-PACTs have more complex and intense health care needs than Veterans enrolled in general PACTs. In initial assessments, enrollment in H-PACTs has been associated with greater health outcomes.

Existing programs:

Housing and Urban Development-VA Supportive Housing (HUD-VASH) case management: 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. HUD-VASH is a collaborative effort, combining HUD Section 8 "Housing Choice" tenant-based rental assistance with 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. Based on planned program expansion, an additional 12,200 Veterans and their families will be housed in permanent supportive housing by the end of 2013, bringing the total number housed to nearly 54,000. Historically, HUD-VASH primarily funded case management staff. In 2013, the HUD-VASH program funded a total of 562 additional positions in various disciplines, including peer support positions, employment specialists, psychiatrists, nurses, and housing specialists. This furthered VHA's goal of using 2013 funding to more fully support implementation of Housing First principles by creating greater diversity among the existing teams. VA was also able to fund over 20 additional Enhanced Housing First teams in cities identified as being high priority by VA, HUD and USICH. In 2014, VA projects that more than 64,000 Veterans will receive services through the HUD-VASH program.

Grant and Per Diem (GPD) Program: Under authority of the Veterans Benefits, Health Care, and Information Technology Act, P.L. 109-461, through the Homeless Providers GPD Program, VA awards grants to community-based agencies to create transitional housing programs and offer per diem payments to GPD funded organizations. These per diem payments help offset the operational costs of the program. The purpose is to promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. The GPD Program has more than 600 funded projects and over 15,000 beds nationwide. It is estimated that program expansions will create capacity for GPD to serve approximately 40,000 Veterans in 2013 and 40,000 Veterans in 2014.

Health Care for Homeless Veterans (HCHV): HCHV provides outreach and case management as well as residential services programs which target homeless Veterans transitioning from literal street homelessness, those being discharged from institutions, and Veterans who recently became homeless and require safe and stable living arrangements while they seek permanent housing. The program operates at 135 VA medical centers. In 2012, over 119,878 homeless Veterans were served through HCHV outreach, an increase of more than 21% from 2011. It is expected that more than 120,000 visits will occur with homeless and at-risk Veterans through these programs in each of 2013 and 2014. HCHV will fund outreach, contract residential treatment, and Community Resource and Referral Centers (CRRCs).

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): In 2012, 17 CRRCs were established in strategically selected locations to provide services in a "one-stop" environment to assist homeless and at-risk for homeless Veterans and their families. CRRCs enhance community engagement; fill gaps in community services for the local homeless Veteran population; and enable enhanced access to services, especially for chronic or newly homeless, women and women with children, and other hard to reach populations. In 2012, over 6,452 Veterans received services from CRRCs, accounting for more than 13,470 visits. Currently, 17 CRRCs have been established, and 15 are currently servicing Veterans. The remaining two CRRCs are expected to open in 2013. Based on demonstrated positive contribution to the community, additional CRRC investment is anticipated in FY 2013 and FY 2014.

Supportive Services for Low Income Veterans and Families (SSVF): At-risk Veterans benefit from early interventions to avoid homelessness for themselves and their families. VA has used the authority mandated in the Veterans Mental Health and Other Care Improvements Act of 2008, P.L. 110-387, and authority provided in other legislation to establish the SSVF program. VA provides resources through the SSVF program to provide supportive services to very low-income Veteran families. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veterans and their families by providing a range of supportive services designed to promote housing stability. In September 2012, VA awarded nearly $100 million in grants to 151 community agencies in 49 states and the District of Columbia. The sites encompass both rural and urban locations with the goal of preventing homelessness and maintaining housing stability for the Veteran's family. 2012 was the first full year of program operation, using grants awarded in 2011. In 2012, SSVF provided assistance to over 35,000 Veterans and their family members, including more than 8,800 children. In 2013, VA will award approximately $300 million in grants and expects to serve an estimated 100,000 Veterans and their family members. The requested 2014 funding of $300 million will allow VA to maintain this level of service in 2014.

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. In FY 2012, the NCCHV assisted 80,558 callers. It is anticipated that in 2013, the NCCHV will provide information and referral to approximately 86,000 Veterans and other interested parties and to 103,000 Veterans and other interested parties in 2014. The NCCHV is a national vehicle for VA to respond to 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, and Veterans in local county and city jails. A VJO Specialist is located at each VA medical center and works with local justice system partners to facilitate access and adherence to treatment for justice-involved Veterans. Funding for 178 full-time VJO Specialist positions was distributed in 2010, 2011, 2012, and 2013, and these Specialists supported collaboration with the Department of Labor's Incarcerated Veterans Transition Program. In 2012, 27,251

reentry Veterans were provided services through the program. Program enhancement is expected to provide services for 30,000 Veterans in 2013. Due to significantly increased community demand for VA outreach services to Veterans in jails and courts not yet served, additional staffing is planned for 2014 to bring the number of VJO Specialist positions to 248.

VJO funding will also support Health Care for Reentry Veterans (HCRV), a program designed to address the community reentry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment, and decrease the likelihood of re-incarceration for those leaving prison. In 2012, 10,572 justice-involved Veterans were provided services through HCRV.

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 and trained as Vocational Rehabilitation Specialists (VRS) to provide these services to Veterans enrolled in HCHV, GPD, HUD-VASH, and Domiciliary Care for Homeless Veterans, Health care for Reentry Veterans and VJO programs. Vocational and employment services are based on rapid engagement, customized job development, and competitive community placement. Services are provided within a community-based, as opposed to VAMC-based context, to promote community integration among homeless Veterans. The Veterans served by HVSEP are also provided with on-going supports after job placement to assist with employment maintenance. A Veteran participating in HVSEP will continue to receive case management services from the homeless team provider. In 2012, 12,815 unique homeless Veterans received services through HVSEP. It is expected that 20,000 Veterans will be served in 2013.

Getting to Zero: The Getting to Zero initiative provides funding for the Office of Public and Intergovernmental Affairs (OPIA) Homeless Veterans Initiative Office (HVIO). HVIO is the lead organization for the coordination, communication, and monitoring of the plan to eliminate homelessness among Veterans. Using performance data collected by HUD, VA, and other organizations, HVIO operates on behalf of the Secretary of the Department of Veterans Affairs to lead, learn, and recommend appropriate changes to internal and external programs to improve outcomes regarding the elimination of homelessness among Veterans. HVIO is the lead organization in the coordination with HUD to release Point-In-Time (PIT) data on homelessness among Veterans. Additionally, HVIO works

with USICH to coordinate efforts with Federal partners to assist homeless and at-risk Veterans and leads the collaboration with other Federal agencies to synchronize programs and services. HVIO also is responsible for the development and coordination of critical legislative authorizations and program re-authorizations to advance the program and administers the comprehensive national homeless outreach campaign to include major media events to increase awareness of VA services for homeless and at risk Veterans.

National Homeless Registry: VA has established a database to track and monitor homeless expansion and prevention initiatives and treatment outcomes for approximately 500,000 Veterans. The Registry serves as a data warehouse to identify and monitor 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): Working toward the objective of alleviating Veteran homelessness, VA is in process of fully executing the BURR initiative, whereby unused and underused buildings on existing VA property are evaluated for homeless housing potential through public-private collaboration and VA's Enhanced-Use Lease (EUL) program. The BURR initiative identified available property; in December of 2011, VA signed 38 leases to repurpose assets identified as part of this initiative. The execution of the BURR leases is projected to significantly advance VA's mission of ending Veteran homelessness by providing safe, affordable housing for Veterans on a priority basis. The BURR initiative allows VA to match supply (available VA buildings and land) with Veteran housing demand using third-party development, financing, and supportive services. This approach has the dual benefit of (1) supporting VA's initiative to end homelessness among our Veterans, while (2) contributing to the President's Federal real property initiatives by reducing the cost of operating VA's inventory of underutilized buildings and land.

VA first obtained legislative authority in 1991 to enter into EULs. An EUL is a cooperative arrangement in which underutilized VA properties are made available to public or private entities in exchange for consideration that furthers VA's mission. VA's EUL authority expired on December 31, 2011 but was reinstated, in modified, form via P.L. 112-154. Among other changes, the new authority stipulates that VA may enter into EULs only for the purpose of creating supportive housing. VA will propose certain amendments to Title 38 U.S.C. to authorize VA to pursue EULs for purposes beyond creating supportive housing,

similar to the broader authority that existed prior to expiration in December 2011. The current restricted EUL authority hinders VA's ability to enter into a wide range of agreements that could benefit Veterans.

Together through BURR and the EUL program, VA expects to increase the number of transitional and homeless housing facilities with the goal of providing housing and services for homeless Veterans and Veterans at risk of homelessness. Pending finalization of project financing and other aspects of project due-diligence, the 38 EULs executed under the BURR initiative in 2012 will contribute approximately 4,100 additional housing units. VA continues efforts to identify underutilized buildings and land suitable for repurposing as supportive housing for Veterans through future EUL projects.

Income Verification Match (IVM)

		2013			2015	2013-2014	2014-2015
	2012 Actual	Budget Estimate	Current Estimate	2014 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)							
VHA Support	$11,306	$11,645	$11,645	$11,645	$11,645	$0	$0
IT Support	$4,559	$7,114	$5,125	$5,125	$5,125	$0	$0
Total	$15,865	$18,759	$16,770	$16,770	$16,770	$0	$0

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 a co-pay-exempt 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 co-pays for medical care received during that particular income year. Additionally, the Veteran's enrollment status may be impacted as a result.

Long-Term Care

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Institutional:							
Obligations ($000)							
VA Community Living Centers	$3,486,115	$3,700,760	$3,685,521	$4,022,694	$4,152,766	$337,173	$130,072
Community Nursing Home	$617,412	$766,914	$663,162	$725,545	$762,005	$62,383	$36,460
State Home Nursing	$800,304	$947,135	$922,662	$1,012,740	$1,117,516	$90,078	$104,776
Subtotal (VA CLC, CNH, SNH)	$4,903,831	$5,414,809	$5,271,345	$5,760,979	$6,032,287	$489,634	$271,308
State Home Domiciliary	$58,133	$57,534	$59,877	$61,571	$63,933	$1,694	$2,362
Geriatric Evaluation & Mgmt (GEM)	$0	$0	$0	$0	$0	$0	$0
Total Institutional	$4,961,964	$5,472,343	$5,331,222	$5,822,550	$6,096,220	$491,328	$273,670
Average Daily Census							
VA Community Living Centers	9,992	9,928	9,758	9,527	9,305	(231)	(222)
Community Nursing Home	6,875	6,884	7,134	7,362	7,563	228	201
State Home Nursing	20,820	20,111	21,464	22,190	23,086	726	896
Subtotal	37,687	36,923	38,356	39,079	39,954	723	875
State Home Domiciliary	3,160	3,762	3,224	3,387	3,594	163	207
Total Institutional	40,847	40,685	41,580	42,466	43,548	886	1,082
Per Diem Costs							
VA Community Living Centers	$953.25	$1,021.26	$1,034.77	$1,156.83	$1,222.72	$122.05	$65.90
Community Nursing Home	$245.37	$305.22	$254.68	$270.01	$276.04	$15.33	$6.03
State Home Nursing	$105.03	$129.03	$117.77	$125.04	$132.62	$7.27	$7.58
State Home Domiciliary	$50.26	$41.90	$50.88	$49.80	$48.74	($1.08)	($1.07)
Denominator							
VA Community Living Centers	366	365	365	365	365	0	0
Community Nursing Home	366	365	365	365	365	0	0
State Home Nursing	366	365	365	365	365	0	0
State Home Domiciliary	366	365	365	365	365	0	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.

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Non-Institutional:							
Obligations ($000)							
VA Adult Day Health Care	$17,673	$16,868	$18,429	$19,645	$20,112	$1,216	$467
State Adult Day Health Care	$553	$621	$629	$716	$815	$87	$99
Community Adult Day Health Care	$52,963	$72,129	$66,866	$74,056	$78,753	$7,190	$4,697
Home-Based Primary Care	$477,408	$660,683	$572,937	$705,193	$734,783	$132,256	$29,590
Other Home Based Prgs:							
Home Respite Care	$22,712	$48,626	$29,021	$31,209	$32,357	$2,188	$1,148
Purchased Skilled Home Care	$165,644	$193,003	$186,366	$200,221	$206,065	$13,855	$5,844
Hospice Care	$67,341	$86,457	$75,651	$81,297	$81,694	$5,646	$397
Homemaker/Hm. Hlth. Aide Prgs	$321,817	$469,477	$396,318	$451,065	$467,863	$54,747	$16,798
Spinal Cord Injury Home Care	$10,861	$11,039	$11,325	$12,174	$12,661	$849	$487
Telehealth	$179,659	$155,100	$190,349	$208,526	$221,732	$18,177	$13,206
Community Residential Care	$27,171	$34,610	$27,728	$29,112	$29,912	$1,384	$800
Total Non-Institutional	$1,343,802	$1,748,613	$1,575,619	$1,813,214	$1,886,747	$237,595	$73,533
Total Long-Term Care	**$6,305,766**	**$7,220,956**	**$6,906,841**	**$7,635,764**	**$7,982,967**	**$728,923**	**$347,203**
Clinic Stops (VA Care)/Procedures (Purchased LTC)							
VA Adult Day Health Care	134,195		134,717	137,922	135,757	3,205	(2,165)
State Adult Day Health Care (ADC)	29	32	32	36	39	4	3
Community Adult Day Health Care	817,089		971,354	1,012,997	1,014,356	41,642	1,359
Home-Based Primary Care	1,048,717		1,177,402	1,252,638	1,283,851	75,236	31,213
Other Home Based Prgs:							
Home Respite Care	268,892		334,227	349,636	352,624	15,409	2,988
Purchased Skilled Home Care	1,598,397		1,749,373	1,828,236	1,830,349	78,863	2,112
Hospice Care	440,351		481,217	503,046	491,734	21,829	(11,312)
Homemaker/Hm. Hlth. Aide Prgs	6,224,690		7,414,568	8,130,194	8,203,277	715,627	73,083
Spinal Cord Injury Home Care	21,821		22,008	22,792	22,828	784	36
Telehealth (Participation Months)	826,257		861,162	889,971	911,338	28,810	21,367
Community Residential Care	77,667		76,662	77,545	76,730	883	(815)
Cost Per Clinic Stop/Procedure							
VA Adult Day Health Care	$131.70		$136.80	$142.44	$148.15	$5.64	$5.71
State Adult Day Health Care	$75.67	$77.33	$78.31	$79.24	$83.26	$0.93	$4.02
Community Adult Day Health Care	$64.82		$68.84	$73.11	$77.64	$4.27	$4.53
Home-Based Primary Care	$455.23		$486.61	$562.97	$572.33	$76.36	$9.36
Other Home Based Prgs:							
Home Respite Care	$84.47		$86.83	$89.26	$91.76	$2.43	$2.50
Purchased Skilled Home Care	$103.63		$106.53	$109.52	$112.58	$2.98	$3.07
Hospice Care	$152.93		$157.21	$161.61	$166.13	$4.40	$4.53
Homemaker/Hm. Hlth. Aide Prgs	$51.70		$53.45	$55.48	$57.03	$2.03	$1.55
Spinal Cord Injury Home Care	$497.73		$514.59	$534.13	$554.63	$19.55	$20.49
Telehealth	$217.44		$221.04	$234.31	$243.30	$13.27	$9.00
Community Residential Care	$349.84		$361.69	$375.42	$389.83	$13.73	$14.41
Denominator							
State Adult Day Health Care	252	251	251	251	251	0	0

Average cost per service shown may vary due to additional services that VA requests and pays for, as well as retroactive payments.

Note: With the exception of State Adult Day Health Care, the Non-Institutional Long-Term Care obligations are no longer derived based on the Average Daily Census (ADC) as it is not the optimal way to measure outpatient workload. This funding is now estimated based on a case mix of VA and non-VA (purchased care) visits and procedures and average cost per service.

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 Veterans who wish 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 four venues: VA Community Living Centers (CLCs); Community Nursing Homes; State Veterans Nursing Homes; and State Veterans Home Domiciliaries.

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 respite 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 Nursing 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) a 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, adult day health care, homemaker and home health aide services, Veteran-directed home- and community-based services, home respite care, home hospice care, community residential care, and 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

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Treatment Modality ($000):							
VA Inpatient Hospital	$1,702,601	$1,666,600	$1,723,290	$1,758,251	$1,780,154	$34,961	$21,903
Contract Inpatient Hospital	$296,309	$274,000	$332,260	$371,976	$416,115	$39,716	$44,139
Psychiatric Res. Rehab. Trmt	$315,270	$544,200	$335,978	$355,303	$376,021	$19,325	$20,718
VA Dom. Residential Rehab. Trmt	$510,182	$305,500	$565,677	$611,566	$650,277	$45,889	$38,711
VA Outpatient Clinics	$3,193,720	$3,406,189	$3,516,771	$3,842,390	$4,201,776	$325,619	$359,386
Purchased Outpatient	$26,651	$7,400	$30,815	$34,738	$38,657	$3,923	$3,919
Total	$6,044,733	$6,203,889	$6,504,791	$6,974,224	$7,463,000	$469,433	$488,776
Included Above:							
Improving Veteran Mental Health Initiative	$34,759	$19,791	$19,791	$17,224	$0	($2,567)	($17,224)
Not Included Above:							
VA - Mental Health in non MH Setting	$201,639	$242,933	$219,378	$236,677	$254,270	$17,299	$17,593
Major Characteristics of Program ($000):							
SMI - PTSD	$383,553	$417,688	$423,240	$457,377	$491,841	$34,137	$34,464
SMI - Substance Abuse	$588,070	$557,685	$633,202	$657,500	$683,183	$24,297	$25,684
SMI - Other Than PTSD & SA	$3,937,398	$4,176,129	$4,280,418	$4,636,762	$5,010,673	$356,345	$373,911
Subtotal, SMI	$4,909,021	$5,151,502	$5,336,860	$5,751,639	$6,185,697	$414,779	$434,058
Suicide Prevention Outreach[1]	$72,275	$72,812	$81,231	$83,203	$86,716	$1,972	$3,513
Other Mental Health (Non-SMI)	$1,063,437	$979,575	$1,086,700	$1,139,382	$1,190,587	$52,682	$51,205
Total Mental Health	$6,044,733	$6,203,889	$6,504,791	$6,974,224	$7,463,000	$469,433	$488,776
Included Above:							
OEF/OIF/OND POPULATION *ONLY*:[2]							
SMI - PTSD	$107,036		$135,688	$155,656	$175,614	$19,968	$19,958
SMI - Substance Abuse	$77,409		$102,041	$120,827	$139,858	$18,786	$19,031
SMI - Other Than PTSD & SA	$415,393		$472,711	$536,291	$612,817	$63,580	$76,526
Subtotal, SMI	$599,838		$710,440	$812,774	$928,289	$102,334	$115,515
Other Mental Health (Non-SMI)	$155,748		$177,610	$203,194	$232,072	$25,584	$28,878
Total OEF/OIF/OND	$755,586	N/A	$888,050	$1,015,968	$1,160,361	$127,918	$144,393
Average Daily Census:							
Acute Psychiatry	2,705	2,781	2,637	2,548	2,445	(89)	(103)
Contract Hospital (Psych)	326	284	372	415	455	43	40
Psy Residential Rehab	1,091	803	881	651	453	(230)	(198)
Dom Residential Rehab	5,090	6,362	5,264	5,380	5,410	116	30
Total	9,212	10,230	9,154	8,994	8,763	(160)	(231)
Outpatient Visits / Encounters:							
VA - Mental Health in non MH Setting	10,701,745	11,130,110	11,120,701	11,527,958	11,790,794	407,257	262,836
Fee Care - Mental Health	245,075	242,192	261,356	273,435	286,310	12,079	12,875
Not Included Above:							
VA - Mental Health in non MH Setting	609,183	602,470	641,937	666,306	681,226	24,369	14,920

SMI = Serious Mental Illness

[1] Suicide Prevention Outreach obligations were developed by the Office of Mental Health Services.
[2]This is the cost to provide mental health care to veterans who have separated from service and who served in the OEF/OIF/OND conflicts. PTSD funding includes all care where the Primary Diagnosis is for PTSD and all care provided by a PTSD subspecialty clinic or treating specialty where there is a secondary diagnosis of PTSD. Some mental health care is provided in non-Mental Health specialty areas such as Primary Care and Traumatic Brain Injury (TBI) clinics.

Overview of Mental Health Services:

Mental Health in VA Central Office has two components:

1. Mental Health Services (MHS) in the Office of Patient Care Services (OPCS) 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 (OMHO) 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 rehabilitation treatment, and inpatient care are available to meet the range of needs that Veterans have.

Mental Health Services (MHS) was responsible for developing the recommendations of the VHA Comprehensive Mental Health Strategic Plan (MHSP), implemented beginning in 2005 and completed in 2009. MHS 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 IVMH was tracked through the Major Initiative monthly reporting process during 2011 and 2012, and through the routine reporting processes in MHS beginning in 2013

The Office of Mental Health Operations (OMHO) is the operational partner to 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 within this section 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 later in this section.

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 and inpatient 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) Veterans.
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. 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 2012, VA medical centers have implemented 96% of the Handbook requirements.

VA is working closely with DoD and the Department of Health and Human Services (HHS) to implement President Barack Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Service Members, and Military Families," signed on August 31, 2012. The executive order reaffirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The executive order strengthens suicide prevention efforts, supports recovery-oriented mental health services through peer counseling, and supports VA in using a variety of recruitment strategies to hire 1,600 new mental health clinicians and 300 administrative personnel in support of mental health programs.

As of January 29, 2013, 3,262 mental health professionals and administrative support have been hired and are providing services to Veterans since the start of VA's Mental Health Hiring Initiative in April, 2012. Of these, 1,058 mental health providers have been hired specifically as part of the initiative to add 1,600 mental health professionals by June 30, 2013. A comprehensive recruitment and hiring plan is also being implemented to ensure the 800 peer specialists are hired and trained by December 31, 2013, including: identification of sites needing additional peer specialist positions, distribution of sufficient funding to facilities, and certification training to meet appropriate standards.

VHA has developed and implemented an aggressive recruiting and marketing effort to fill vacancies in mental health care occupations. This effort includes the following actions: working directly with mental health provider associations and training programs, conducting numerous media advertising efforts, developing a professional recruitment contract, and using incentives such as pay flexibilities and loan repayment to promote hiring of mental health professionals. Additionally, VA partners with the National Rural Recruitment and Retention Network for outreach to difficult-to-recruit areas and is partnering with HHS to collaborate on pilots that increase access to underserved areas.

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

Mental Health Integrated in Patient Aligned Care Teams (PACT): The *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook requires that integrated mental health services operate in PACT in primary care clinics in VA medical centers, very large Community-Based Outpatient Clinics (CBOCs), and large CBOCs. Integrated mental health 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. Integrated mental health services 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 on the following page.

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. Additionally, 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 November 2012, there were 96 VA Central Office-funded, formally designated PRRCs, and others are under development. Most PRRCs must be CARF-accredited (Commission on Accreditation of Rehabilitation Facilities) by the end of 2012. Currently, 79 PRRCs are CARF-accredited. Program evaluation efforts in collaboration with NEPEC have commenced.

VA Mental Health strongly promotes the use of certified peer specialists in the provision of treatment services. Veterans who are currently confronting a serious mental illness may be more willing to seek treatment and to share their experiences when they share a common bond of duty, honor, and service with the provider. Peers can be found in a wide variety of mental health programs, including inpatient mental health units, PRRCs, Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) and substance use disorder programs. Mental Health Services and the Office of Mental Health Operations are significantly expanding peer support services throughout VHA, with funding for an additional 800 Peer Specialists provided to the VISNs in 2013, in accordance with the Executive Order 13625. The ultimate goal is to have, at minimum, three certified Peer Specialists at each medical center and two certified Peer Specialists at each very large CBOC. This hiring initiative will not only improve existing services to Veterans but will also be a positive employment opportunity for Veterans who have mental health conditions to become successfully employed in meaningful and well-paying jobs. Many newly hired peer support staff will begin in apprentice roles and attend certification training paid for by VHA under a contract with the Depression and Bipolar Support Alliance (DBSA).

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. Increasing the incorporation of psychosocial rehabilitation and recovery-oriented values and practices on these teams is a major priority in the coming year. MHICM teams primarily serve urban and suburban Veterans in larger market areas, and RANGE serves Veterans in rural and small market areas. There are 112 MHICM teams serving over 8,000 Veterans with serious mental illness. A newer program, RANGE has expanded MHICM level care to rural areas and areas where the population

density has been too sparse to be served by conventional MHICM programs. There are now 30 RANGE programs serving over 900 Veterans.

Inpatient Care: Inpatient mental health services are available 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. Recovery-oriented principles and practices are being introduced into inpatient mental health settings to further the incorporation of this approach to care across the full continuum of mental health services. Facilities are incorporating 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. Additionally, facilities are being encouraged to incorporate design elements within their inpatient units to create warm, healing, and safe environments of care that promote patient and staff engagement and interaction.

Mental Health Residential Rehabilitation 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 complex mental health and substance use disorder treatment needs as well as co-occurring medical conditions and other psychosocial needs including homelessness. The MH RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration while providing specific treatment and services for mental health and substance use disorders and homelessness. Currently, VHA operates 241 MH RRTPs at 102 VA medical center facilities with a total of 8,429 operational beds located in all 21 VISNs. This includes programs providing specialized treatment for Post-Traumatic Stress Disorder (40 programs), substance use disorders (63 programs), and for Veterans who are homeless (44 programs). 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 Mental Health Services (MHS) 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,

MHS developed a MH RRTP Transformation Plan, which included a full review of all MH RRTPs and the development of a unified VHA MH RRTP Handbook. The Handbook, VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Programs*, established the policies, procedures and reporting requirements for the MH RRTP bed level of care; the current edition was published December 22, 2010. In addition, all MH RRTPs are directed to achieve and maintain CARF-accreditation.

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 Addictions Specialists are associated with these PTSD services. In accordance with the Mental Health Handbook, PTSD services are also provided in CBOCs. 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 consensus conferences based on thorough literature reviews support the efficacy of concurrent treatment of PTSD and these co-occurring disorders, following the guidance of the VA/ DoD Clinical Practice Guidelines. VA also supports research on new treatments including Complementary and Alternative Medicine approaches and innovative strategies for delivering care.

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 condition and those near them, substance use disorders are generally treatable with evidence-based psychosocial and pharmacological interventions.

Within the Veteran population, unhealthy drinking and other forms of substance misuse occur in forms that vary in frequency and severity. The most common and uncomplicated cases are best identified and treated in primary care and other general medical settings through programs that include screening, brief interventions, collaborative care within those settings and referral to specialty programs as needed. When these problems occur in the presence of other mental health conditions, they can be treated in various mental health clinic settings that provide integrated care for the co-occurring conditions. In recognition of this principle, VA has incorporated substance use disorder 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 from intensive residential care or multiple sessions of outpatient treatment several times per week, to less frequent ambulatory care visits. Monitoring response to treatment and sustaining patient improvement following initial stabilization are important components of the continuum of care.

Treatment for alcohol and other substance use disorders recognizes the principle that these are often chronic or recurring conditions. For some Veterans, treatment begins with medically-supervised detoxification provided in ambulatory or inpatient settings. However, for care to be effective over the long term,

detoxification and initial stabilization must be followed by continuing care using evidence-based psychosocial and/or pharmacological treatments. Evidence-based medication assisted treatment for opioid dependence, including buprenorphine, has expanded to 125 of the VA's 140 parent health care systems plus 129 sub-facilities or CBOC's.

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 available as part of the electronic health record and 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.

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 education/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 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. 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). Many facilities provide this care through specialized women only outpatient treatment teams. For those in need of more intense treatment, many facilities offer Mental Health Residential Rehabilitation Treatment Programs (MH RRTP), including women-only programs that specialize in women's care and MST-specific treatment.

To improve the care provided to women Veterans, monthly trainings are available to all VA staff on women's mental health topics and a SharePoint site is under construction to make up–to-date information and treatment materials readily available for providers. In addition, during 2011 the Women's Section of MHS completed a national survey of all VA facilities to further describe current mental health care delivery for women Veterans and those who experience MST,

including existing services, challenges, and best practices for provision of gender-sensitive mental health care.

Given the needs of the rapidly growing population of women served by VHA, OMHS has recently expanded its Women's Mental Health Section and is working on a strategic analysis with DoD that will focus on identifying current practice, disparities and opportunities for improvement.

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 has also completed a pilot initiative to disseminate and implement an adapted evidence-based psychosocial intervention (STAR-VA) for managing challenging behaviors associated with dementia in CLC residents; evaluation results indicate that the intervention was associated with significant reductions in the frequency and severity of challenging dementia-related behaviors and in reductions in depression and anxiety symptoms. In light of these positive findings, VA plans to engage in further implementation of STAR-VA at additional CLCs in 2013. 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, as documented in an October 2011 Government Accountability Office (GAO) report titled, *VA MENTAL HEALTH: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*. 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 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. In 2012, VA hired and trained additional staff to increase the capacity of the Veterans Crisis Line by 50 percent. Through a nationwide public information campaign launched in September 2012 in conjuction with DoD – "Stand by Them" - 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 an award-winning, 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 traditional media (radio and television), internet, and social media (Facebook and You Tube) to reach as many Veterans as possible. At the heart of the campaign is a comprehensive, interactive website (www.maketheconnection.net) where Veterans and their friends and families can confidentially and easily connect with information and services that are most relevant to their own experiences and needs. The website features extensive videos of dozens of Veterans who share their personal stories of facing life events, experiences, physical injuries or psychological symptoms and overcoming a wide variety of challenges. To reach as many Veterans as possible with the Stand by Them and Make the Connection 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. A specific effort focused on increasing awareness of PTSD, "About Face" (http://www.ptsd.va.gov/apps/AboutFace/) has also been developed by the

National Center for PTSD and fully complements the messages and strategies of Make the Connection.

- **The SMI Re-engagement Program** is designed to re-engage in treatment 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 has been implemented nationally in 2012, with initial efforts targeting those Veterans most at risk for mortality. Subsequent efforts are focusing on re-engaging all Veterans with serious mental illness who have been lost to follow-up care since the end of the OMI project and will expand to identify such Veterans in as close to real time as possible.

- **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), relationship distress, substance use, and behavioral health conditions (e.g., insomnia and pain) widely available to Veterans who can benefit from them. The Uniform Mental Health Services Handbook requires 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, Behavioral Couples Therapy, Motivational Enhancement, and Contingency Management for substance use disorders; Motivational Interviewing for promoting motivation and adherence; Cognitive Behavioral Therapy for insomnia; and Cognitive Behavioral Therapy for chronic pain.

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 6,400 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 five years ago, relatively few facilities had evidence-based psychotherapy for PTSD available. In 2014, 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. VA is also proposing legislation that would allow VA to provide MST services to Veterans who experienced sexual trauma while serving on inactive 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 programs that offer specialized sexual trauma treatment in VA residential or inpatient settings. 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, MHS

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 was issued in January 2012. This training requirement complements pre-existing and ongoing training opportunities provided by the MST Support Team, including monthly trainings on MST-related topics that are available to all interested 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.

Family Services: The Substance Abuse and Mental Health Services Administration (SAMHSA), in HHS, has defined one of its mental health recovery principles as "*Recovery is supported through relationship and social networks.*" *In accordance with this principle, p*artnering 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 education/training, consultation, and marriage and family counseling. National training programs in several evidence-based practices for marital and family counseling are available for clinicians. While some of these are specific to diagnosis (for example, Behavioral Couples Therapy for Substance Use) others are cross-diagnostic (for example, Integrative Behavioral Couples Therapy). The VA continues an active collaboration with the National Alliance on Mental Illness (NAMI), through a Memorandum of Understanding (MOU) to offer the family peer led Family-to-Family Education Program at VAs throughout the country. The VA also has an active monthly training program for clinicians on family issues and interventions of particular relevance to Veterans.

Collaboration with the Department of Defense (DoD): MHS also oversees the collaboration with DoD 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 Servicemembers 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 Servicemembers, 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 Servicemembers, 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); 3 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. Because of its particular prominence, additional information specifically on the NCPTSD follows.

Informatics: The Mental Health Informatics group within VHA Mental Health Services works closely with the Office of Information Technology (OI&T), VHA Office of Informatics and Analytics (OIA), and other VHA program offices to design and implement technology tools that support the transformation of Mental Health Services. For example, this includes the development of a variety of new products and resources for the My HealtheVet website, such as the My Recovery Plan component, and a number of self-assessment tools information resources. Particular emphasis is placed on providing tools for clinicians to support the delivery of evidence-based services; development of patient facing tools to support patient-centered care and preventative interventions; and on improving the monitoring of patient outcomes to support continuous improvement in care delivery.

Program Evaluation Centers: OMHO includes three Program Evaluation Centers that serve its needs as well as those of Mental Health Services. These include the Northeast Program Evaluation Center (NEPEC) in West Haven, CT; the Program Evaluation Resource Center (PERC) in Palo Alto, CA; and the Serious Mental Illness Treatment Resource and Education Center (SMITREC) in Ann Arbor, MI. 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 provides greater detail about the performance of each VISN and medical center in three domains: the Department's major transformation or "T21" initiatives, overall implementation of the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook, 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: OMHO also 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, 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

		2013			2015	2013-2014	2014-2015
	2012 Actual	Budget Estimate	Current Estimate	2014 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)	$16,307	$16,664	$16,666	$17,288	$17,919	$622	$631

The VA National Center for Post-Traumatic Stress Disorder (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 (P.L. 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 Mental Health Services (MHS) 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 Primary Care-PTSD (the questionnaire used in VA and DoD to screen for PTSD), and the PTSD Checklist (the most widely-used measure of PTSD symptom severity).
- Conducted the first VA Cooperative Study on PTSD, involving 15 national sites.
- Conducted the first study of PTSD treatment for female Veterans and active duty personnel, involving 12 national sites.
- Established the PTSD Resource Center and the PILOTS database, the Center's online database of the Published International Literature on Traumatic Stress.
- Created the leading website on trauma and PTSD, www.ptsd.va.gov.
- Produced the *Iraq War Clinician Guide* to help providers treat returning Service members.
- Created the *Psychological First Aid manual*, with the National Child Traumatic Stress Network, to help with mental health needs in the immediate aftermath of a disaster.
- Developed *PTSD 101*, an online curriculum focusing on issues related to warzone stress and PTSD.
- Developed an effective PTSD mentoring program to guide VA treatment nationally so that the most effective treatments and best practices for organizing care are supported throughout the system.
- 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 with a PTSD related question.
- 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 National Center for Telehealth and Technology (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.
- Launched a PTSD educational campaign, AboutFace: an online video gallery of Veterans talking about living with PTSD and how treatment turned their lives around.

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

		2013			2015	2013-2014	2014-2015
	2012 Actual	Budget Estimate	Current Estimate	2014 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)							
Non-Recurring Maintenance (Object Class 32).....	$1,491,107	$710,450	$1,335,300	$709,800	$460,600	($625,500)	($249,200)
Operating Leases (Object Class 23).....	$444,356	$559,400	$542,300	$626,700	$652,500	$84,400	$25,800
Total.....	$1,935,463	$1,269,850	$1,877,600	$1,336,500	$1,113,100	($541,100)	($223,400)

VHA uses its NRM projects to make additions, alterations, and modifications to 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 1,000 square feet 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 and development infrastructure 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 four 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 for infrastructure system housing not to exceed 1,000 square feet. 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 fifty 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 2013 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.

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

		2013			2015	2013-2014	2014-2015
	2012 Actual	Budget Estimate	Current Estimate	2014 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)	$2,924,868	$3,279,147	$3,566,000	$4,059,200	$4,552,400	$493,200	$493,200
Unique Patients	539,970	610,416	607,362	674,754	742,146	67,392	67,392
Cost Per Patient	$5,417	$5,372	$5,871	$6,016	$6,134	$455	$145

OEF/OIF/OND obligations reflect the total cost of medical care, including outreach services that are documented as medical encounters. These obligations do not include benefits or Readjustment Counseling.

VA provides 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 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 Servicemembers. The Department's outreach network ensures that returning Servicemembers 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 10% of the overall VA patients served. The funding estimates reflect the anticipated costs associated with the scheduled withdrawl of troops.

Pharmacy

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$5,775,545	$6,071,280	$6,042,234	$6,350,895	$6,709,726	$308,661	$358,831
# of 30-Day Prescriptions (millions)	266	283	270	273	276	3	3

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. One component of this effort is the VA Medication Order Check Healthcare Application (MOCHA). This application will provide clinical decision support for drug interactions and will become operational across all VA medical centers, replacing the previous system with a more efficient and safer product. Minor development is planned to be completed in December 2013. 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, such as DoD and the Indian Health Services, and with the National Library of Medicine. The Pharmacy Re-engineering project will begin to transition for inclusion under the VA/DoD integrated Electronic Health Record.

Prosthetics

		2013			2015	2013-2014	2014-2015
	2012 Actual	Budget Estimate	Current Estimate	2014 Estimate	Advance Approp.	Increase / Decrease	Increase / Decrease
Obligations ($000)	2,082,351	$2,586,000	$2,280,000	$2,478,000	$2,684,000	$198,000	$206,000

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 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

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$180,726	$197,000	$197,000	$205,000	$212,500	$8,000	$7,500
Obligations T-21 ($000)	$24,894	$25,000	$25,000	$25,000	$25,000	$0	$0
Total RCS Obligations ($000)	$205,620	$222,000	$222,000	$230,000	$237,500	$8,000	$7,500
Visits (000)	1,505	1,508	1,540	1,574	1,637	34	63
Unique Patients (RCS Only)	69,108	77,700	71,872	74,747	77,737	2,875	2,990
Total Patients*	193,665	207,873	201,412	209,468	217,847	8,056	8,379
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 FTE in 300 Vet Centers, 70 Mobile Vet Centers, and the Vet Center Combat Call Center. These Vet Centers are located in all 50 states, American Samoa, the District of Columbia, Guam, and Puerto Rico. In 2012, over 193,500 Veterans and families were provided over 1.5 million visits at these locations. 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 conflicts 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 Servicemembers 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 the Vet Center Combat Call Center, 877-WAR-Vets, where combat Veterans and family members can call at any time to talk confidentially to combat Veterans or family members of combat Veterans (all 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 Veterans Crisis Line and the Dayton VA Primary Care Triage Hotline when medical care is needed. In 2012, the Vet Center Combat Call Center took over 37,000 calls from Veterans, their families, and concerned citizens.

With the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163, the Vet Center program was given the authority to extend services to members of the Armed Forces, including members of the National Guard or Reserve, who served on active duty in the Armed Forces in OEF/OIF/OND. VA and DoD are working together to implement this expansion of services.

Rural Health

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$248,040	$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: supporting rural clinics and rural home-based primary care; identifying and addressing 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; accelerating and expanding telehealth opportunities; operating the Rural Health Resource Centers to support implementation of innovative pilot projects; and collaborating with Federal and non-federal community partners to share resources and expand access to care for rural Veterans.

ORH continues to partner with Office of Academic Affiliations, Office of Telehealth Services, Office of Specialty Care Transformation, Office of Geriatrics and Extended Care, Women Veterans Health, Office of Mental Health Services, and others to improve the provision of primary and specialty care to Veterans living in rural and highly rural areas and enhance educational opportunities in rural communities.

Spinal Cord Injury

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)	$525,298	$583,000	$561,800	$601,400	$643,500	$39,600	$42,100
Unique Patients	14,451	14,628	14,748	15,064	15,380	316	316

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

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)							
TBI - All Veterans	$231,333	$280,139	$239,800	$245,600	$246,200	$5,800	$600
TBI-OEF/OIF/OND	$51,013	$60,401	$53,000	$50,600	$48,100	($2,400)	($2,500)

VA estimates the ten-year costs (2014-2023) to be $2.6 billion for TBI-All Veterans and $0.4 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 109 facilities with specialized rehabilitation programs for Veterans and Servicemembers 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; 86 Polytrauma Support Clinic Teams (PSCTs) that provide specialized evaluation, treatment, and community re-integration services; and 39 Polytrauma Points of Contact that facilitate referrals and access to PSC services.

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 services 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 assessment, treatment, and 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,
- Mandatory TBI Screening for possible 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. Additionally, 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 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, 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 about 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

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	2015 Advance Approp.	2013-2014 Increase / Decrease	2014-2015 Increase / Decrease
Obligations ($000)							
Gender-Specific Health Care	$326,074	$403,000	$370,800	$421,900	$476,500	$51,100	$54,600
Total Care	$4,110,659	$3,467,400	$4,485,700	$4,879,100	$5,291,800	$393,400	$412,700
Gender-Specific Unique Patients*	215,427	259,066	233,191	252,656	271,732	19,465	19,076
Women Veterans Total Unique Patients	354,210	375,545	370,098	385,192	399,532	15,094	14,340

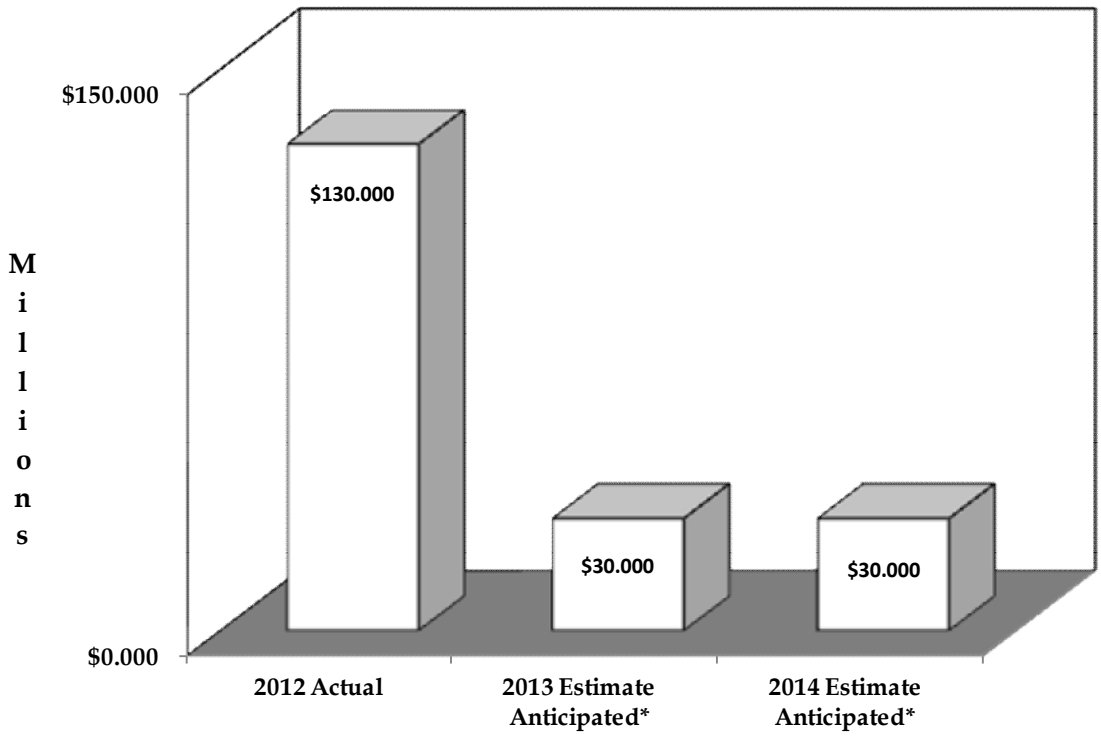
*Included in Women Veterans Total Unique Patients.

Women comprise nearly 15% of today's active duty military forces and 18% of National Guard and Reserves. Correspondingly, women are enrolling for VA health care at record levels: the number of women Veterans using VA health care has more than doubled since 2001. 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 using 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.

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 DOD-VA 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 benefit both VA and DOD.

The JIF 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 that Secretary's Department. The DOD-VA Health Care Sharing Incentive Fund was effective on 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	2012 Actual	2013 Budget Estimate	2013 Current Estimate*	2014 Estimate*	Increase/ Decrease
Transfer from Medical Services, P.L. 111-84	$15,000	$15,000	$15,000	$15,000	$0
Transfer from Medical Support & Compliance, P.L. 111-84	$50,000	$0	$0	$0	$0
Transfer from DOD, P.L. 111-84	$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	$57,650	$70,000	$94,000	$94,000	$0
FTE	151	140	225	250	25

* As required, VA and DOD will each transfer a minimum of $15 million to this fund (established by P.L. 107-314 and extended by P.L. 111-84).

Administrative Provision. An administrative provision related to the JIF is included in the VA chapter of the President's Budget Appendix.

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."

Governance and Accountability. 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 the following FY 2013 projects:

55th Medical Group (MedGrp) Offutt Air Force Base (AFB)/Omaha Veterans Affairs Medical Center (VAMC)
(Dermatology)
This initiative proposes to hire a Dermatologist and two technicians to work at the Dermatology clinic at the 55th Medical Group clinic and service both Veterans and DOD beneficiaries in Nebraska and the surrounding areas. This project will allow the 55th Medical Group to expand its dermatology service and provide more capacity for beneficiaries while also enhancing the training opportunities for our 72 military/civilian residents and 6 Physician Assistant students rotating through the clinic.

60th Medical Group (MedGrp) Travis AFB/Northern California Health Care System (HCS)
(Orthopedic Care)
This initiative will take advantage of excess orthopedic surgical capacity and a new 60th Medical Group musculoskeletal outpatient modernization project with the purpose of recapturing approximately 125 surgical cases and 500 consultations. This proposal calls for the hiring of 7 VA positions to support the administrative and clinical demands associated with the increased workload; purchase an automated patient check-in kiosk system to support the new modernization project by efficiently utilizing check-in throughput of the musculoskeletal clinic; and purchase a state of the art 3D portable X-ray (C-Arm) for the operating rooms.

355th Medical Group (MedGrp) Davis-Monthan AFB/Raymond W. Bliss Army Health Center (AHC)/Southern Arizona Health Care System (HCS)
(Mental Health)
This proposal seeks to enhance access to inpatient and outpatient mental health services for DOD beneficiaries and Veterans by hiring 1 psychiatrist, 2 registered nurses and 3 health technicians; as well as renovating existing space at Southern Arizona HCS. The proposal will establish a joint inpatient partnership providing dedicated beds to DOD beneficiaries and contribute to the modernization resources of the VA facility. This initiative will significantly reduce the inpatient and outpatient mental health purchased care costs while allowing the three facilities to manage the mental health services more efficiently. The hands-on delivery of services will provide greater control of the care delivered, more efficiently track/record workload, and better management of medical documentation.

375th Medical Group (MedGrp) Scott AFB/St. Louis Health Care System (HCS)
(CBOC Renovation)
The project calls for the renovation of approximately 10,000 square feet of space on the 5th Floor, main Medical Group clinic, in order to move the existing Community Based Outpatient Clinic from Belleville, IL to Scott AFB. This initiative will allow for shared space, radiology and laboratory ancillary services, as well as the shared service of an Orthopedic Physician's assistant and Licensed Practical Nurse to provide a full range of outpatient Orthopedics services.

AF Medical Support Agency/South Texas Health Care System (HCS)
(Telehealth ENT)
This project proposes to purchase hardware, software and 1 FTE project manager to provide global awareness and visibility of all endoscopic images, videos and interpretive reports, as well as seamless integration with the DOD/VA Integrated Electronic Health Record (iEHR) and other Military Health System applications. Having a system that provides this capability will give DOD and VA otolaryngologists, gastroenterologists and other subspecialists utilizing endoscopic video imaging easy access to state-of-the-art diagnostic, consultative, mentoring and educational otolaryngology services. Once the operational capability have been met, this system will be expanded to additional Air Force, Army and Veterans Affairs facilities adding teleconsultation, education and mentoring capabilities.

Eisenhower Army Medical Center (AMC) Fort Gordon/Charlie Norwood Veterans Affairs Medical Center/Carl Vinson Veterans Affairs Medical Center VAMC
(Expanded Orthopedic Services)
The project is a collaboration among three federal facilities in Georgia which comprise the Georgia Federal Healthcare Executive. This joint effort calls for hiring an orthopedic physician assistant, a registered nurse coordinator/case manager and an operating room nursing assistant at Eisenhower AMC, and occupational therapists and assistants, and one certified occupational therapy assistant at Charlie Norwood and Carl Vinson VA Medical Centers. This project will provide much needed joint replacement services to the Veteran population of Georgia, while maximizing utilization of orthopedic surgical services and operating room facilities at Eisenhower AMC. The project will recapture Veteran health care currently being delivered in the local civilian markets of Carl Vinson VAMC and relieve the backlog at Charlie Norwood VAMC due to capacity limitations. This project will also provide an opportunity for the Eisenhower AMC orthopedic surgical team to grow its caseload and proficiency in joint replacement surgery.

Barquist Army Health Clinic/Veterans Affairs CBOC Fort Detrick

(Specialty Care Treatment Services)
This project proposes to hire Behavioral Health, Podiatry, Dermatology, and Neurology service providers, Registered Nurses and Technicians; and to purchase supplies and equipment that will allow Barquist and the Community-Based Outpatient Clinic (CBOC), collocated at Fort Detrick, to offer these much needed services to Veterans, Active Duty personnel and eligible family members. This initiative will increase capacity at the VA CBOC for specialty product lines while dramatically reducing purchased care costs by Barquist for these services.

Tripler Army Medical Center (AMC)/Pacific Islands Health Care System (HCS)
(Intra-Governmental Payment and Collection System – IPAC)
The VistA Fee IPAC project will automate current manual workaround processes and allow for timely and accurate payment from a VA Medical Center to a DOD Medical Treatment Facility for reimbursement. VistA Fee IPAC payments will comply with the Department of Treasury IPAC standardized inter-agency fund transfer mechanism between federal agencies. VistA Fee IPAC development, testing, and implementation at the Tripler Army Medical Center and VA Pacific Islands Health Care System will pave the way for national implementation where VA medical centers are reimbursing DOD for clinical services to Veteran beneficiaries.

Tripler Army Medical Center (AMC)/Pacific Islands Health Care System (PIHCS)
(Orthotics Prosthetics Fabrication 2)
This proposal seeks to expand the existing Delta Systems II Computer Aided Design/Computer-Aided Milling (CAD/CAM) for Orthotics and Prosthetics services by purchasing current software and training modules in order to make a wider variety of items including prosthetic limbs, body braces, cranial helmets and mastectomy devices. In addition, VAPIHCS desires to utilize the system for prosthetic work currently provided through their network and to expand the orthotic capabilities by placing remote scanners in the Pacific Islands, saving both network and travel costs.

Womack Army Medical Center (AMC) Fort Bragg/Fayetteville Veterans Affairs Medical Center (VAMC)
(Community Rehabilitation Clinic)
This initiative seeks to expand Physical Therapy, Speech Pathology, and Occupational Therapy services at the Womack Army Medical Center by leasing a 10,000 square foot space and hiring 8 physical therapists, 3 occupational therapists, 1 speech pathologist, and 13 therapy technicians to staff the facility to provide state of the art rehabilitation outpatient care to Veterans and DOD beneficiaries in the greater Fayetteville area. This jointly staffed and jointly

operated clinic will enhance in-house capabilities and accessibility enabling the facilities to capture care that's currently obtained in the purchased care network.

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

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate*	2014 Estimate*	Increase/ Decrease
Transfer from Medical Services, P.L. 111-84	$15,000	$15,000	$15,000	$15,000	$0
Transfer from Medical Support & Compliance, P.L. 111-84	$50,000	$0	$0	$0	$0
Transfer from DOD, P.L. 111-84	$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	$189,230	$140,000	$263,448	$199,448	($64,000)
Unobligated Balance (EOY):					
No-Year	($263,448)	($100,000)	($199,448)	($135,448)	$64,000
Change in Unobligated Balance (Non-Add)	($74,218)	$40,000	$64,000	$64,000	$0
Recovery Prior Year Obligations	$1,868	$0	$0	$0	$0
Obligations	$57,650	$70,000	$94,000	$94,000	$0
Outlays:					
Obligations	$57,650	$70,000	$94,000	$94,000	$0
Obligated Balance (SOY)	$41,611	$28,340	$36,393	$393	($36,000)
Obligated Balance (EOY)	($36,393)	($18,340)	($393)	($14,393)	($14,000)
Recovery Prior Year Obligations	($1,868)	$0	$0	$0	$0
Outlays, Net	$61,000	$80,000	$130,000	$80,000	($50,000)
FTE	151	140	225	250	25

*As required, VA and DOD will each transfer a minimum of $15 million to this fund (established by P.L. 107-314 and extended by P.L. 111-84).

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

Financial Highlights
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Current Estimate[1]	2014 Estimate[1]	Increase/ Decrease
Appropriation, Transfers From:					
Medical Services	$172,750	$177,673			
Medical Support & Compliance	$24,168	$24,857			
Medical Facilities	$37,162	$38,221			
VA Information Technology	$6,605	$6,605			
Subtotal, VA Appropriation	$240,685	$247,356			
Department of Defense (DoD)	$119,016	$139,495			
Appropriation, Total	$359,701	$386,851			
Collections	$16,057	$18,404			
Reimbursements	$8,770	$6,391			
Unobl Bal (SOY)	$2,047				
Unobl Bal (EOY)	($7,190)				
Lapse	($218)				
Obligations	$379,167	$411,646			
FTE:					
Civilian	1,957	1,961			
DoD Uniformed Military	799	724			
Total FTE	2,756	2,685			

[1]The Department of Veterans Affairs (VA) and the Department of Defense (DoD) intend to contribute 2013 and 2014 funding to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund. This funding will support the continuing operations of the Captain James A. Lovell Federal Health Care Center (FHCC), which began operations on December 20, 2010. In 2013, VA anticipates transferring approximately $240.8 million from VA Medical Care appropriations and $6.6 million from the VA Information Technology appropriation, and DoD anticipates transferring approximately $135.6 million from the Defense Health Program appropriation to the Joint Fund, as authorized by the Continuing Appropriations Resolution, 2013 (P.L. 112-175). VA and DoD also expect to transfer 2014 funds from these accounts to support FHCC operations. VA and DoD anticipate supporting over 2,000 full time equivalent employees in both 2013 and 2014.

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 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) began using a single unified budget in 2011 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"), was effective beginning in 2011 (4th Quarter). Once validated and approved by VA, DoD Health Affairs, and the Navy Bureau of Medicine and Surgery (BUMED), the reconciliation model will be used as the basis for preparing future budgets.

The reconciliation methodology will be used to determine the FHCC expenses that can be attributed to VA and DoD, based on cost, workload, and the consumption of resources by each Department's beneficiaries. 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 workload 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 at least three years after the date of the enactment of National

Defense Authorization Act of FY 2010, P.L. 111-84. Such review shall include detailed statements of the uses of the Fund and an evaluation of the adequacy of the proportional share contributed to the Fund by the Secretary of Defense and the Secretary of Veterans Affairs.

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

Administrative Provisions
VA is proposing the following administrative provisions in accordance with P.L. 111-84, NDAA FY 2010:

> SEC. 221. Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2014 for "Medical services'', "Medical support and compliance'', "Medical facilities'', "Construction, minor projects'', and "Information technology systems'', up to $254,257,000, 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 (P.L. 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 (P.L. 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 (P.L. 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 (P.L. 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 (P.L. 110–417; 122 Stat. 4500).

Also in accordance with P.L. 111-84, NDAA FY 2010, DoD is proposing the following general provision in the Budget:

Section 8049. From within the funds appropriated for operation and maintenance for the Defense Health Program in this Act, up to $143,087,000, shall be available for transfer to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund in accordance with the provisions of section 1704 of the National Defense Authorization Act for Fiscal Year 2010, P.L. 111-84: Provided, That for purposes of section 1704(b), the facility operations funded are operations of the integrated Captain James A. Lovell Federal Health Care Center, consisting of the North Chicago Veterans Affairs Medical Center, the Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility as described by section 706 of P.L. 110-417: Provided further, That additional funds may be transferred from funds appropriated for operation and maintenance for the Defense Health Program to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Defense to the Committees on Appropriations of the House of Representatives and the Senate.

The above administrative and general provisions are necessary for the following reasons:

The first VA provision (Sec. 221) is required to permit the transfer of funds from specific VA appropriations for the purpose of transferring the funding to the Fund, which was establishd by P.L. 111-84, the National Defense Authorization Act for 2010, section 1704. Section 1704(a)(2)(A) and (B) specify that the Fund 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.

The VA's 2014 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.

The second provision (Sec. 222) will permit the transfer of funds from the Medical Care Collections Fund to the Fund. Section 1704 of P.L. 111-84 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 to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified in subsection (c).

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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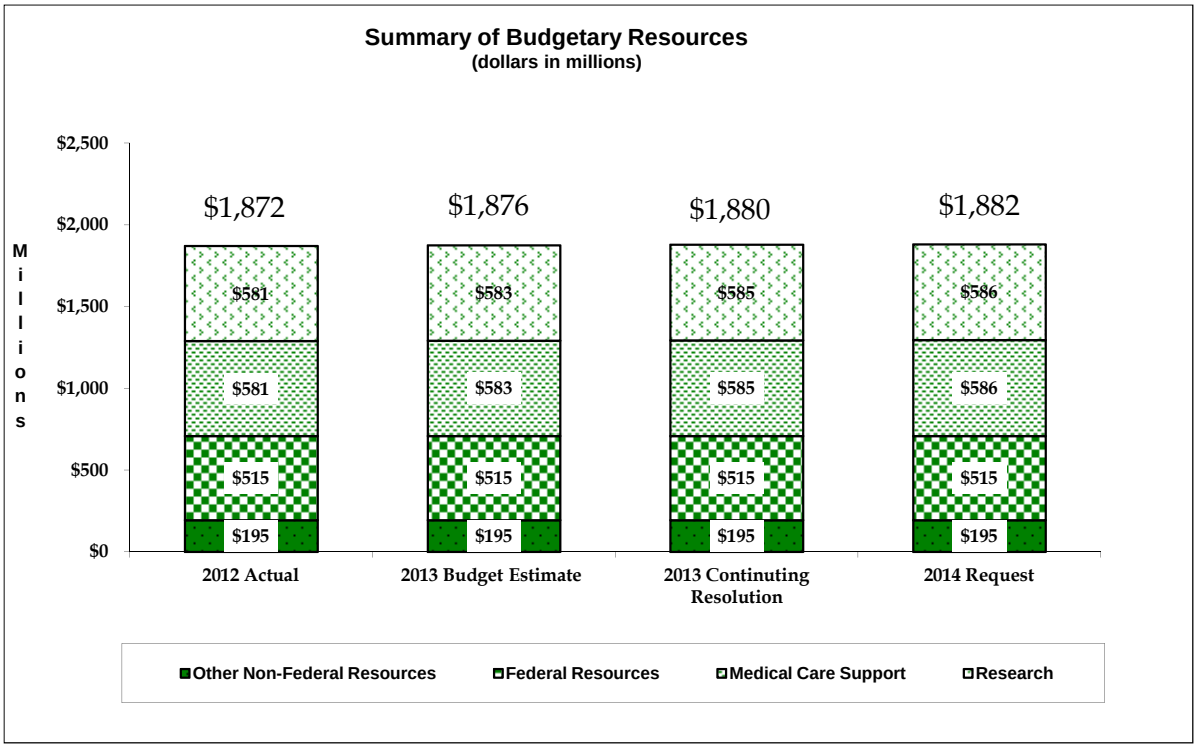
Medical and Prosthetic Research



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, $585,664,000, plus reimbursements, shall remain available until September 30, 2015. Note.--*A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.*

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 R&D 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 R&D 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 serves 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 health.

Enhancing research on genomic medicine and the Million Veteran Program (MVP) will be also be a major goal for VA R&D in 2014. VA is undertaking a ground-breaking genomic medicine program called MVP, which seeks to collect genetic samples and general health information from one million Veterans over the next 5 to 7 years. 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's health. The goal of the 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. This resource will be made available to VA researchers to pursue genomic discoveries that can lead to personalized healthcare for Veterans and to improve the speed and quality of scientific discoveries for the nation.

In 2014, VA R&D priorities will also emphasize the critical needs of our newest Veterans, specifically those from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF)/(OIF)/(OND), while continuing to address the special healthcare needs of all Veterans. VA R&D will continue to support studies dedicated to understanding chronic multi-symptom illnesses of Gulf War Veterans (Gulf War Veterans' Illnesses), long-term health effects of potentially hazardous substances to which Gulf War Veterans may have been exposed during deployment, and conditions such as Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), and brain cancer. VA also supports a wide array of research and development in engineering and technology to improve the lives of Veterans with disabilities. Work ranges from "classical prosthetics" that focuses on replacing an amputated limb, to more advanced "neural prostheses" that deliver small amounts of electrical stimulation to the nervous system. VA's commitment to the health and care of the increasing number of women Veterans is supported by a comprehensive research program. Research topics include VA's organization of care for women Veterans and their general health care needs, reproductive health, access and quality of care, and understanding the experiences of women Veterans regarding risks and treatment, particularly as related to sexual and other military traumas.

To fulfill the commitment to provide superior health care to our Veterans and their beneficiaries, VA is requesting $586 million in direct appropriations in 2014, which is an increase of $4.7 million, or 0.8%, over the 2012 level. 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 over $1.8 billion in 2014. The estimated direct research program employment level is 3,491 full-time equivalents (FTE), with all VA researchers being VA employees. The budget request and table below reflect the civilian pay raise of 0.5% for 2013 and 1% for 2014. It is estimated that VA R&D will support 2,224 projects during 2014.

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

		2013			
	2012 Actual	Budget Estimate	Continuing Resolution	2014 Request	2012-2014 Inc/Dec
Appropriation	$581,000	$582,674	$584,556	$585,664	$4,664
Obligations	$580,359	$627,674	$667,474	$625,664	$45,305
Average Employment	3,496	3,526	3,526	3,491	(5)
Employment Distribution					
Direct FTE	3,015	3,045	3,045	3,010	(5)
Reimbursable FTE	481	481	481	481	0
Total	3,496	3,526	3,526	3,491	(5)

Net Change Medical and Prosthetic Research 2014 Summary of Resource Requirements (dollars in thousands)	
Description	Budget Authority
2012 Enacted	$581,000
2014 Request:	
Pay Raise	$2,591
Staff Attrition (5 FTE)	($456)
Other Personnel Cost & Benefit Increases (1.1%)	$2,455
Other Costs	($16,775)
Inflation - Biomedical Research and Development Price Index (2.9%)	$16,849
Subtotal	$4,664
2014 Total Current Services	$585,664

Research Focus Highlights for 2014

In 2014, VA R&D priorities will emphasize the critical needs of our newest Veterans, specifically those from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF)/(OIF)/(OND), while continuing to address the special healthcare needs of all Veterans.

A major focus remains on the transformational workstreams (Major Initiative #13) centering on medical informatics and information technology, point-of-care clinical research, genomic medicine, and VA Central Office and field research resources. These transformational efforts have the potential to significantly increase the effectiveness of VA research in addressing the diverse conditions in the Veteran population, and to increase VA's leadership role in U.S. medical research.

In addition, VA R&D will increase its emphasis on critical areas that will impact VA for years to come: pain, traumatic brain injury, sensory loss, military occupational exposures, post traumatic stress disorder (PTSD), risky behaviors, suicide, patient centered care, complementary/alternative medicine, health promotion and disease prevention, healthcare efficiency, women Veterans, homelessness, and young investigator development. These focused expansions reflect the commitment of VA to maintain a world-class research program supporting the world-class medical care our Veterans deserve.

With so many of VA's clinician-investigators providing care for homeless Veterans, VA R&D can unveil important new discoveries through unique insights arising from the intersection of care and scientific inquiry. VA R&D will support efforts to end Veteran homelessness by expanding its research in this area and providing critical data on interventions, risk factors, and health care usage patterns in this high priority group.

Access to care is closely related to homelessness. One of the critical missions of VA research is to identify system-wide gaps in Veterans' health care. This includes assessing specific barriers to care for vulnerable populations, including rural Veterans. VA R&D seeks to expand its efforts in this area through the development, evaluation, and implementation of new tele-medicine technologies to improve access to VA health care. VA R&D will continue to prioritize access as a component of validating the quality of care in all VA health care services, organizational structures, and mechanisms for delivering care.

Enhancing research on personalized medicine and the Million Veteran Program (MVP) will also be major goals for VA R&D in 2014. MVP, a partnership with Veterans, seeks to collect genetic samples and general health information from one million Veterans while keeping privacy and safety at its core. MVP will take personalized medicine research to an unprecedented level. VA plans to expand sample collection methodology, use advanced sample analysis platforms for genetic analysis, and establish a shadow banking facility where a portion of genetic samples collected from each Veteran will be stored as a back-up, duplicate sample in case of a natural disaster or other unanticipated event affecting the primary banking facility. As of September 28, 2012, over 165,000 Veterans had agreed to participate and over 95,000 had completed enrollment in the program. By the end of 2013, VA anticipates that over 250,000 Veterans will have agreed to participate. MVP is a centerpiece effort that illustrates the fruitful partnership VA research has with our Veteran research volunteers to gain knowledge in all areas of medicine.

Protocols are under development to use information from MVP to clarify biological pathways associated with PTSD enabling the development of improved measures of preventing, identifying, and treating this often devastating consequence of military service. Other efforts are targeting schizophrenia, bipolar disorder, and amyotrophic lateral sclerosis (Lou Gehrig's disease), in an effort to improve life for Veterans and their family members suffering from these conditions.

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

Research and Development Program Funding
(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Request	2012-2014 Inc/Dec
OEF/OIF/OND					
Pain	$10,462	$13,961	$13,961	$14,105	$3,643
Post deployment Mental Health	$52,891	$46,043	$52,891	$53,367	$476
Sensory Loss	$17,799	$23,166	$17,886	$17,680	($119)
Spinal Cord Injury	$26,936	$29,486	$29,486	$29,791	$2,855
Traumatic Brain Injury and Other Neurotrauma	$31,894	$28,564	$31,894	$32,189	$295
Prosthetics	$17,051	$17,393	$17,393	$17,573	$522
Women's Health	$14,291	$11,935	$14,291	$14,414	$123
Gulf War Veterans Illness	$6,480	$4,862	$7,200	$15,000	$8,520
ALS and Other Neurodegenerative Disorders	$30,253	$30,253	$30,253	$30,405	$152
Genomic Medicine including MVP	$37,169	$37,169	$37,169	$45,204	$8,035

Medical and Prosthetic Research Program Description

For nearly a century, VA has conducted groundbreaking research dedicated to improving care for our nation's Veterans and has brought substantial benefits to people from all walks of life. Although VA's research history is filled with significant discoveries in medicine, VA R&D is looking ahead to a productive future focused on genomic medicine, improving health care systems, and finding better treatments for illnesses affecting Veterans.

One major advantage of VA's research program is that it is an intramural program where clinical care and research occur together, supported by a state-of-the-art electronic health record. More than 70% of VA researchers are active clinicians, making them keenly aware of the pressing health care issues of our Veteran population. These factors create a unique environment for the discovery of new medical knowledge and the translation of that knowledge into improved health for Veterans. The fundamental goal of VA R&D is to address the needs of the entire Veteran population from the young recruit who returns with injuries from recent conflicts to the aging Veteran.

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

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

to diseases affecting Veterans. This work directly supports the development of new diagnostic tests and drugs that improve Veteran health.

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

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

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

VA's research program is fully integrated with the medical community through partnerships with academic affiliates, non-profit and commercial entities, and other federal agencies. VA investigators are highly successful in competing for federal grants and utilizing these resources for medical research to improve health care. VA R&D engages key stakeholders including Veterans' families and caregivers, VA health care providers, Veterans Service Organizations, the Federal research community, academic health centers, and practitioners throughout the nation.

Post Deployment Care

Mental Health

VA's research program remains committed to further understanding and promoting advances to prevent and treat mental health disorders and enhance the quality of life among those with them. In these efforts, VA strives to balance the needs of the older generations and newest generations of Veterans. VA research has had profound impact on mental health clinical care, with information from our studies shaping practice. For example, thousands of mental health staff are now trained to provide one of two Institute of Medicine recommended treatments for PTSD, Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE). This is a direct result of a large, multi-site clinical trial of prolonged exposure therapy in women Veterans that VA supported at a cost of $6.6 million. Another example is a large clinical trial published in 2011 that examined whether a commonly prescribed drug for PTSD, Risperidone, was effective for chronic, unremitting PTSD. The study found the use of Risperidone

for PTSD to be ineffective, informing clinical practice in VA to remove this often-used yet unproven treatment. The contributions of VA PTSD studies cannot be overstated. A recent Government Accountability Office (GAO) audit (2010) summarized VA's PTSD research contributions, showing millions of dollars spent on the scientific efforts to advance prevention and treatment of PTSD.

VA research has also made long-term investments in studies dedicated to following subpopulations of Veterans who may suffer from mental health conditions following specific deployments. For Vietnam Veterans, two rich cohorts have been developed and studied over time: the Vietnam Era Twins Registry and the National Vietnam Veterans Longitudinal Study. Continued use of these cohorts will improve our understanding of Veterans' healthcare status and provide insight into mental healthcare needs now and in the future. In addition, VA has made a substantial investment to establish a new cohort of Vietnam era women, who have not been comprehensively studied to date, designed specifically to address women Veterans' mental health issues. Likewise, VA R&D has directed considerable effort to understanding the mental health needs of Veterans from Iraq and Afghanistan. Taking into account past lessons on the need for prospective data, VA has capitalized on opportunities with Iraq and Afghanistan Veterans by collecting baseline/pre-deployment health assessment measures. Using this approach will allow VA to better understand the consequences of military service on mental health, emotion, and cognition.

Concurrent with longitudinal studies aimed at understanding Veterans' mental healthcare needs globally, a range of VA sponsored clinical trials are testing new treatments. A large definitive trial of Prazosin is underway to determine effectiveness for PTSD-related sleep disturbance. If Prazosin is shown effective, the drug is easily available at a low cost for clinical use. Simultaneously, a smaller study is looking at a drug, Mifepristone, to reduce PTSD symptoms. If Mifepristone study results are positive, VA may consider sponsoring a more definitive large-scale trial to help determine whether to implement it in clinical care. In other trials, a newly developed drug for Schizophrenia based on genetic findings is being tested in early phase work, as are new psychotherapies for other mental health disorders.

Another emphasis area is in mood disorders, highly prevalent conditions in the Veteran population. Two multi-site clinical trials are scheduled to begin in 2012. One will test treatment using a device, rTMS, on patients who have not responded to other treatments. The second will determine whether the more effective strategy of prescribing anti-depressants is to add on a second drug or switch from one anti-depressant to a new one, should the response not be satisfactory to alleviate depression. Information from both of these studies will increase VA's ability to adequately treat depressive disorders. Beyond treatment,

VA is also planning to compare vocational rehabilitation approaches aimed at helping Veterans with PTSD to stay in jobs and improve their quality of life. This study builds upon a previous successful, but smaller effort, that evaluated the concept of supported employment. In addition, given the scope of mental health care needs, VA has large-scale investments for mental health studies involving genetics. In one study, VA scientists are collecting and analyzing samples to determine a potential basis for diseases such as Schizophrenia and Bipolar Disorder.

Gulf War Veterans' Illnesses and Exposures

During and after the conclusion of the first Gulf War, a significant proportion of Gulf War (GW) Veterans reported a range of chronic symptoms and health problems at rates that exceeded non-deployed era Veterans. These symptoms included persistent headaches, joint pain, fatigue, muscle pain, attention and memory (cognitive) problems, gastrointestinal difficulties, sleep disturbances, and skin abnormalities. While some of these ill Veterans meet case definition(s) for other chronic multi-symptom illnesses such as Chronic Fatigue Syndrome (CFS) or fibromyalgia (FM), the majority have defied exact diagnoses. A VA 10-year follow-up survey of GW era Veterans found that deployed GW Veterans had a higher rate of multi-symptom illnesses, Chronic Fatigue Syndrome (CFS), PTSD, major depressive disorders, and anxiety disorders than non-deployed GW Veterans. VA, along with other federally funded epidemiology studies, provided the basis for case-definitions of chronic, multi-symptom Gulf War Veterans' Illnesses (GWVI). Because there are no objective laboratory tests to diagnose the chronic, multi-symptoms illnesses that some Gulf War Veterans are experiencing, treating these cases is challenging. Although the precise cause for these symptoms remains unknown, the fact that GW Veterans are ill and suffer adverse effects on their daily lives is unquestioned.

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

VA investigators are conducting clinical trials to find, examine, and deliver therapies for GW Veterans and problems they experience such as sleep disturbances and gastrointestinal problems, as well as testing the feasibility of performing cognitive behavioral therapy via telephone. Another major focus of

VA's Gulf War research portfolio is to identify biomarkers, or biological indicators, that can distinguish ill GW Veterans from their healthier counterparts. Projects in this area range from studies about genetic markers to investigations about advanced neuroimaging procedures and altered protein profiles in blood or cerebrospinal fluid. Studies using cutting-edge imaging techniques will also be important parts of this research portfolio. While much of VA's current GWVI research is aimed at understanding chronic multi-symptom illnesses, VA also recognizes the importance of studying other conditions that may affect Gulf War Veterans, such as brain cancer, ALS, and Multiple Sclerosis. VA maintains additional research portfolios in each of these areas because they impact Veterans of all deployments. A study entitled, "Genetic Epidemiology of ALS in Veterans" is currently being conducted by CSP. The study is investigating the roles of genes and environment in the development of ALS in a cohort of 1,200 Veterans. The genetic samples have undergone analyses, including copy number variation, and a manuscript of the results has been published:

Long-term GWVI research plans include the design and implementation of a new study of a national cohort of GW Veterans. This effort will create a resource for researchers to study the diverse set of problems facing these Veterans and place an emphasis on better understanding genetic influences on GWVI as well as responses to treatments. This project will be based on an evaluation of the existing body of knowledge about the illnesses affecting GW Veterans and recommendations received from the VA Research Advisory Committee on Gulf War Veterans' Illnesses (RAC).

To further expand its Gulf War research portfolio, VA R&D issued three new requests for applications. The lists of topics of interest in these requests incorporated over 80% of the research recommendations contained in the 2008 report from the RAC. VA remains committed to funding new clinical trials to identify therapies for ill GW Veterans. The results of these and other clinical investigations, together with new discoveries based on the use of the newest and most advanced technology, are expected to lead to improved treatments and a better quality of life for GW Veterans.

Prosthetics

VA supports a wide array of research and development in engineering and technology to improve the lives of Veterans with disabilities. Work ranges from "classical prosthetics" that focuses on replacing an amputated limb, to more advanced "neural prostheses" that deliver 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, and this innovative technology is not just limited to applications for 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 and development 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. Cutting edge work at these centers includes: 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.

While some efforts aim to develop new and inventive technologies, others focus on moving into manufacturing and commercial distribution. Put another way, VA continues its tradition of bringing innovation from the laboratory to the Veteran. One such project is a study testing a high-tech prosthetic arm being developed for the Department of Defense's Defense Advanced Research Projects Agency (DARPA). VA is a primary transition partner with DARPA and is concluding a clinical optimization study on the arm to inform its development by DEKA Integrated Solutions. VA is in the planning stages for additional follow-up studies in upper extremity prosthetics, particularly take-home trials of the latest version of the arm that was developed based on the results of the optimization study. If future research is successful, U.S. Food and Drug Administration approval can be obtained, allowing the arm to become commercially available for Veterans to obtain through VA's Prosthetic and Sensory Aids Service. VA is also looking at the transition of these advanced prosthetic arms to additional applications, such as mounting on wheelchairs for Veterans with high-level spinal cord injuries, enabling them to control the arms to increase independence in activities of daily living. VA researchers have also successfully demonstrated the feasibility of using a brain computer interface to control the DEKA arm. In the future, this technology may allow more precise and dexterous control of prosthetic arms.

Another example of an exciting prosthetic technology supported by VA is the "bionic ankle." This device advances previous technologies by propelling users forward using tendon-like springs and an electronic motor. In turn, Veterans can have less fatigue, improved balance, and walk with a more fluid gait.

Traumatic Brain Injury (TBI)

Veterans wounded in OEF/OIF/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 and maintaining functional recovery and the quality of life for Veterans with TBI.

Recent VA research suggests that chronic disorders relating to mental health and neurodegenerative disease may be related to the effects of repetitive mild TBI during a lifetime. Since many of our Veterans of OEF/OIF/OND have had multiple exposures to multiple types of injury mechanisms, VA R&D has launched initiatives to determine if risks exist to our Veterans' long-term health due to these exposures. These initiatives focus on the question of whether there are chronic effects related to repetitive TBI and, if these effects exist, whether there are Veterans who are more susceptible to neurodegenerative disease from their injuries. Further, this initiative seeks to determine whether these chronic changes can be detected and treated. DOD and VA are combining efforts by forming a research consortium to address the long-term consequences associated with mild TBI and PTSD. The Consortium will work to improve diagnostics, prognostics, and advance treatments to mitigate negative long-term effects caused by these traumatic exposures both separately and as co-occurring conditions.

In addition, VA continues to focus on developing neuro-imaging techniques, utilizing technology such as magnetic resonance imaging (MRI) and diffusion tensor imaging (DTI). The goals of this research are to: 1) better "map" the brain changes associated with long-term TBI, 2) develop effective evidence-based rehabilitation strategies and therapeutics 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 treatments.

These initiatives are not only necessary to the future health of our Veterans, they are changing the way the field of neurotrauma is conducting research. VA is at the forefront of this growing area of scientific interest in the chronic effects of TBI. VA R&D is exploring ways to make this new field of chronic TBI research feasible to conduct for our investigators, as well as developing the careers of new investigators in the fields of chronic TBI research and rehabilitation. This work will follow on successful ongoing VA research focused on improving diagnosis of mild TBI and repetitive mild TBI, developing biomarkers for long-term neurodegeneration, and determining if risk factors exist that predispose certain Veterans to neurodegenerative disease from TBI. Other ongoing work focuses on the use of a transdermal patch to treat mild cognitive impairment related to TBI.

Spinal Cord Injury (SCI)
VA is dedicated to promoting the health and independence of those with SCI and is studying a variety of ways to help Veterans recover or rehabilitate after chronic SCI. This area has particular importance to returning OEF/OIF/OND Veterans.

In a recent study involving SCI Veterans who had not been previously employed, VA found that a "supported employment" approach resulted in a three times greater likelihood to obtain and retain employment compared to ones who received standard vocational rehabilitation services.

In groundbreaking laboratory work, VA scientists have transplanted human stem cells and demonstrated that regeneration and functional integration can occur in rodents with severed spinal cords. Other VA scientists have used the Geron oligodendrocyte progenitor cells in models of demyelination in non-human primates. They have discovered that transplantation of these cells results in remyelination of axons suggesting that the body's normal repair process is insufficient to produce meaningful recovery.

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

The data and tools developed from this SCI research can also be used to create breakthroughs in other neurological disorders such as stroke, age-related neurological diseases, and multiple sclerosis.

Pain
Pain associated with back and limb injuries and TBI plagues Veterans of all service eras. VA will continue its significant efforts to improve pain control through research. In one exciting line of research, VA is developing novel strategies to restore and preserve function in people with neuropathic pain, using cellular and molecular approaches, by understanding the role of sodium channels as modulators and mediators of neuropathic pain, based on genetic analyses of individuals with hereditary pain syndromes. This work has led to additional research on the role(s) of sodium channels in disease and trauma related painful conditions including multiple sclerosis, spinal cord injury, human neuromas, and diabetic neuropathy. Since establishing a link between sodium

channels and chronic pain, VA is now focusing on mechanisms underlying the development of chronic pain and developing strategies to mitigate the transition as well as the treatment of painful conditions.

Homelessness Among Veterans and Access to Care Research

Homelessness Among Veterans

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

Current VA studies are focusing on reducing disparities and enhancing quality care and services to homeless Veterans. One study will compare vocational rehabilitation supplemented with supported employment techniques to manual based vocational rehabilitation to determine whether time in employment increases and if rates of homelessness decrease. Another study is assessing the impact of service customization on improving access to care and health care outcomes of homeless Veterans, while a third is developing an innovative program to engage homeless Veterans in primary care. This research demonstrates that outreach and engagement of homeless in primary care can reduce disparities and improve access and care.

Rural Health and Access to Care

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

patients compared to urban patients, including higher rates of suicide, more frequent hospitalization for ambulatory care sensitive conditions, and later stage of cancer presentation. The review noted, however, that only a small minority of that research had included Veterans.

Returning OEF/OIF/OND Veterans have provided a new set of research challenges. Research is being conducted to identify: 1) the best approaches to providing services to Veterans with SCI, HIV, TBI, and amputations; 2) those geographic areas with the greatest need for specialized VA rehabilitation care; and 3) modeling methods to provide those needs. Other VA research initiatives are examining new methods of providing caregiver support and training for family members of recently returned Veterans in order to facilitate transition to civilian life, new methods of adapting care to different social and cultural settings, and innovative ways to expand Telehealth to portable devices such as smart phones.

Improving access to specialty services for rural Veterans is a major priority for the VA. Research is examining new models for improving the ability of clinicians in community based outpatient clinics (CBOCs) to care for complicated conditions such as Hepatitis C, heart failure, chronic pain, and complex diabetes. A recent VA study implemented a 5-component educational project to increase access to dermatology care for underserved Veterans living in rural areas. At onset, 9% of providers were performing shave biopsies and 33% were performing excisions, but by the end, 100% of providers were performing these procedures.

For the large number of Veterans with PTSD or other mental health conditions, the condition may sometimes exacerbate more traditional barriers to access. The ability to initiate care and to maintain a regular schedule of contact with mental health providers is a key factor in the success of treatment. Research is focusing on ways to address barriers to mental health care, particularly for unique Veteran groups such as women Veterans, homeless Veterans, and Veterans with co-occurring medical and mental health conditions. One recently completed study showed that patients with PTSD who received therapy via Telemedicine had fewer cancellations (24% vs. 34%) and no shows (5% vs. 19%) than patients who received therapy in person, while the number of PTSD patients that dropped out of treatment was higher for in-person (29%) than Telemedicine (6%).

Caregiving

Long-term home care is frequently provided by family members or other informal caregivers and is vital to many Veterans who wish to be cared for at home, despite chronic illness or severe disability, including that from combat-related injuries. Some of the factors that increase the need for caregiver services are: 1) Veterans' preferences for remaining in the home environment, 2)

increased numbers of aging Veterans with multiple chronic illnesses, 3) increased numbers of Veterans of OEF/OIF/OND returning home to areas that lack traditional inpatient or rehabilitation facilities, and 4) Telemedicine advances that allow clinicians to manage complex conditions in the home environment. Informal caregiving continues to be a critical part of the VA care environment and VA R&D is an essential partner to the VA health care system as it seeks to increase capacity to support caregivers to provide non-institutional long term care for Veterans and to improve caregiver programs.

In response to Public Law 111-163, *Caregivers and Veterans Omnibus Health Services Act of 2010,* and the increasing need for informal caregiving, VA R&D issued a Request for Applications (RFA) to study health delivery system factors, characteristics of Veterans and caregivers and how they interact, and the clinical outcomes and cost of informal caregiving. Research conducted in these areas will help VHA build effective systems to evaluate and track caregiving abilities, assess the needs of Veterans' informal caregivers, enhance caregiver support services, and provide caregiving education and training. One recently funded study is evaluating effective interventions to address how caregivers engage in end-of-life preparations when caring for Veterans with terminal conditions. Aims of the intervention are to improve care for Veterans and reduce caregiver anxiety, depression, anticipatory grief, and burden. Preliminary findings of a second study show that structured automated Telemonitoring with feedback to informal caregivers and health care teams (for urgent problems) may be a feasible strategy to increase patients' access to self-management support.

Equity/Disparities

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

The causes of disparities are complex, and research is focused on reducing disparities. Several studies are examining the role of communication in causing and reducing disparities, while others are assessing the relationship between culture and communication. Several research efforts have focused on the needs of OEF/OIF/OND Veterans by, for example, both evaluating the impact of education materials specifically written for Puerto Rican Veterans and their families, and cultural adaptation of a particular PTSD therapy treatment for Hispanics. Culturally sensitive Telehealth techniques are being assessed for their effectiveness at improving access and care for Hawaiians with PTSD, and to provide cognitive processing therapy for rural combat Veterans with PTSD.

The current focus on ending homelessness among Veterans is reflected in the ongoing VA research program. Efforts are underway in the areas of engagement, peer support, risk assessment, housing, substance use treatment, and medical care. In addition, expectations are that new projects will focus on assessment and prediction of Veterans at risk for becoming homeless, with an eye towards engaging at-risk Veterans earlier and offering services that may help prevent homelessness.

The breadth and depth of research in VA disparities provide a strong foundation for future efforts to expand intervention and implementation research to translate the research results into practice.

Women's Health Research

VA's commitment to the health and care of the increasing number of women Veterans is supported by a comprehensive research program. Research topics include VA's organization of care for women Veterans and their general health care needs, reproductive health, access and quality of care, and understanding the experiences of women Veterans regarding risks and treatment, particularly as related to sexual and other military traumas.

In order to facilitate research and implementation of findings into practice, VA recently established a research consortium. This consortium is helping build the infrastructure and capacity to develop expertise in women's health research. To ensure our research recruits a representative cross-section of women Veterans, VA R&D developed a national VA practice-based research network and has begun to fund studies capitalizing on this infrastructure. This network has capitalized on VA strengths having strategically involved a diverse set of policy, research, and healthcare stakeholders throughout the agency.

To accelerate knowledge and implementation of research, VA recently initiated a new funding mechanism for programs of related projects -- Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE) -- developed in partnership with VHA stakeholders. In the initial round of CREATEs, VA approved a Women's Health CREATE aimed at accelerating implementation of comprehensive women's health care delivery in the VA health care system. The CREATE will examine patient, provider, and organizational barriers and facilitators of the implementation of comprehensive women's health care delivery; assess determinants of these factors underlying delivery of comprehensive care and their implications for the quality and experience of VA care for women Veterans; and evaluate the effectiveness and impact of alternate models of delivering comprehensive care to women Veterans.

A recent VA study using data from a large national survey found that women Veterans reported consistently poorer health compared with comparable non-Veterans and women on active duty or in the reserves. Women Veterans indicated poorer general health, greater likelihood of health-risk behaviors (e.g., smoking), and greater likelihood of chronic conditions and mental health disorders. To better understand the relationship between military service and health, VA is currently funding a five-year national study focused on women who served in Vietnam, representing a new contribution to understanding the needs of female Veterans as they near retirement age. As of March 2013 over 4,800 women Vietnam Veterans have been enrolled. The study will assess the prevalence of PTSD and other mental and physical health conditions, and the relationship of PTSD to deployment experiences, disability, functioning, and utilization.

Due to the rising number of women who are serving in combat-forward positions in OEF/OIF/OND, VA R&D is increasing its focus on the needs of these Veterans. This includes effective screening for mental health needs, the impact of military stressors and emotional issues on post-deployment reintegration and readjustment, and gender differences in stigma and barriers to obtaining care of PTSD.

A recent review by VA researchers documented a number of important risks associated with military service for women Veterans, including increased risks for new-onset depression, suicide, and suicide by firearm. Given the clear healthcare needs of women Veterans, research is also focusing on which women stay engaged with VA health care. A research/operations partnership that reviewed the histories of 232,491 women in VA care found that 11% had discontinued care, with attrition rates higher in new and younger women patients.

Precision Medicine and Personalized Care

Medical research has among its major objectives the development of ways in which to prevent disease, and the development of strategies that assure that each patient receives a treatment that works for him or her the first time, and which does not cause harmful side effects. The Million Veteran Program – a Partnership with Veterans (MVP) was launched in 2010 to advance these objectives. This program's goal is to recruit one million Veterans to volunteer a tube of their blood and allow access to their medical records in order to build the world's largest longitudinal reference cohort to date, while keeping privacy as a key factor. As of August 2012, over 150,000 Veterans have responded to an invitation to participate and completed a baseline health survey. This exciting research effort now forms a significant base for genetic studies of PTSD, bipolar disorder, and schizophrenia, as well as a platform for studying Veterans who have returned from overseas

deployment for signs of deployment-related lung disease. This work will use the most advanced genetic technologies available, including exome sequencing and full genome sequencing, to identify genetic underpinnings of disease, elucidate pathways by which these diseases develop, and identify therapeutic interventions that will work for individual patients.

Scientists are helping to establish VA's leadership in genomic medicine by developing tools that incorporate the latest technologies that make personalized medicine research more feasible. A VA Pharmacogenomics Analysis Lab (PAL) is poised to perform pharmacogenomic polymorphic marker testing which identifies how people react to various medications and treatments due to genetic differences. Use of this genomic data in combination with Genomic Information System for Integrative Science (GenISIS)—a computer program that will allow for merging clinical information from the electronic health record with a Veteran's genetic information—will enable better tracking between adverse reactions and genetic variations susceptible to those reactions. These tools will provide unprecedented vigilance to the Veteran's researcher and potentially the Veteran's caregiver.

In addition, VA stores valuable brain and rare tissues at its tissue banks. Study of these anatomic gifts is enabling VA scientists to better understand the consequences of TBI and its possible relationship to later neurodegenerative disease. When used together with information from the MVP, scientists are able to better link predisposition, cause, and consequences of brain injury, both physical and psychological, in the search for treatment and cure.

The development of these tools would not be possible without the extraordinary generosity of the Veterans that participate in research. Having once sacrificed for our country through the gift of military service, they once again give generously as research participants, caring for their fellow Veterans by sharing in the search for causes and cures of disease.

Patient-Centered Care

VA is transforming the healthcare system, shifting from problem-based disease care to personalized, proactive health care that optimizes health and minimizes disease with active patient engagement. In alignment with the VA Mission to provide exceptional healthcare that improves health and well-being, this transformation involves an approach to care that enhances the Veterans and their families' experiences, expands the medical model from a focus on disease management to also include health and well being, engages the patient to become the owner of his/her individualized health plan, and continues the focus on quality and safety. Patient Centered Care (PCC) is defined in VA as an approach

to healthcare that prioritizes the Veteran and his/her values, and partners with him/her to create a personalized strategy to optimize their health, healing, and well-being.

Culture change for an organization of the size and complexity of VA is a lengthy process and requires an ongoing approach of piloting and testing innovations, evaluating outcomes, and deploying effective strategies across the system. VA R&D has been at the forefront of this transformation to improving the value and quality of health care from the perspective of Veterans and their families.

VA investigators have substantially contributed to PCC from its inception, providing many of the conceptual models that define PCC and many of the measurement methods necessary to understand and improve PCC. VA R&D has built an evidence base to support clinician understanding of Veterans values, goals, and preferences for health care interventions and for quality of life outcomes. VA investigators have also developed patient-centered measures of preferences and patient-reported outcomes, shared decision aids that enhance Veteran involvement in health care decisions, and motivational interventions to increase patient engagement in health care. Research on the application of patient preference measures in clinical settings now is needed to fully realize the potential of care informed by patient values and goals. VA investigators are well poised to study how understanding patient preferences improves clinician ability to provide culturally sensitive health care for diverse Veterans.

Beyond providing a foundational basis for PCC, VA investigators have been among the first to study how patients and health care professionals communicate about patient preferences. While we know from this research that Veterans would like to have their values and goals considered in health care decisions, similar to what has been found in health care systems beyond the VA, research shows that discussions of Veterans preferences are not consistently incorporated in clinical encounters. The close alignment with the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) will be key in closing this gap in patient centered care. Future efforts will focus on the development of decision support tools for patients and clinicians alike, and validation of these tools and other PCC strategies in improving health outcomes.

Cardiovascular Health

For decades, cardiovascular health has been a central focus of medical care for Veterans and the general population, during which time VA R&D has been a leader in guiding the clinical practice and understanding of heart disease and its various forms, including coronary heart disease, high blood pressure, stroke, and heart failure. VA achievements such as the development of the cardiac

pacemaker, the definitive clinical trials on treating high blood pressure with medication, and recent findings from comparative effectiveness studies on optimal medical therapy have been integrated into care nationwide. Recently, there has been a noted decline in the number of deaths associated with heart disease. However, it remains the leading cause of deaths and medical costs in the nation.

Cardiovascular disease is often centrally linked to several prevalent diseases impacting Veterans. Diabetes is one example, and VA has recognized the importance of conducting research on managing cardiovascular risk factors to prevent and treat diabetes. Furthermore, VA is investigating complications of diabetes, such as renal failure, which are linked with cardiovascular outcomes. VA research on patients with SCI has found that they exhibit low blood pressure which in turn can lead to further cardiovascular complications and challenges with cardiovascular rehabilitation. The prevalence of smoking among Veterans can lead to concurrent pulmonary and cardiovascular problems. Other studies in infectious disease and neurological disorders have also been examining relationships with cardiovascular disease and related outcomes. In addition, there is a large evidence base showing that PTSD is linked with adverse cardiovascular outcomes. VA is currently supporting multiple studies looking at the long-term associations between deployment and physical and mental health with a particular emphasis on cardiovascular outcomes.

To further enhance VA's ability to provide world-class cardiovascular care for Veterans and the general public, VA is leading collaborative clinical trials to provide definitive evidence for practice. In a cooperative study developed by VA to be conducted in Australia, efforts will begin in late 2012 to prevent serious adverse events associated with the dyes commonly used in cardiovascular imaging procedures. The Prevention of Serious Adverse Events Following Angiography (PRESERVE) trial will seek to enroll over 8,600 patients to compare intravenous isotonic sodium bicarbonate with intravenous isotonic sodium chloride and oral N-acetylcysteine with oral placebo for the prevention of serious adverse outcomes, including death and decline in kidney function following angiographic procedures in high-risk patients. Another major trial is planned involving National Heart, Lung, and Blood Institute support that will seek to determine the efficacy of a new anti-platelet therapy for reducing cardiovascular outcomes, including death, associated with coronary artery bypass graft surgery. This trial will involve approximately 4,000 patients in efforts to reduce major cardiovascular and cerebrovascular events, including death and stroke.

Because cardiovascular disease is a significant contributor to disability and mortality in older Veterans, VA is committed to remaining a national leader in cardiovascular disease research and is uniquely positioned to develop and

execute an extensive body of scientific investigations focused on prevention, diagnosis, and treatment of heart disease.

Cancer

Cancer continues to be another highly prevalent disease in Veterans and the general population. VA's pre-clinical successes in cancer treatment include studies involving the enzyme Cyclooxygenase-2 (COX-2). COX-2-generated prostaglandin E_2 (PGE_2) has been found to positively correlate with *in vitro* development of cancer and the development of lung cancer in animal models. A COX-2 inhibitor, Celecoxib, has been shown to inhibit *in vitro* carcinogenesis and lung cancer in animal models. Conversely, elevated levels of COX-2 in human lung cancers is a major cause of cancer-related death and is correlated with poor prognoses. These findings provided a strong rationale for a clinical trial in older former smokers to determine whether inhibition of COX-2 and the subsequent synthesis of PGE_2 by Celecoxib can affect biomarkers that are related to lung cancer. Positive findings support the continued investigations of Celecoxib for lung cancer chemoprevention in former smokers at a low risk of cardiovascular disease.

Cell adhesion molecule (CD44) is a protein marker on the surface of tumor-initiating cells found in prostate cancers. Enhanced presence of CD44 is found in tumorigenic, proliferative and metastatic prostate cancers. A VA study has demonstrated that a specific endogenous small piece of ribonucleic acid, called micro RNA or miRNA, regulates the expression of CD44 and, therefore, the progression of prostate cancer. This miRNA may, therefore, represent a novel therapeutic target or a diagnostic/prognostic biomarker for prostate cancer.

Efficiency in Health Care Delivery

Research on the comparative effectiveness of health care interventions provides findings that allow VA to deliver the most effective healthcare interventions while avoiding unnecessary healthcare expenditures. One example of such VA research comes from the highly anticipated results of VA's Prostate Cancer Intervention Versus Observation Trial (PIVOT) trial that compared observation to a surgical approach, radical prostatectomy. This study showed that watchful waiting provided results equivalent to radical prostatectomy for the treatment of most prostate cancer patients. The success of this 15-year investigation demonstrates the ability of VA to plan and execute long-term research investigations that define ways to optimize healthcare delivery.

In another long-term study, VA has also begun a major comparative effectiveness research study looking at screening approaches to colon cancer, one of the most

preventable forms of cancer. The Colonoscopy Versus Fecal Immunochemical Testing in Reducing Mortality From Colorectal Cancer (CONFIRM) trial will enroll 50,000 Veterans to determine over 10 years whether colonoscopy or a less invasive and more efficient fecal occult blood testing method is better at preventing colorectal cancer death.

The PIVOT AND CONFIRM trials come from the VA Cooperative Studies Program (CSP). CSP has for several decades conducted large VA clinical trials that have transformed the practice of medicine, and is regarded by many as the world's premier clinical trials organization. In 2012, all five CSP Data Management and Statistical Coordinating Centers have received ISO 9001:2008 certification for quality management, an acknowledgement of their high quality standards. This is the first time a federal clinical research program has achieved this certification at a national level. The CSP Clinical Research Pharmacy Coordinating Center in Albuquerque, N.M., received ISO 9001 certification in 2004, and the President's Malcolm Baldrige National Quality Award in 2009.

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) interventions are widely used by consumers to treat physical and mental health conditions. A recent survey concerning CAM practice in VA in 2011 indicated that 89% of VA facilities offer CAM therapies. The five most common CAM interventions provided are Meditation; Stress Management/ Relaxation Therapy; Guided Imagery; Progressive Muscle Relaxation; and Biofeedback (50%). However, there is a paucity of data to support their use. Accordingly, VA R&D is significantly expanding the funding for CAM research in line with its mission to provide the evidence-base for VA care. A broad array of areas including evaluation of natural products, dietary supplements, diet, mind body medicine (e.g., meditation, yoga, acupuncture), manipulative body based practices (e.g., spinal manipulation, massage therapy), and practices using energy fields (light and magnet therapy) are part of funded efforts. Additional research projects on CAM are planned that address diverse medical conditions including meditative techniques for PTSD. One recently published VA supported clinical trial on mantra meditation showed that it was helpful in reducing PTSD symptoms, demonstrating the promise of CAM approaches that complement the traditional medical approach to PTSD treatment.

Technology Transfer

VA is committed to assuring that its research results provide maximum benefit to both Veterans and taxpayers. VA R&D's Technology Transfer Program (TTP) endeavors to patent significant inventions and foster Cooperative Research and Development Agreements (CRADAs) that enhance efforts of both VA and the commercial sector. VA was represented on 30 patents granted in 2011, participated in 192 licensing agreements, and entered into 17% of all CRADAs in the federal government. VA R&D is also committed to increasing the number of licenses issued by 10% each year, using standardized licensing agreements to the degrees possible in an effort to facilitate transitioning government technology into the private sector. Examples of recent successes include a solution for prolonged organ preservation prior to transplantation and a technology for optimizing statin dosing, both of which were licensed to the private sector.

In response to the Presidential Memorandum – Accelerating Technology Transfer and Commercialization of Federal Research, TTP will implement a plan over the next five years that focuses on enhancing and streamlining commercialization efforts.

Designated Research Areas

Designated Research Areas (DRA) represent areas of particular importance to our Veteran patient population. The funding shown on the following page 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	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Request	2012-2014 Inc/Dec
Acute & Traumatic Injury	$28,541	$39,359	$27,683	$27,050	($1,491)
Aging	$41,306	$38,816	$41,512	$41,028	($278)
Autoimmune, Allergic & Hematopoietic Disorders	$12,528	$15,384	$12,090	$12,044	($484)
Cancer	$44,693	$39,543	$44,915	$44,293	($400)
CNS Injury & Associated Disorders	$42,828	$29,486	$43,540	$43,841	$1,013
Degenerative Diseases of Bones & Joints	$19,546	$19,654	$19,643	$19,015	($531)
Dementia & Neuronal Degeneration	$24,971	$25,315	$25,095	$25,104	$133
Diabetes & Major Complications	$34,023	$34,279	$34,192	$33,393	($630)
Digestive Diseases	$14,976	$13,518	$15,051	$14,875	($101)
Emerging Pathogens/Bio-Terrorism	$659	$1,276	$662	$655	($4)
Gulf War Veterans Illness	$6,480	$4,862	$7,200	$15,000	$8,520
Health Systems	$45,394	$40,091	$45,319	$45,090	($304)
Heart Disease/Cardiovascular Health	$49,880	$54,666	$50,124	$49,546	($334)
Infectious Diseases	$27,986	$27,453	$28,123	$27,797	($189)
Kidney Disorders	$17,808	$19,082	$17,895	$17,088	($720)
Lung Disorders	$13,678	$13,585	$13,745	$12,886	($792)
Mental Illness	$83,874	$90,107	$84,587	$84,911	$1,037
Military Occupations & Environ. Exposures	$3,571	$4,017	$3,588	$3,547	($24)
Other Chronic Diseases	$1,507	$1,075	$1,514	$1,197	($310)
Sensory Loss	$17,799	$23,166	$17,886	$17,680	($119)
Special Populations	$26,196	$25,515	$26,324	$26,020	($176)
Substance Abuse	$22,756	$22,425	$23,868	$23,604	$848
Total	$581,000	$582,674	$584,556	$585,664	$4,664

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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 on the following page exceeds the number of distinct projects actually supported.

Projects by Designated Research Areas

Description	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Request	2012-2014 Inc/Dec
Acute & Traumatic Injury	161	198	157	154	(7)
Aging	252	213	252	251	(1)
Autoimmune, Allergic & Hemaptopoietic Disorders	80	76	78	78	(2)
Cancer	243	210	244	241	(2)
Central Nervous System Injury & Associated Disorders	213	118	217	218	5
Degenerative Diseases of Bones & Joints	115	105	115	113	(2)
Dementia & Neuronal Degeneration	145	130	145	146	1
Diabetes & Major Complications	187	175	188	184	(3)
Digestive Diseases	100	90	100	100	0
Emerging Pathogens/Bio-Terrorism	7	9	7	7	0
Gulf War Research Illness	24	14	28	67	43
Health Systems	156	158	156	155	(1)
Heart Disease	300	300	301	299	(1)
Infectious Diseases	159	164	159	158	(1)
Kidney Disorders	106	101	106	103	(3)
Lung Disorders	84	85	84	80	(4)
Mental Illness	411	408	415	416	5
Military Occupations & Environ. Exposures	20	23	20	20	0
Other Chronic Diseases	5	6	5	4	(1)
Sensory Loss	90	106	90	90	0
Special Populations	113	102	113	112	(1)
Substance Abuse	141	136	146	145	4

Obligations by Sub-Activity

(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Request	2012-2014 Inc/Dec
Research Programs (Investigator Initiated)	$370,286	$371,051	$427,943	$384,882	$14,596
Career Development	$74,931	$76,508	$88,069	$89,935	$15,004
Centers of Excellence	$41,139	$73,443	$45,157	$45,157	$4,018
Service Directed/Service Specific Research	$29,099	$51,617	$40,540	$40,540	$11,441
Research Compliance (PRIDE)	$4,911	$3,438	$5,157	$5,157	$246
R&D Specific Costs	$59,993	$51,617	$60,608	$59,993	$0
Total Obligations	$580,359	$627,674	$667,474	$625,664	$45,305
Appropriation	$581,000	$582,674	$584,556	$585,664	$4,664

Projects by Sub-Activity

Description	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Request	2012-2014 Inc/Dec
Research Programs (Investigator Initiated)	1,601	1,623	1,648	1,643	42
Career Development	516	491	520	516	0
Centers of Excellence	83	88	62	55	(28)
Service Directed Research	8	7	11	10	2
Total Projects	2,208	2,209	2,241	2,224	16

Employment Summary, FTE by Grade				
GS Grade or Title 38	2012 Actual	2013 Estimate	2014 Estimate	2012-2014 Inc/Dec
SES	0	0	0	0
Title 38	110	111	110	0
15 or higher	149	150	149	0
14	184	186	184	0
13	658	664	657	(1)
12	386	389	385	(1)
11	546	551	546	0
10	22	22	22	0
9	535	540	534	(1)
8	72	72	71	(1)
7	378	382	378	0
6	151	152	151	0
5	182	183	181	(1)
4	44	44	44	0
3	16	16	16	0
2	12	12	12	0
1	5	5	5	0
Wage Board	46	47	46	0
Total Number of FTE	3,496	3,526	3,491	(5)

Analysis of FTE Distribution Headquarters/Field		
GS Grade or Title 38	2012 HQ-Actual	2012 Field-Actual
SES	0	0
Title 38	5	105
15 or higher	7	142
14	4	180
13	0	658
12	2	384
11	0	546
10	0	22
9	4	531
8	0	72
7	0	378
6	0	151
5	0	182
4	0	44
3	1	15
2	0	12
1	0	5
Wage Board	0	46
Total Number of FTE	23	3,473

Obligations by Object

(dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Request	2012-2014 Inc/Dec
10 Personal Services	$318,811	$341,524	$331,563	$336,153	$17,342
21 Travel & Transportation of Persons:					
Employee Travel	$5,627	$6,881	$6,881	$4,537	($1,090)
All Other	$260	$286	$286	$286	$26
Subtotal	$5,887	$7,167	$7,167	$4,823	($1,064)
22 Transportation of Things	$131	$376	$376	$376	$245
23 Communication, Utilities & Misc	$3,434	$3,365	$3,365	$3,399	($35)
24 Printing & Reproduction	$693	$503	$503	$478	($215)
25 Other Services:					
Medical Care Contracts & Agree. w/Insts. & Orgs	$51,614	$54,079	$59,079	$56,880	$5,266
Fee Basis - Medical & Nursing Services, On-Station	$649	$415	$415	$411	($238)
Consultants & Attendance	$22,972	$19,291	$24,291	$19,098	($3,874)
Scarce Medical Specialist	$363	$509	$509	$504	$141
Repair of Furniture & Equipment	$2,122	$1,682	$1,682	$1,665	($457)
Maintenance & Repair Services	$425	$719	$719	$712	$287
Administrative Contractual Services	$110,746	$106,543	$123,343	$110,165	($581)
Training Contractual Services	$949	$1,137	$1,137	$1,126	$177
Subtotal	$189,840	$184,375	$211,175	$190,561	$721
26 Supplies & Materials	$42,389	$36,340	$44,301	$35,877	($6,512)
31 Equipment	$18,977	$53,692	$68,692	$53,665	$34,688
32 Lands & Structures	$197	$332	$332	$332	$135
Total Obligations	$580,359	$627,674	$667,474	$625,664	$45,305

Medical and Prosthetic Research

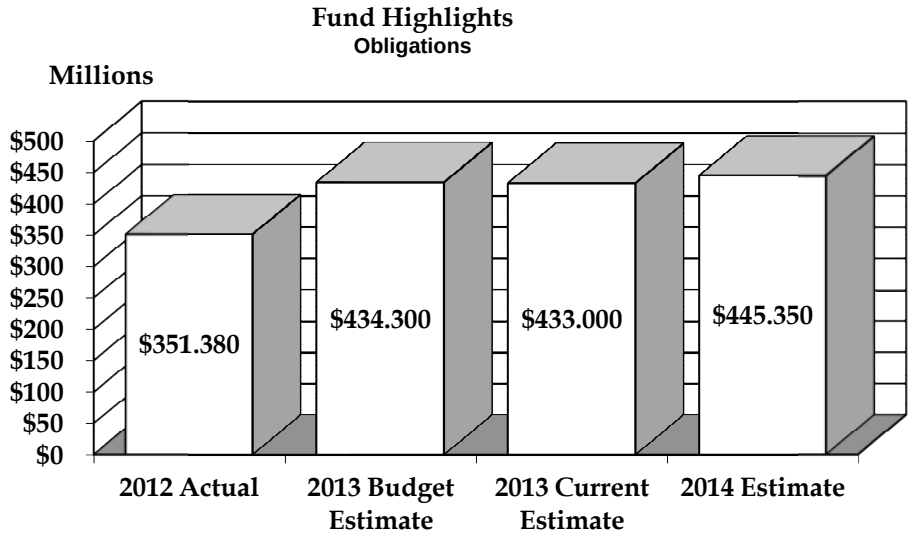
(dollars in thousands)

Appropriation	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Request	2012-2014 Inc/Dec
Medical research and support	$581,000	$582,674	$584,556	$585,664	$4,664
Budget Authority	$581,000	$582,674	$584,556	$585,664	$4,664
Reimbursements	$30,458	$35,000	$35,000	$35,000	$4,542
Budget Authority (Gross)	$611,458	$617,674	$619,556	$620,664	$9,206
Adjustments to obligations:					
Unobligated balance (SOY):					
No-year	$706	$0	$0	$0	($706)
2-year	$71,113	$45,000	$101,907	$53,989	($17,124)
Supplemental	$0	$0	$0	$0	$0
Emergency Designation	$0	$0	$0	$0	$0
Subtotal unobligated balance (SOY)	$71,819	$45,000	$101,907	$53,989	($17,830)
Unobligated balance (EOY):					
No-year	($693)	$0	$0	$0	$693
2-year	($101,214)	($35,000)	($53,989)	($48,989)	$52,225
Supplemental	$0	$0	$0	$0	$0
Subtotal unobligated balance (EOY)	($101,907)	($35,000)	($53,989)	($48,989)	$52,918
Change in Unobligated balance (non-add)	($30,009)	$10,000	$47,918	$5,000	$35,009
Unobligated balance expiring (lapse)	($1,011)	$0	$0	$0	$1,011
Obligations	$580,359	$627,674	$667,474	$625,664	$45,305
Obligations	$580,359	$627,674	$667,474	$625,664	$45,305
Obligated Balance (SOY)	$253,003	$293,705	$211,284	$269,224	$16,221
Obligated Balance (EOY)	($211,284)	($313,181)	($269,224)	($283,682)	($72,398)
Adjustments in Expired Accounts	($7,196)	$0	$0	$0	$7,196
Chg. Uncol. Cust. Pay Fed. Sources (Unexp.)	($58)	$0	$0	$0	$58
Chg. Uncol. Cust. Pay Fed. Sources (Exp.)	$0	$0	$0	$0	$0
Outlays, Gross	$614,824	$608,198	$609,534	$611,206	($3,618)
Offsetting Collections	($30,527)	($35,000)	($35,000)	($35,000)	($4,473)
Outlays, Net	$584,297	$573,198	$574,534	$576,206	($8,091)
Full-Time Equivalents (FTE):					
Direct FTE	3,015	3,045	3,045	3,010	(5)
Reimbursable FTE	481	481	481	481	0
Total FTE	3,496	3,526	3,526	3,491	(5)

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)

Description	2012 Actual	2013 Estimate	2014 Estimate	Increase/ Decrease
Total revenue.....	$365,151	$437,500	$450,000	$12,500
Obligations.....	$351,380	$433,000	$445,350	$12,350
Outlays (net).....	($21,392)	$3,000	$3,000	$0
Average employment.....	3,294	3,500	3,550	50

* The numbers in the chart above reflect an estimate of the activity during the Federal Government Fiscal Year (October – September), as the Veterans Canteen Service uses a retail industry fiscal year (February – January) used by similar private sector retailers to enhance their ability to compare their operations to their private sector peers.

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 2014. 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 2013 Budget Request
(dollars in thousands)

Description	2013 Budget Estimate	2013 Current Estimate	Increase/ Decrease
Total revenue	$434,400	$437,500	$3,100
Obligations	$434,300	$433,000	($1,300)
Outlays (net)	$0	$3,000	$3,000
Average employment	3,450	3,500	50

Analysis of Increases and Decreases - Obligations
(dollars in thousands)

	2013 Current Estimate	2014 Estimate
Prior Year Obligations	$351,380	$433,000
Increases and Decreases:		
Cost of Merchandise Sold	$35,000	$3,500
Personnel Cost	$2,000	$3,733
Other Operating Expenses	$13,567	$2,000
Indirect Expenses	$10,053	$2,017
Equipment, Inventory, Open Orders	$21,000	$1,100
Net Change	$81,620	$12,350
Obligations Estimate	$433,000	$445,350

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 2012 through 2014:

Summary of Employment

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	Increase/ Decrease
Average Employment.....	3,294	3,450	3,500	3,550	50

Revenues and Expenses
(dollars in thousands)

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	Increase/ Decrease
Sales Program:					
Revenue.....	$365,151	$434,400	$437,500	$450,000	$12,500
Less operating expenses.....	($351,380)	($434,300)	($433,000)	($445,350)	($12,350)
Net operating income-sales.....	$13,771	$100	$4,500	$4,650	$150
Nonoperating income or loss (-):					
Proceeds from sale of equipment.....	$50	$50	$50	$50	$0
Net book value of assets sold.....	($22)	($125)	($125)	($125)	$0
Net Gain or (Loss).....	$28	($75)	($75)	($75)	$0
Interest income.....	$0	$0	$0	$0	$0
Miscellaneous income/(loss).....	($12,352)	($200)	($4,183)	($4,350)	($167)
Net non-operating income.....	($12,324)	($275)	($4,258)	($4,425)	($167)
Net income for the year.....	$1,447	($175)	$242	$225	($17)

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 2014 and beyond.

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2014. Changes from year to year are the result of anticipated changes in revenues, obligations and outlays previously portrayed.

Financial Condition
(dollars in thousands)

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	Increase/ Decrease
Assets:					
Cash with Treasury, in banks, in transit	$31,979	$21,549	$22,000	$22,000	$0
Accounts receivable (net)	$39,453	$31,748	$40,000	$42,000	$2,000
Inventories	$39,155	$41,193	$42,000	$43,000	$1,000
Real property and equipment (net)	$51,947	$38,469	$50,368	$49,068	($1,300)
Other assets	$0	$365	$197	$371	$174
Total assets	$162,534	$133,324	$154,565	$156,439	$1,874
Liabilities:					
Accounts payable including funded accrued liabilities	$73,103	$46,131	$64,702	$65,371	$669
Unfunded annual leave and coupons books	$6,810	$7,020	$7,000	$7,980	$980
Total liabilities	$79,913	$53,151	$71,702	$73,351	$1,649
Government equity:					
Unexpended balance:					
Unobligated balance	$27,625	$32,804	$25,074	$34,902	$9,828
Undelivered orders	$3,049	$5,801	$5,789	$3,554	($2,235)
Invested capital	$51,947	$41,568	$52,000	$44,632	($7,368)
Total Government equity (end-of-year)	$82,621	$80,173	$82,863	$83,088	$225

Government Equity
(dollars in thousands)

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	Increase/ Decrease
Retained Income:					
Opening Balance	$81,174	$80,348	$82,621	$82,863	$242
Transactions:					
Net Operating Income	$13,771	$100	$4,500	$4,650	$150
Net Operating Gain	($12,324)	($275)	($4,258)	($4,425)	($167)
Closing Balance	$82,621	$80,173	$82,863	$83,088	$225
Total Government Equity (end-of-year)	$82,621	$80,173	$82,863	$83,088	$225

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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 nonprofit 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, 84 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 84 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 2012 to 2014.

Contribution Highlights
(dollars in thousands)

	2012	2013		2014	Increase/
		Budget	Current		
	Estimate	Estimate	Estimate	Estimate	Decrease
Contributions	$250,390	$279,000	$284,865	$298,040	$13,175
Expenses.....	$243,830	$279,000	$284,865	$298,040	$13,175

The following table is a list of research corporations that have received approval for formation along with their estimated 2012 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 2012
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	$12,750,000
4. Augusta Biomedical Research Corporation	Augusta	GA	$75,000
5. Baltimore Research and Education Foundation	Baltimore	MD	$3,700,000
6. Bedford VA Research Corporation, Inc.	Bedford	MA	$1,600,000
7. Biomedical Research and Education Foundation of Southern Arizona	Tucson	AZ	$1,550,000
8. Biomedical Research Foundation	Little Rock	AR	$750,000
9. Biomedical Research Foundation of South Texas, Inc.	San Antonio	TX	$475,000
10. Biomedical Research Institute of New Mexico	Albuquerque	NM	$9,500,000
11. Boston VA Research Institute, Inc.	Boston	MA	$12,500,000
12. Brentwood Biomedical Research Institute	Los Angeles	CA	$12,250,000
13. Bronx Veterans Medical Research Foundation	Bronx	NY	$1,650,000
14. Buffalo Institute for Medical Research, Inc.	Buffalo	NY	$350,000
15. Carl T. Hayden Medical Research Foundation	Phoenix	AZ	$1,750,000
16. Central Florida Research and Education Foundation, Inc.	Orlando	FL	$50,000
17. Central New York Research Corporation	Syracuse	NY	$1,250,000
18. Central Texas Veterans Research Foundation	Temple	TX	$300,000
19. Charleston Research Institute, Inc.	Charleston	SC	$1,050,000
20. Chicago Association for Research and Education in Science	Hines	IL	$5,200,000
21. Cincinnati Foundation for Biomedical Research and Education	Cincinnati	OH	$1,100,000
22. Clinical Research Foundation, Inc.	Louisville	KY	$275,000

Corporations	City	State	Estimated Revenues (Contributions) for 2012
23. Collaborative Medical Research Corporation	White River Junction	CT	$350,000
24. Dallas VA Research Corporation	Dallas	TX	$2,200,000
25. Dayton VA Research and Education Foundation	Dayton	OH	$0
26. Denver Research Institute	Denver	CO	$1,550,000
27. Dorn Research Institute	Columbia	SC	$225,000
28. East Bay Institute for Research and Education	Martinez	CA	$0
29. Great Plains Medical Research Foundation	Sioux Falls	SD	$100,000
30. Houston VA Research and Education Foundation	Houston	TX	$1,100,000
31. Huntington Institute for Research and Education	Huntington	WV	$0
32. Indiana Institute for Medical Research, Inc	Indianapolis	IN	$550,000
33. Institute for Clinical Research, Inc	Washington	DC	$3,600,000
34. Institute for Medical Research, Inc	Durham	NC	$2,000,000
35. Iowa City VA Medical Research Foundation	Iowa City	IA	$700,000
36. Lexington Biomedical Research Institute, Inc	Lexington	KY	$100,000
37. Loma Linda Veterans Association for Research and Education, Inc	Loma Linda	CA	$3,400,000
38. Louisiana Veterans Research and Education Corporation	New Orleans	LA	$0
39. McGuire Research Institute, Inc	Richmond	VA	$3,200,000
40. Metropolitan Detroit Research and Education Foundation	Detroit	MI	$225,000
41. Middle Tennessee Research Institute, Inc	Nashville	TN	$200,000
42. Midwest Biomedical Research Foundation	Kansas City	MO	$2,200,000
43. Minnesota Veterans Research Institute	Minneapolis	MN	$3,800,000
44. Missiouri Foundation for Medical Research	Columbia	MO	$400,000
45. Montrose Research Corporation	Montrose	NY	$0
46. Mountain Home Research and Education Corporation	Mountain Home	TN	$250,000
47. Mountaineer Education and Research Corporation	Clarksburg	WV	$125,000
48. Narrows Institute for Biomedical Research, Inc	Brooklyn	NY	$1,150,000
49. Nebraska Educational Biomedical Research Association	Omaha	NE	$625,000
50. North Florida Foundation for Research and Education, Inc	Gainesville	FL	$700,000
51. Northern California Institute for Research and Education, Inc	San Francisco	CA	$50,000,000
52. Ocean State Research Institute, Inc	Providence	RI	$525,000
53. Overton Brooks Research Corporation	Shreveport	LA	$0
54. Pacific Health Research and Education Institute	Honolulu	HI	$3,300,000
55. Palo Alto Institute for Research and Education, Inc	Palo Alto	CA	$24,000,000

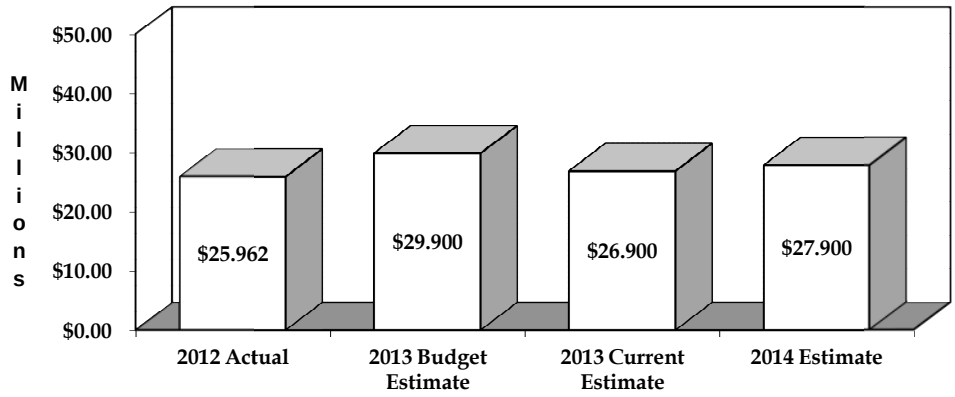
Corporations	City	State	Estimated Revenues (Contributions) for 2012
56. Philadelphia Research and Education Foundation	Philadelphia	PA	$825,000
57. Portland VA Research Foundation, Inc	Portland	OR	$3,700,000
58. Research Mississippi, Inc	Jackson	MS	$525,000
59. Research, Incorporated	Memphis	TN	$1,500,000
60. Salem Research Institute, Inc	Salem	VA	$500,000
61. Salisbury Foundation for Research and Education	Salisbury	NC	$25,000
62. Seattle Institute for Biomedical and Clinical Research	Seattle	WA	$12,500,000
63. Sepulveda Research Corporation	Sepulveda	CA	$3,000,000
64. Sierra Biomedical Research Corporation	Reno	NV	$425,000
65. Sociedad de Investigacion Cientificas, Inc	San Juan	PR	$225,000
66. South Florida Veterans Affairs Foundation for Research and Education	Miami	FL	$2,100,000
67. Southern California Institute for Research and Education	Long Beach	CA	$4,000,000
68. Tampa VA Research and Education Foundation	Tampa	FL	$1,250,000
69. The Bay Pines Foundation, Inc	Bay Pines	FL	$1,250,000
70. The Cleveland VA Medical Research and Education Foundation	Cleveland	OH	$800,000
71. The Research Corporation of Long Island, Inc	Northport	NY	$450,000
72. Tuscaloosa Research and Education Advancement Corporation	Tuscaloosa	AL	$1,500,000
73. VA Black Hills Research and Education Foundation	Fort Meade	SD	$70,000
74. VA Connecticut Research and Education Foundation	West Haven	CT	$3,200,000
75. Vandeventer Place Research Foundation	St Louis	MO	$125,000
76. Veterans Bio-Medical Research Institute, Inc	East Orange	NJ	$1,850,000
77. Veterans Education and Research Association of Michigan	Ann Arbor	MI	$650,000
78. Veterans Medical Research Foundation of San Diego	San Diego	CA	$27,500,000
79. Veterans Research and Education Foundation	Oklahoma City	OK	$625,000
80. Veterans Research Foundation of Pittsburgh	Pittsburgh	PA	$2,900,000
81. VISTAR, Inc	Birmingham	AL	$220,000
82. Western Institute for Biomedical Research	Salt Lake City	UT	$2,300,000
83. Westside Institute for Science and Education	Chicago	IL	$450,000
84. Wisconsin Corporation for Biomedical Research	Milwaukee	WI	$825,000
Total			$250,390,000

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	2012 Actual	2013 Estimate	2014 Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite).....	$25,962	$26,900	$27,900	$1,000
Obligations:				
Trust Fund and Donation.....	$22,350	$23,200	$24,100	$900
Therapeutic Residences.....	$1,033	$1,100	$1,100	$0
Total Obligations.....	$23,383	$24,300	$25,200	$900
Outlays.....	$24,321	$25,200	$26,100	$900

Changes From Original 2013 Budget Estimate

(dollars in thousands)

Description	2013 Budget Estimate	2013 Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite)....	$29,900	$26,900	($3,000)
Obligations:			
Trust Fund and Donation.....	$25,900	$23,200	($2,700)
Therapeutic Residences.....	$1,100	$1,100	$0
Total Obligations.....	$27,000	$24,300	($2,700)
Outlays.....	$27,500	$25,200	($2,300)

Program Activity

Trust Fund and Donations
Estimates of trust fund obligations revised for 2013 and 2014 are $24,300,000 and $25,200,000 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 2013 and 2014 is estimated to be approximately $45,495,000 and $25,239,000 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 2013 and 2014 are estimated to reach $23,200,000 and $24,100,000 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)

	2012 Actual	2013 Budget Estimate	2013 Current Estimate	2014 Estimate	Increase/ Decrease
Balance beginning of year:					
Cash	$3,142	$3,342	$23,382	$44,230	$20,848
Investments	$84,255	$86,655	$65,161	$45,495	($19,666)
Property, Plant, Equipment & Other Assets	$28,498	$34,198	$28,108	$27,707	($401)
Total	$115,895	$124,195	$116,651	$117,432	$781
Increase during period:					
Cash	$75,920	$160,600	$78,198	$80,544	$2,346
Investments	$33,717	$96,500	$34,729	$35,771	$1,042
Property, Plant, Equipment & Other Assets	$6,320	$11,200	$6,510	$6,705	$195
Total	$115,957	$268,300	$119,437	$123,020	$3,583
Decrease during period:					
Cash	$55,680	$160,400	$57,350	$59,071	$1,721
Investments	$52,811	$94,000	$54,395	$56,027	$1,632
Property, Plant, Equipment & Other Assets	$6,710	$5,400	$6,911	$7,118	$207
Total	$115,201	$259,800	$118,656	$122,216	$3,560
Balance at end of year:					
Cash	$23,382	$3,542	$44,230	$65,703	$21,473
Investments	$65,161	$89,155	$45,495	$25,239	($20,256)
Property, Plant, Equipment & Other Assets	$28,108	$39,998	$27,707	$27,294	($413)
Total	$116,651	$132,695	$117,432	$118,236	$804

Information and Technology

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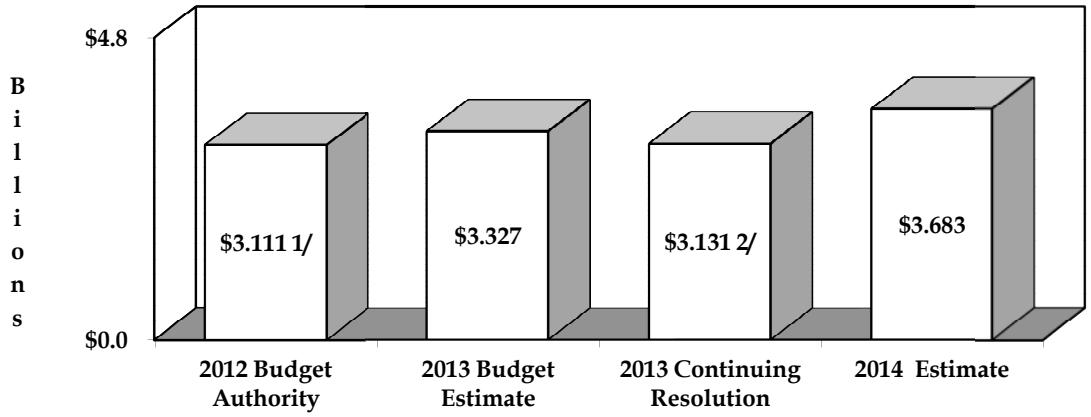
Budget Authority



Notes:
1/ Reflects the FY 2012 Veterans Affairs Appropriation (P.L. 112-74).
2/ Full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution

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, $3,683,344,000, plus reimbursements: Provided, That $1,026,400,000 shall be for pay and associated costs, of which not to exceed five percent of this amount shall remain available until September 30, 2015: Provided further, That $2,161,653,000 shall be for operations and maintenance, of which not to exceed ten percent of this amount shall remain available until September 30, 2015: Provided further, That $495,291,000 shall be for information technology systems development, modernization, and enhancement, and shall remain available until September 30, 2015: Provided further, That amounts made available for salaries and expenses, operations and maintenance, and information technology systems development, modernization, and enhancements may be transferred among the three subaccounts after the Secretary of Veterans affairs submits notice thereof to the Committees on Appropriations of both Houses of Congress.

Explanation of Language Change

The Administration proposes to amend the appropriations language under Information Technology Systems to establish the amount of two-year funding as a percentage of the appropriation, rather than as a dollar amount. This change will allow the amount to be adjusted each year as funding changes. The proposed percentages are 10% for sustainment and 5% for pay and administration and are roughly equivalent to the percentage shares in current law.

Appropriation Highlights

(Dollars in Thousands)

	2012	2013		2014	
	Actual	Budget Estimate	Continuing Resolution	Estimate	2012-2014 Increase/ Decrease
Appropriation Subaccounts:					
Development	580,358	494,399	518,962	495,291	-85,067
Sustainment 1/	1,616,018	1,812,046	1,636,987	2,161,653	545,635
Pay & Administration	915,000	1,021,000	975,000	1,026,400	111,400
Subtotal 2/	**$3,111,376**	**$3,327,444**	**$3,130,949**	**$3,683,344**	**$571,968**
Transfers 3/	-6,605				6,605
Appropriation	3,111,376	3,327,444	3,130,949	3,683,344	571,968
Reimbursements (+)	71,843	47,000	110,000	186,568	114,725
Available Balance SOY (+) 4/	107,591		33,426		-107,591
Available Balance EOY (-)	-33,426				33,426
Unobligated Balance (Expiring) Lapse	-1,395				1,395
Change in Uncollected Orders					
Total Obligations	**$3,249,384**	**$3,374,444**	**$3,274,375**	**$3,869,912**	**$620,528**
Average Employment	7,311	7,580	7,536	7,459	
Direct	7,210	7,435	7,435	7,355	
Reimbursement	101	145	101	104	

Numbers may not add due to rounding.

1/ FY2013 CR includes Hurricane Sandy Emergency Supplemental PL 113-2 funding of $531k.

2/ Numbers include actual appropriations received or requested.

3/ FY 2012 reflects a $6,605 transfer to the North Chicago facility.

Executive Overview

FY 2014 Budget Request

The 2011 – 2015 Strategic Plan Refresh 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 Fiscal Year (FY) 2014 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 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 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.

For FY 2014, the Office of Information and Technology (OIT) is requesting $3.683 billion, an increase of $572 million (18%) above the 2012 level. The request is separated into three subaccounts, as follows:

- **Development** – The request of $495.3 million is $85 million (14.7%) below the FY 2012 level. The funds will support development of IT solutions, which are comprised of three categories: integrated Electronic Health Record (iEHR) and Virtual Lifetime Electronic Record (VLER) Health, Major Transformation Initiatives (MTI), and other continuing development.

- **Operations and Maintenance** – The request of $2.161 billion is $545.6 million (33.8%) above the FY 2012 level. The funds will provide for the operation and maintenance of existing infrastructure systems and marginal sustainment for MTI development efforts. It also includes funding for activating medical facilities, protecting Veterans' personal information, and implementing projects that contribute to cost efficiencies.

- **Staffing and Administration** – The request of $1.026 billion is $111.4 million (12%) above the FY 2012 level. The funds will support staffing and administrative expenses for 7,355 FTE.

In addition, VA anticipates $174 million in collected non-pay reimbursements from other federal agencies, credit reform programs and non-appropriated insurance benefits programs. The increase in non-pay reimbursements of $115.1 million above the FY2012 level is due to iEHR and VLER Health related work in the Interagency Program Office (IPO). Also, anticipated pay reimbursements of $13 million will fund 104 FTE.

Resource Band Perspective

The FY 2014 request can be broken down into resource bands and spending categories. Resource bands are used in the prioritization process to determine funding allocations among IT projects. Resource band types are described as: Mandatory sustainment which covers "must pay" and one-time and/or recurring cost; Discretionary sustainment includes necessary but non-critical sustainment efforts to continue or enhance OIT operations; Marginal sustainment supports newly deployed projects that have not fully rolled over into mandatory sustainment; and Development to cover development modernization and enhancements (DME) of projects.

By resource bands, the request is broken down into nine spending categories: staffing and administration; mandatory sustainment; activations discretionary sustainment; other discretionary sustainment; iEHR and VLER Health development; iEHR and VLER Health marginal sustainment; MTI development; MTI marginal sustainment; and other continuing development.

In 2014, the largest category of IT spending by resource band is mandatory sustainment, which accounts for $1,748 million (47%) of the total FY 2014 estimate. The second largest resource band category of spending in FY 2014 is staffing and administration, which will support 7,355 FTE in headquarters and regional and field offices and in VA hospitals nationwide.

The table below provides a resource band view of the FY 2014 IT budget request.

FY 2014 Budget Request
(Dollars in Thousands)

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Estimate	2012-2014 Increase/ Decrease
Staffing and Administration	$ 910,572	$ 1,021,000	$ 975,000	$ 1,026,400	$ 115,828
Mandatory Sustainment	$ 1,332,344	$ 1,526,000	$ 1,408,346	$ 1,748,085	$ 415,741
Activations - Discretionary Sustainment	$ 53,959	$ 112,000	$ 76,000	$ 180,397	$ 126,438
Other Discretionary Sustainment	$ 153,257	$ -	$ 31,198	$ 156,762	$ 3,505
iEHR & VLER Health - Development	$ 35,410	$ 104,000	$ 133,550	$ 251,882	$ 216,472
iEHR & VLER Health - Marginal Sustainment	$ 278	$ 65,000	$ 35,450	$ 38,700	$ 38,422
Major Transformational Initiatives- Development	$ 456,749	$ 376,808	$ 302,233	$ 208,409	$ (248,340)
Major Transformational Initiatives- Marginal	$ 56,313	$ 111,136	$ 85,993	$ 36,709	$ (19,604)
Other Continuing Development 1/	$ 78,134	$ 11,500	$ 83,179	$ 36,000	$ (42,134)
Total	**$ 3,077,016**	**$ 3,327,444**	**$ 3,130,949**	**$ 3,683,344**	**$ 606,328**

Note: Numbers may not add due to rounding.
1/ In FY2014 $1M of ICD -10 is marginal sustainment

IT Development

VA is requesting $495 million for IT Development in 2014. The request is separated into three categories: MTI, iEHR and VLER Health, and other continuing development as described below.

- **MTIs**. In 2014, $208 million (42%) of the request for development activity will be conducted within the framework of the MTIs. IT staff are assigned to each MTI, and are key partners with all of the VA business lines during the planning, implementation, and follow-on Operations and Maintenance (O&M) phase of each MTI. In 2014, development work for three MTIs - *Preparedness*, *Strategies to Drive Performance*, and *Research and Development* - will be completed and the initiatives will be transitioned into sustainment. With the transitioning of these initiatives, development work will be directed toward the Secretary's priorities. The Secretary's priorities are: (1) end homelessness by developing data sharing capabilities between VA and Housing and Urban Development's (HUD) Homeless Management Information System (HMIS), (2) eliminate the claims backlog by deploying Veterans Benefits Management Systems (VBMS) to all 56 Regional Offices by the end of calendar 2013, and (3) develop technologies to expand access to benefits and services. In 2014, focus will also be placed on developing Veterans Relationship Management (VRM) capabilities. VRM will provide secure and personalized access to benefits information for Veterans and beneficiaries.

  iEHR and VLER Health. In 2014, $252 million (51%) of the request for development activity will fund the Interagency Program Office (IPO), which will manage iEHR and VLER Health. In FY 2014, The most critical goal for 2014 is to successfully achieve iEHR Initial Operating Capability (IOC). IOC deployment will provide the first subset of clinical capabilities (to include initial lab and immunization) for facilities in two separate locations—San Antonio, TX and Hampton Roads, VA. The joint applications, accessed

through a common enhanced GUI, will utilize the respective "EHR cores" from VA and DoD, but will use common standards, infrastructure, and core services to ensure interoperability between the Departments. VLER Health is a portfolio of programs that manage the exchange and use of important health information with private partners, other agencies and the Veteran according to nationally-established standards. This portfolio has been known in VA as the Nationwide Health Information Network or NwHIN. Now known as the eHealth Exchange, information sharing is rapidly spreading across the country and VA is in the lead. In FY2013–2014, VLER Health will begin to seamlessly integrate with the new EHR, to seamlessly "serve up" this private sector and other agency, including DoD, data that comes through the eHealth Exchange or via "Direct" secure messaging.

- **Other continuing development.** In 2014, $35 million (7%) of the request for development will support other continuing development. This includes enhancements to the Electronic Data Interchange (EDI) transactions. EDI will improve VA's ability to continue to meet its health care financial goals, such as collecting approximately $3 billion in third party insurance and Veteran co-payments, which support the operating cost of VA Medical Centers. This request will also fund implementation of the IT capability under the Healthcare Reform/Affordable Healthcare Act.

Operations and Maintenance

In 2014, VA is requesting $2.162 billion for the Operation and Maintenance (O&M) of existing IT infrastructure systems, including marginal sustainment to support MTI and iEHR and VLER Health. Highlights are presented below, and additional details are presented in the Sustainment subaccount section:

- **Mandatory sustainment.** In 2014, $1.748 billion (80.9%) of the total request for (O&M) is for mandatory sustainment, which are "must pay" costs of telecommunications, software licenses, hardware maintenance, IT support contract costs, and sustainment costs of IT solutions that directly execute VA information protection, including cyber security and privacy requirements within VA.
- **Discretionary sustainment.** In 2014, $337 million (15.6%) of the total request for (O&M) is for discretionary sustainment which includes activations, Voice as Service (VaaS), the wireless infrastructure program, and lifecycle replacement for hardware and desktop.
- **Marginal Sustainment.** In 2014, $76 million (3.5%) of the total request for (O&M) is for marginal sustainment to support continuing development, MTI, and iEHR and VLER Health efforts.

VA's major 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. 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.

Operations and Maintenance funding is required to ensure that there is an IT infrastructure platform fully capable of providing for VA's data storage, transmission, and communications requirements. These requirements have grown steadily since FY 2010, and are expected to continue growth into FY 2014. The growth in spending by the business line elements of VA (medical care, benefits delivery) is one driver. There are also additional factors that continue to exert upward pressure on IT infrastructure spending. These include: aging hardware, demands for mobile computing, new employees and VA facilities, more automated data activities and data exchanges, and complex security requirements.

The IT Infrastructure provides the backbone necessary to meet the day-to-day operational needs of VA Medical Centers (making the Veterans Health Administration (VHA) one of the "most wired" healthcare systems in the world), 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 request allows IT to perform according to Service Level Agreements (SLAs) 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 assures 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 that IT supports. As additional investment is made in the lines of business (non-IT costs), the required O&M support (IT costs) has also increased. 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 and data center consolidation. 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.

As equipment ages, the risk of failures and outages increase exponentially. IT hardware moves "beyond useful lifespan" when it is no longer able to run acceptable versions of operating system or application and is no longer able to meet federal security standards. The aggregate total of replacement costs for IT hardware has been increasing over the past few years as the VA has been forced to defer replacement costs in lieu of other IT needs. Additionally, the eight key business drivers noted below continue to exert upward pressure on IT costs because growth in the businesses continues. This upward pressure (historical analysis suggests between 5-8% growth in all categories of sustainment costs) is projected to continue despite the cost containment and cost avoidance strategies adopted so far.

During the past five years, secular trend costs have pushed IT O&M costs upwards on an annual basis. Some of the current trends are:

- New employees
  - Approximately 45,000 new users in 6 years
- New facility activations
  - Approximately 300 new facilities in 6 years
- New systems and platforms released into production
  - Approximately 280 new systems in 6 years
  - As the Project Management Accountability System matures, more systems/platforms move to completion
- Increase in proportion of staff with mobile computing and communicating requirement
  - Percentage of mobile users is increasing to approximately 25% of the workforce
  - Mobile worker numbers driven by Telework legislation, Green-Carbon Reduction legislation, increasing utilization of virtual team work
- Increased reliance on Wide Area Network (WAN)/Local Area Network (LAN) and other Telecom costs
  - Traffic on WAN doubles every 18 months
  - VHA's emphasis on Telehealth as a signature program for providing a new model of 21st century healthcare
- More tools on the IT 'Tool belt'
  - Employees use many more IT tools than in the past
- 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 VA's dependency on IT increases. Those future trends are:

- Wireless point of care devices for clinical care and administrative roles (horizon scanning suggests that as much as 35% of the VA's workforce will have a mobile computing/communicating requirement by 2015).
- Increasing virtual collaboration of employees working as virtual teams and/or teleworking.
- Increasing numbers of external connections (e.g. VA to Department of Defense (DoD), or to private 'accountable care' organizations).
- Increasing storage with concomitant mandate for record retention, legal recovery, and disaster tolerance/recovery.
- "Cloud" computing and greater reliance on network connectivity.
- Innovations represent unknowns for future O&M costs.

The consequences of not keeping pace with these 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 could manifest through poor system operating performance, as well as increased equipment outages and system down time. The FY2014 request will help to eliminate the IT infrastructure backlog and decrease the risk of major outages at health care facilities. To mitigate the cost associated with maintaining the IT infrastructure, OIT established the Ruthless Reduction Task Force (RRTF) to identify opportunities for cost avoidance in VA. OIT has put into place a number of cost avoidance strategies such as pursuing fee-for-service projects (e.g. VaaS) and the server virtualization project.

Staffing and Administration

In 2014, VA is requesting $1.026 billion for IT staffing and administration, primarily for pay and benefits for its 7,355 FTE. This request reflects the pay raise of 1.0 percent and inflation of 1.7 percent for non-pay contracts. Additionally, the FY 2014 request reflects a realignment of FTE between VHA and OIT. Additional detail on the staffing realignment can be found in the Staffing and Administration section.

The funding will support staffing for 8 major components of the Office of Information Technology:

- Office of Quality Performance and Oversight
- IT Information Security

- Architecture, Strategy and Design
- IT Resources Management
- Product Development
- Office of Service Delivery and Engineering
- VLER Program Office
- Interagency Program Office

Additional detail on office functions is provided in the Staffing and Administration section.

Development, Modernization, and Enhancement Subaccount

Development Activities Highlights
(Dollars in Thousands)

Activities:	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Estimate	2012-2014 Increase/ Decrease
Integrated Electronic Health Record (iEHR) & VLER Health	$ 68,833	$ 104,000	$ 133,550	$ 8,125	$ 251,882	$ 183,049
Veterans Relationship Management (VRM)	$ 68,547	$ 96,218	$ 82,713	$ -	$ 120,157	$ 51,610
Automated GI Bill (Chapter 33)	$ 51,998	$ -	$ 4,400	$ -	$ -	$ (51,998)
Veterans Benefits Management System (VBMS)	$ 104,163	$ 38,525	$ 40,125	$ -	$ 32,834	$ (71,329)
New Models of Care	$ 24,703	$ 35,724	$ 39,883	$ -	$ 32,647	$ 7,944
Integrated Operating Model (IOM)	$ 17,516	$ 14,100	$ 17,950	$ -	$ -	$ (17,516)
Virtual Lifetime Electronic Record (VLER)	$ 46,191	$ 49,939	$ 45,857	$ -	$ 11,352	$ (34,839)
Health Informatics	$ 7,643	$ 7,500	$ 7,500	$ -	$ 7,774	$ 131
Healthcare Efficiency	$ 2,456	$ 4,659	$ 8,689	$ -	$ -	$ (2,456)
ICD-10	$ 44,119	$ 11,500	$ 14,664	$ -	$ 4,600	$ (39,519)
Human Capital Investment Plan (HCIP)	$ 5,450	$ 14,640	$ 2,720	$ -	$ -	$ (5,450)
Access to Healthcare	$ 40,071	$ 67,816	$ 23,414	$ -	$ 3,645	$ (36,426)
Homelessness	$ 4,650	$ 3,075	$ 2,792	$ -	$ -	$ (4,650)
Mental Health	$ 6,476	$ 8,818	$ 5,844	$ -	$ -	$ (6,476)
Preparedness (PIV)	$ 16,154	$ 3,025	$ 6,485	$ -	$ -	$ (16,154)
Systems to Drive Performance (STDP)	$ -	$ 4,062	$ -	$ -	$ -	$ -
Strategic Capital Investement Plan (SCIP)	$ 737	$ 1,000	$ 1,000	$ -	$ -	$ (737)
Other	$ 60,587	$ 29,798	$ 81,375	$ 19,544	$ 30,400	$ (30,187)
Total Development 1/	**$ 570,293**	**$ 494,399**	**$ 518,962**	**$ 27,669**	**$ 495,291**	**$ (75,002)**
Funding Sources:						
Appropriation	$ 570,293	$ 494,399	$ 518,962	$ -	$ 495,291	$ (75,002)
Reimbursements (+)	$ 28,202	$ 1,000	$ 68,823	$ -	$ 130,012	$ 101,810
Available Balance SOY (+)	$ 19,611	$ -	$ 23,358	$ -	$ -	$ (19,611)
Available Balance EOY (-)	$ (23,358)	$ -	$ -	$ -	$ -	$ 23,358
Unobligated Balance (Expiring) Lapse	$ -	$ -	$ -	$ -	$ -	$ -
Change in Uncollected orders	$ -	$ -	$ -	$ -	$ -	$ -
Total Resources	**$ 594,748**	**$ 495,399**	**$ 611,143**	**$ -**	**$ 625,303**	**$ 30,555**

Note: Numbers may not add due to rounding.
1/ Numbers do not include reimbursements and FY 2011/2012 and FY 2012/2013 carryovers.

Major Transformational Initiatives (MTIs)

The majority of VA IT development activity is now conducted within the framework of the MTIs. 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 CIO, 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 initiatives and are key partners with all of the VA business lines during the planning, implementation and follow-on O&M of each initiative. In FY 2014, funding by MTI can be found in

Appendix 3 "Analysis of spending on Major Transformational Initiatives FY 2012-14."

Integrated Electronic Health Record (iEHR) and Virtual Lifetime Electronic Record (VLER) Health: $251.9 million

The iEHR program represents an integrated, multi-increment effort between the VA and Department of Defense, one that is bound by a common architecture, data model, and presentation layer. The iEHR program will include a mix of Commercial Off the Shelf (COTS), Government Off the Shelf (GOTS), and Open Source capabilities, in addition to reuse of enduring unique capabilities. VLER Health is the portfolio of programs that manage the exchange and use of clinically relevant health information on service members and Veterans between VA, DoD, and other federal and non-federal health exchange partners.

In 2014, $252 million (51%) of the budget request, will be used to fund the required development activities within the Interagency Program Office (IPO), specifically for iEHR and VLER Health. In FY 2014, the IPO plans to roll out an interoperable electronic health record system in two facilities located in San Antonio, Texas and Hampton Roads, Virginia. This includes the development and implementation of a common clinical care user interface, acquisition and implementation of laboratory information system and immunization capability, pharmacy enhancements in North Chicago, and the enabling infrastructure capabilities required to support iEHR.

VLER Health is a portfolio of programs that manage the exchange and use of important health information with private partners, other agencies and the Veteran according to nationally-established standards. This portfolio has been known in VA as the Nationwide Health Information Network or NwHIN. Now known as the eHealth Exchange, information sharing is rapidly spreading across the country and VA is in the lead. In FY2013 –2014, VLER Health will begin to seamlessly integrate with the new EHR, to seamlessly "serve up" this private sector and other agency, including DoD, data that comes through the eHealth Exchange or via "Direct" secure messaging.

Veterans Relationship Management (VRM): $120.2 million

The goal of the VRM initiative is to enhance Veterans' access to comprehensive VA services and benefits especially in the delivery of compensation and pension claims processing. 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.

VRM capabilities will empower Veterans and beneficiaries through multiple accurate and flexible communication channels, while providing secure and personalized access to benefits information. The enhanced bi-directional communication, based upon life events and Veteran preference, will improve VA's ability to respond to customer inquiries by providing consistent and complete information in a reduced amount of time. VRM's added 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.

FY 2014 Request: In FY 2014, the request for $120.2 million will allow VRM to continue migrating toward enterprise solutions and begin its evolution to a future-state operating model, where ongoing business process improvements and solution development can continue to impact VA at the enterprise level. The request will:

- Implement CRM for the Health Resource Center and the Debt Management Center, and expand capabilities for the VHA Health Administration Center and Case Management capabilities for the VBA Fiduciary Beneficiary System.
- Enhance eBenefits and the Veterans' On-line Application System (VONAPP) to accommodate the expected growth in new users. Veterans will be able to file benefits claims online, and upload supporting claims information that feeds the VA paperless claims process.
- Provide the ability for all systems to have access to a consolidated history of a Veteran's interactions with VA.
- Create networking tools so Veterans share employment and transition experiences (e.g. messaging boards and social networking sites).
- Enhance Veteran Transition resources such as interactive maps for assisting Veterans' transition to college, career, retirement and family life.
- Implement chat, browse, and co-browse tools to support online capabilities offered on VA web sites.

FY 2013 Deliverables: In FY 2013, VA business lines will implement tailored VRM customer service solutions. Self-service capabilities will continue to be a key focal point. This includes an expansion of self-service functionality to Veteran Service Organizations (VSOs), partners, and third party providers, with a focus on targeted access for authorized and authenticated individuals. VRM will help the organizations realize an increased capability to perform and deliver more detailed and in-depth analyses of customer trends, performance metrics and other business opportunities as a result of deployed analytics capabilities.

Veterans Benefits Management Systems (VBMS): $32.8 million

VBMS is a business transformation initiative supported by technology to improve VBA service delivery. VBMS is central to VA's goal of eliminating the claims backlog and reducing the total processing time for a claim from inception to award in less than 125 days within 98 percent accuracy in 2015.

Key features of VBMS include:
- A web-based system that provides real-time, on-demand access to information.
- An electronic environment that accelerates benefits delivery by removing current inefficiencies associated with paper-based claims processing.
- Automated processes, workflow and workload management capabilities that result in improved quality, accuracy and timeliness of claims decisions.

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.

FY 2014 Request: In FY 2014, the request for $32.8 million will allow the VA to:
- Improve workflow efficiency through enhanced business processing.
- Increase access to VBMS for third-party claim submission in order to leverage a greater number of electronic filings.
- Retire legacy software applications.
- Expand rating calculator efficiencies to improve decision timeliness, quality, and consistency.
- Begin development of paperless claims processing technology for other VBA business lines.

FY 2013 Deliverables: VBA plans to complete VBMS national deployment to all 56 regional offices by the end of FY 2013. Three major software releases are also planned for FY 2013:
- VBMS 4.0 will provide the ability for VBMS to intake all claims and associated documents that are submitted electronically through VONAPP Direct Connect (VDC). For the first time, VBMS will be able to accept claims filed by Veterans online, as opposed to the current paper submission process.
- VBMS 4.1 will focus on reducing VBMS dependency on legacy applications and adding letter generation capabilities, which will increase correspondence consistency and system automation.
- Decreasing the frequency of switching between multiple legacy applications will improve the overall efficiency of the claims process. VBMS 5.0 will focus on continuing to build and publish Claims Data Information Exchange

Specifications to enable other systems and initiatives to leverage or integrate their information with VBMS.

New Models of Health Care (NMHC): $32.6 million

NMHC has been designed to transform the delivery of healthcare within the VA and to position the Department as a leader in the healthcare industry through innovations for both Veterans and providers.

NMHC is composed of nine sub-initiatives: Patient Aligned Care Team, Prevention, Virtual Medicine Non-Telehealth, Telehealth, Non-Institutional Long Term Care, Specialty Care, Women's Health, Mobile Applications, and Patient Centered Care. Although each sub-initiative is composed of unique programs, significant interdependencies and relationships have been identified.

NMHC will explore novel uses of Telehealth technology to bring specialized services to more remote locations, thus improving access and reducing patient travel.

NMHC will improve access by supporting more convenient ways of providing care. NMHC will also contribute to VA having a world class, right-sized infrastructure by developing a systematic, value-driven approach to ensure the provision of optimal care for all enrolled Veterans. Coordinated care will improve patient outcomes and satisfaction with the services VHA offers.

FY 2014 Request: In FY 2014, the request for $32.6 million will be used to integrate VA and DoD Secure Messaging (SM) Solution environments as well as address desired modifications to enhance functionality and improve usability. NMHC will also allow VA to implement an enterprise-wide common service for information sharing allowing Veterans to easily authorize and manage their preferences for information sharing (e.g., delegation, surrogacy, and sharing patient generated data with the VA health care team) across all patient-facing applications and services.

FY 2013 Deliverables:
- Expand VA Blue Button capability to allow Veterans to see their Home Telehealth data such as vitals, while logged in to the My Health*e*Vet portal.
- Continue to expand the types of information that are available to Veterans from the VA Electronic Health Record by adding an array of additional data classes to the VA Blue Button (e.g., Vitals and Readings, Radiology Reports, Pathology Reports, Progress Notes).
- Expand secure messaging capability to surgical and specialty care areas to enhance access to care and support communication for VA patients.
- Continue to implement improvements to VA's My Health*e*Vet portal to improve usability (Veteran Focused Website Redesign), enhance system

performance and scalability (Capabilities Enhancements), and expand services, such as the integration of the Veterans Health Library, Health Risk Assessment, and eMOVE.
- Provide Veterans with Single Sign-On access to other VA accredited systems while enhancing online remote identity proofing. This will enhance Veterans' ability to access their health records online via My Health*e*Vet rather than mailing a form to their local VA facility.

- Develop an automated scheduling system for Clinical Video-Teleconferencing that will assist in delivering health care services using telecommunications technologies in situations where patients and clinicians are geographically distant from one another.
- Develop software to track abnormal test results; a Breast Cancer Clinical Case Registry; and alerts to clinicians about medications such as teratogenic drugs, which cause miscarriages, birth defects and harm to breast fed infants.
- Pilot the Telepathology prototype enhancement in VHA Veterans Integrated Service Networks (VISNs) for evaluation by the Clinical Pathologist Working Group while delivering desktop interoperability with the Home Telehealth Wound Care program for VHA providers.

Virtual Lifetime Electronic Record (VLER): $11.4 million

FY 2014 Request: Funding will cover VLER Memorial Affairs Redisign project. In FY 2014, the focus is to redesign Burial Operations Support System (BOSS) Enterprise and its subsystems and improve the legacy BOSS Enterprise to develop better data-sharing across the VA.

Other Significant Major Transformational Initiatives (MTIs): $11.4 million

FY 2014 Request: Included in Other Significant MTIs are $7.8 million for Health Informatics (hi2), and $3.6 million for Access to Healthcare (EVEAH).

Health Informatics will deliver software solutions and establish health informatics literacy to modernize VA's Electronic Health Record (EHR) and transition to the adoption of the Health Management Platform (HMP). During FY 2014, hi2 will implement six new software modules into the HMP. It will also provide tools to support Veteran and Active Duty-aligned care teams and add more data domains to Virtual Patient Record for sharing with partner systems.
EVEAH contributes to expanding Veterans' options and availability of healthcare services. Through the implementation of EVEAH, Veterans will be able to easily navigate the VA system to receive desired services. Through new technology, care alternatives will be created in order to meet special population access needs. In FY 2014, Increment 3 and 4 of the Bed Management Solution version 1.0 will deploy nationally. This deployment will provide VA hospitals the ability to

manage bed availability, resulting in reduced wait times for admissions from the emergency departments.

Other Continuing Development

Electronic Data Interchange (EDI) Transactions: $20 million

The EDI Transactions Program executes projects in support of VA's implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. One of the key aspects of HIPAA is to improve the efficiency and effectiveness of the Nation's healthcare systems through the inclusion of Administrative Simplification Act provisions that require HHS to adopt national standards for electronic health care transactions, code sets, and unique identifiers for health care providers and insurance payers. HIPAA, as further amended by the Patient Protection and Affordable Care Act, Public Law 111-148, further reforms the health insurance industry and develops a set of operating rules for the transmission of EDI administrative transactions. Through the use of EDI, both health care providers and payers can automate transactions more quickly and at a lower cost, as compared to manual paper and telephone-based processing.

VA receives payments for health care services it provides to Veterans for non-service connected care, reimbursable by approximately 1,675 insurance payers and plans. The generated revenue directly supports the operational budgets of VA Medical Centers, which cover spending needs such as facilities maintenance and equipment. Revenues and payments are processed through EDI transactions. EDI transactions assure that Veterans and other eligible beneficiaries are able to access and receive care when needed outside of VA facilities and that VA is reimbursed quickly and accurately for services it renders.

FY 2014 Request: In FY 2013 and FY 2014, the EDI Transactions Program will execute projects that modify VHA systems as required to comply with Operating Rules as published in the Federal Register. These Operating Rules are designed to enable the electronic exchange of health care claim-related data and to increase the use of EDI, the latter being a goal of the Administrative Simplification Act of 1994. The requirements for compliance include but are not limited to:

- Operating Rules for Eligibility for a Health Plan, Health Claim Status, electronic funds transfer transactions, and Health Care Payment and Remittance Advice.
- Enumeration of a unique, standard Health Plan Identifier (HPID)
- Additional requirements under the HPID rule for the National Provider Identifier
- Implementation of e-Pharmacy external code list standards
- VA Certification as a health plan

- New Standards for insurance, claims, pharmacy, and payments transactions; Health Care Claims Attachments; Rules for Coordination of Benefits; Health care claims or equivalent encounter information; and Referral, Certification, and Authorization

Healthcare Reform/Affordable Healthcare Act (ACA): $6.2 million

FY 2014 Request: FY 2014 funding will be used to support the information demands by Veterans for the ACA Health Insurance Exchange initiative. In FY 2013, work began to build the interfaces with CMS to the Veteran Enrollment and Eligibility systems to verify current enrollments of Veterans to VA Healthcare and their Minimal Essential Coverage (MEC) through VA. In FY 2014, extensive systems modifications will be needed to provide an automated solution on VA-provided MEC of non-veteran beneficiaries, such as those entitled to care under the Spina Bifida, CHAMPVA, and Caregivers programs.

The work done in FY 2014 will enable VA to identify those veterans whose enrollment status is pending evaluation. It will also allow the Department to fulfill the statutory requirement of reporting all veterans and VA healthcare beneficiaries that have MEC in 2014 and beyond, to both the IRS and individual veterans, to verify that they are not subject to any penalty for failure to meet the individual mandate. This level of funding also allows VA to make code corrections, modifications, and fixes based on operational experience of the FY 13 code deployment in its initial months of production.

International Classification of Diseases (ICD-10): $4.6 million

ICD-10 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 mandates implementation of the ICD-10-CM/PCS code sets on October 1, 2014. The rule applies to private and public sector health systems that exchange billing information electronically.

FY 2014 Request: The FY 14 funding will be used to remediate code changes during final testing. The requested funding will allow timely compliance with the ICD-10 standard. This funding is critical for the VA to complete conversion to ICD-10 in order to bill insurance carriers, which provides revenues in excess of $1.8 billion per year. This conversion also enables VA to provide timely payment to private health care providers for care provided to Veterans outside of VA facilities.

FY 2013 Deliverables:

- Completion of development and internal testing of all clinical and financial applications to support ICD-10.
- Deployment of a majority of the remediated applications in VA medical and business centers.
- External testing of financial applications with electronic trading partners.

Computerized Patient Record System (CPRS): $4.2 million

CPRS is the electronic medical record that within VistA that is used throughout VA in all health care settings (inpatient, outpatient, long-term care) and covers all aspects of patient care and treatment. The primary goal of CPRS is to provide a fast and easy-to-use application that provides a framework that supports clinical workflow and provides the ability to access a patient's clinical information throughout the VHA system.

CPRS integrates clinical packages (laboratory, pharmacy, radiology, etc.) into a patient-centric view and provides the health information technology solution where clinical care is reviewed, documented, and preserved. Accessibility to this online clinical information is a significant factor in the delivery of timely, safe, and quality care to the Veteran population.

FY 2014 Request: In FY 2014, CPRS development projects will address end-user reported issues and enhancements to improve functionality and patient safety. CPRS versions 31 and 32 are necessary to support dependent development projects such as Surgical Quality Workflow Manager, tracking of abnormal results, Veterans Identification Card, teratogenic drug monitoring, State Prescription Drug Monitoring Programs, and Bar Code Expansion – Positive Patient Identification (BCE-PPI) by adding functionality that will enhance business processes, resulting in improved patient care, patient safety and services delivered to Veterans. Additional development projects will work toward addressing gaps in CPRS capability of meeting Stage 2 and anticipated Stage 3 requirements for Meaningful Use as specified in the Health Information Technology for Economic and Clinical Health Act of 2009.

FY 2013 Deliverables: In FY 2013, CPRS version 30 will be completed with national release planned for spring 2013. This version includes: ICD-10 changes, as well as Clinic Orders and Lab Display Status that address patient safety issues. Planning activities will begin on version 31.

Sustainment Subaccount

Sustainment of Operations Highlights
(Dollars in Thousands)

Activities:	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Estimate	2012-2014 Increase/ Decrease
Medical Operations and Maintenance	$ 619,707	$ 808,185	$ 649,829	$ -	$ 863,973	$ 244,266
Benefits Operations and Maintenance	$ 187,011	$ 263,300	$ 189,408	$ -	$ 302,301	$ 115,289
Enterprise Operations and Maintenance	$ 736,103	$ 695,632	$ 700,286	$ -	$ 810,660	$ 74,557
Interagency Operations and Maintenance	$ 53,330	$ 44,929	$ 97,464	$ 1,941	$ 184,720	$ 131,390
Total Operations and Maintenance 1/	**$ 1,596,151**	**$ 1,812,046**	**$ 1,636,987**	**$ 1,941**	**$2,161,653**	**$ 565,502**
Funding Sources:						
Appropriation	$ 1,596,151	$ 1,812,046	$ 1,636,987	$ -	$2,161,653	$ 565,502
Transfer to North Chicago Facility	$ (2,936)	$ -	$ -	$ -	$ -	$ 2,936
Reimbursements (+)	$ 30,420	$ 27,000	$ 28,698	$ -	$ 43,661	$ 13,241
Available Balance SOY (+)	$ 42,470	$ -	$ 6,500	$ -	$ -	$ (42,470)
Available Balance EOY (-)	$ (6,500)	$ -	$ -	$ -	$ -	$ 6,500
Unobligated Balance (Expiring) Lapse	$ (492)	$ -	$ -	$ -	$ -	$ 492
Change in Uncollected orders	$ (5)	$ -	$ -	$ -	$ -	$ 5
Total Obligations	**$ 1,659,108**	**$ 1,839,046**	**$ 1,672,185**	**$ -**	**$2,205,315**	**$ 546,202**

Note: Numbers may not add due to rounding.
1/ Numbers do not include reimbursements, FY 2011/2012 and FY 2012/2013 carryover, and transfers.

FY 2014 Sustainment Estimate (Dollars in Thousands)		
Mandatory Sustainment	**$**	**1,748,085**
Software License and Maintenance	$	307,845
Corporate Data Center Operation's Charges	$	300,000
IT Support Contracts	$	283,843
Telecommunication	$	269,000
Hardware Maintenance	$	103,627
Major Transformational Initiatives and iEHR and VLER Health	$	162,464
Information Security	$	123,258
National Data Center Program (NDCP)	$	19,699
Other	$	178,349
Discretionary Sustainment	**$**	**337,159**
Activations	$	180,397
Voice as a Service	$	115,996
Hardware and Desktop Refresh	$	37,766
Vocational Rehabilitation and Employment-Transition Assistance program	$	3,000
Marginal Sustainment	**$**	**76,409**
Major Transformational Initiatives	$	36,709
iEHR and VLER Health	$	38,700
Other Marginal Sustainment	$	1,000
Total	**$**	**2,161,653**

The VA's IT enterprise is one of the largest consolidated IT organizations in the world. The IT technology profile consists of over 380,000 desktop computers, 46,000 laptops, 23,000 blackberries and other mobile devices. The infrastructure stack, maintained by the IT staff in working condition 24x7x365, contains approximately 2,400 systems or platforms in production, running hundreds of millions of lines of software code and billions of possible configurations. The infrastructure supports:

- More than 10 million Veterans, 320,000 VA employees and 152 hospitals
- 824 community-based outpatient clinics (CBOC)
- 57 benefits processing offices
- 131 cemeteries
- 33 soldier's lots and monuments sites

In 2014, VA requests $2.162 billion for Operations and Maintenance (O&M). This will address growth in the number of Veterans served and the VA workforce; new facility activations; new systems and platforms released into production; and dramatic increases in WAN use to support telehealth, telework, and increases in mobile computing and communication requirements by VA staff. The budget must effectively accommodate secular trends as the OIT requirements adapt to the changing demands of the Department administration that provide Veteran services.

With increasing resource demands, OIT is incorporating a more vigorous resource requirements prioritization process to complement PMAS and other investment reviews. OIT creates a detailed financial plan each fiscal year known as the Budget Operating Plan (BOP) using the Budget Tracking Tool (BTT) database. The plan creates a vehicle for OIT to agree with its customers on what the high priority IT services and projects are, and allocate resources to ensure success on the most important items. The plan also allows OIT to track spending from the planning phase to expenditure and know the business purposes for each dollar spent. On September 17, 2012, VA's Budget Tracking Tool was awarded the Silver Honor for Financial Software Solution of the year by the American Business Association.

In addition, OIT has been identifying efficiencies through various means such as OMB's PortfolioStat as well as the Ruthless Reduction Task Force (RRTF). Detail of the cost avoidance strategies are discussed in the section below.

Cost Avoidance Strategies

The Ruthless Reduction Task Force

This task force was established to identify opportunities for cost avoidance in VA IT expenses by a variety of means including decommissioning redundant systems; consolidation of development and test environments; implementation of service-oriented architecture, data center consolidation and cloud computing; and efficiencies in obtaining security approvals for would-be employees and contractors. These efforts will allow better allocation of resources without impacting safe, reliable, service delivery to Veterans and support for internal VA management processes.

The goal of the task force is to identify efficiencies for re-purposing 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.

The task force is led by the Deputy CIO for Architecture, Strategy, and Design and made up of members nominated by each OIT Deputy Assistant Secretary/Deputy CIO. Representatives of the Administrations and staff offices also participate in the task force.

The task force's approach includes the use of existing enterprise architecture artifacts, plus supplementary data calls; reviewing all major initiative operating plans; combining cross-cutting and programmatic reductions; and expanding application inventory to integrate all known system inventories in VA.

Initial task force findings for possible efficiencies, which are undergoing additional analysis, include the following:

- Expand the application inventory to include more than 2,400 applications.
- Initiate an analysis of the application category that appears to have the highest potential for redundancy (business intelligence).
- Initiate a detailed analysis of the IT sustainment budget to identify key cost drivers and non-value added variations.
- Re-negotiate key enterprise license agreements, including most recently Microsoft.
- Data center consolidation.
- Eliminate personal desktop printers.
- Expand use of common services for software intensive development projects.

Cloud Computing

Another cost containment strategy is to increase VA's use of cloud services. This is a major feature of the President's initiative to modernize information technology. The objective is to create a more agile Federal enterprise, where services can be reused and provisioned on demand to meet business needs. In support of the Federal "cloud first" policy, a pilot project placing a number of VA email users into a cloud e-mail system was undertaken in FY 2012. If successful (both in terms of user satisfaction and return on investment), the project will be expanded to more users in the future.

"Virtualization First" Server Strategy

Server Virtualization is a proven strategy to control costs and improve speed of execution for deployment of new systems. It involves investment in virtualized server farms and shared storage arrays to replace "one-off" server and storage pairs. The program aims to improve the ratio of virtualized servers to physical servers with the goal of hosting all applications on virtualized hardware.

Server consolidation and virtualization are the foundation for a flexible, cost efficient and responsive utility-oriented architecture. Even where the cost of servers continues to decline, total cost of ownership increases with the complexity

of maintaining multiple servers. Getting the same or more work done with fewer servers will be less expensive. Because storage and server consolidation go hand in hand, the project can advance with each lifecycle refresh.

OIT's strategy requires all development and release of new systems and platforms to be designed for a "virtualization first" server release architecture designed to lower overall total cost of ownership.

Eliminate Dedicated Fax Servers

OIT has adopted the project to eliminate dedicated fax servers. The goal is to establish hosted Fax-over-IP Services (FoIP) with direct application integration for enhanced fax services. This will allow for a standard process across VA. Additionally, the project aligns with the green adoption, to include the Managed Print Services/Multi Function Device (MFD) project and has the potential for data sharing and interoperability with DoD for Veterans. The solution will increase effectiveness and accuracy of fax services by eliminating the old analog fax devices and associated maintenance, hardware and software cost. The expected cost avoidance in the first year will exceed 10%, with significantly improved fax service quality and green collaboration.

Voice as a Service (VaaS)

Another fee-for-service project OIT is pursuing is the modernization of telephony services. This modernization plan aims to transition the traditional approach (i.e., PBX replacement, VA buy-own-manage) to the purchase of Voice as a Service (VaaS). VaaS can be thought of as a vendor service that plugs into any given VA facility. This plan is designed to meet the needs of the Administrations and staff offices for modern voice services that include integration with the more comprehensive Unified Communications strategic direction. Detailed discussion of this project is under the Discretionary Sustainment section.

Mandatory Sustainment - $1.748 billion

Mandatory sustainment consists of four categories of expenses – all of which are recurring or "must pay" bills totaling $1.748 billion. This includes funding for:

- Software License costs – recurring payments for existing software and existing numbers of licenses. Costs are driven by the number of users and number of new applications and systems supporting these users. OIT's internal customers must have the ability to use their devices and applications with a standard set of performance expectations. OIT has instituted several cost containment strategies in the area of software license procurement,

software license distribution, and dramatically increased the number of national/enterprise software license procurements to leverage economies of scale. Despite these cost containment strategies the compound annual growth rate (CAGR) for this category between 2008 and 2013 was 15%. This reflects the underlying business drivers for more users and more applications, and the OIT budget for this category must keep pace.

- IT Support contract costs – recurring payments for existing contracts for services/support for IT systems. OIT's internal and external customers expect skilled and prompt service in a variety of areas. For example, in the area of Help Desk Support, OIT has instituted a National Service Desk that is supported by contracted staff. This allows OIT to meet and exceed customer expectation for help. However, as the VA adds more users, more systems and more facilities, the calls to the help desk increase. Despite cost containment strategies in these areas (consolidation of contracts to leverage economies of scale) the CAGR growth in this area has been 6.8% during the period 2008 to 2013.

- Telecommunication costs – recurring payments to support voice, data, and video circuits paid to telecommunication vendors. This includes local voice dialing, long distance voice dialing, toll free dialing, calling cards, and mobile wireless communication charges; i.e., the monthly bills for voice telecommunications. Data includes the core Wide Area Network (WAN) and Gateways that connect the VA to the internet, the distribution WAN that connects the core to the VA's main facilities, and the distal WAN that connects these main facilities to the large number of facilities and campuses tethered to each other. Data includes all IP traffic on the WAN including internet and intranet, applications, video, and more. The service requirement from VA's lines of business is seamless and error free communication from any point to any other point 24 hours a day, 7 days a week, and 365 days per year. The expenditures for this category have increased by 7% annually for the period 2008-2013. With the rate of increases expected in new users, new applications, new facilities and more intense utilization of the WAN (Telehealth, cloud hosting, greater interconnections between VA, DOD and private sector health care entities), the sustainment costs in this category are expected to increase to keep pace. OIT has instituted several cost containment strategies in this category (regional telecommunication business offices, consolidation of contracts) since 2008, but the observed growth rate shows that the underlying business drivers are outstripping the ability of these cost containment strategies to rein in costs.

- Hardware Maintenance costs – recurring payments for extended warranty/support for critical hardware components in support of customer Service Level Agreements (SLAs). OIT's internal customers expect that failure of a device, system or application with the concomitant downtime or

degradation in performance will be followed by prompt return to normal service. The return to normal service (SLA) mandates that this extended warranty/support be provided for downtime and performance to match customer-expected service levels. OIT has instituted several strategies to contain costs in this area (consolidation of hardware maintenance contracts at the national/regional levels to leverage economies of scale; adoption of OIT service lines that create cadres of skilled OIT staff managing the systems) but despite these cost containment strategies, the CAGR growth rate in this category of mandatory sustainment between the period 2008 and 2013 was 15%. This reflects the large and rapid increase in devices, systems and applications seen over this period of time and reflects the increasing size and complexity of the VA's IT infrastructure stack. This infrastructure stack represents over 1.5 million hardware items in inventory, connected by nearly 400,000 voice/data circuits, and comprised of billions of lines of software code and configuration.

These categories, because of the size of the VA IT infrastructure, result in recurring expenditures that require considerable resources. These costs also increase as the VA adds staff, space and systems to the infrastructure. The observed year-over-year growth in these categories is 5-8% annually. Without requested resources, the IT infrastructure cannot be sustained. Cost containment strategies have been applied to this group and most of the one-time cost avoidance has already been reclaimed through economies of scale and acquisition strategy.

While the unit cost per user in these four categories of mandatory sustainment has fallen, the underlying business drivers have all increased (more users, more space, more systems, etc). All four mandatory sustainment groups have CAGR between 6.8%--15% (software license and hardware maintenance costs have a CAGR of 15%). VA has assumed the risk of maintaining obsolete and aging telephony equipment in an effort to contain cost, but continued deferral of lifecycle replacement could provoke a critical system failure at major care facilities. This request mitigates that risk by providing a rapid replacement of obsolete telephony HW and advancing 21st century telephony services within the VA.

In addition to the four categories of mandatory expenses described above, IT budget also includes National Data Center Program (NDCP), North Chicago, E-Gov Expenses, Telehealth, and costs to comply with information security.

Corporate Data Center Operations (CDCO) Charges:

Aligned under VA Office of Information and Technology, CDCO is comprised of five national data centers that are responsible for nearly $100 billion in Veterans' benefits, payments, and payroll processing for the Department as well as national

health and benefits systems. CDCO also operates VA's Records Center and Vault, a storage facility for VA and other Federal agencies' paper records.

Austin Information Technology Center (AITC): The Austin Information Technology Center (AITC) provides cost-effective IT services to VA and other Federal agency customers nationwide on a full cost recovery, fee-for-service basis as a franchise fund organization. The AITC services portfolio includes IT systems hosting services; applications management; 24 x 7 Service desk/help desk support, IT service continuity management, Web design and hosting, information assurance and data conversion; and application integration services.

Hines Information Technology Center (HITC): The Hines Information Technology Center (HITC) is a full service data center providing support primarily for the benefits delivery of compensation, pension, and education programs. These systems supported by the Hines campus are critical to the Veterans Benefits Administration (VBA) as they facilitate processing claims and benefits promised to our Veterans. HITC provides centralized release management for VBA applications, including pre-production and performance testing. HITC also provides hardware/software desktop and server oversight functions for the VBA regional offices, including procedures, guidance and centralized configuration management.

Philadelphia Information Technology Center (PITC): The Philadelphia Information Technology Center (PITC) provides a variety of IT support and services to VA, VBA, veterans, and other stakeholders such as Veterans service organizations. PITC is responsible for the implementation, operation and maintenance of information systems that assist VA regional offices (ROs), the Insurance Center, and Medical Centers in providing benefits and medical care to the nation's Veterans and their families. This includes providing IT services to VBA nationwide for Veterans Insurance. PITC hosts the VBA help desk, which provides support to 56 regional offices and many VA sites in the field. PITC also operates and maintains external and internal Web-based Veteran applications used by the various VBA business lines, manages the VBA and CDCO wide-area network, and manages VBA's enterprise e-mail system. Additionally, PITC is the disaster recovery site for the Benefits Delivery Network (BDN) system, which process benefits for our nation's Veterans, and provides disaster recovery services for AITC.

Quantico Information Technology Center (QITC): The Quantico Information Technology Center (ITC) provides all IT Administration, Operations and Infrastructure services to the VA National Cemetery Administration (NCA) and Application services to the majority of State Veterans Cemeteries (over 180 facilities across 7 time zones). QITC is responsible for design, procurement, implementation, administration, security and management of all data networks, systems and large scale Oracle databases which make up the entire burial benefit delivery systems. This center maintains a multitude of large scale Oracle

databases on IBM frames to include but not limited to; over 10 million decedent records (dated back to the Civil War), the processing of over 150,000 burial records, 350,000 headstone and marker orders yearly (scanning over 1000 marker orders daily), and the process of over 800,000 Presidential Memorial Certificates every year.

Capital Region Data Center (CRDC): The Capital Region Data Center (CRDC) was established to facilitate the consolidation of enterprise information technology (IT) assets from the Washington, DC metropolitan area to an enterprise data center located in Falling Waters, West Virginia. These enterprise IT assets directly support the mission of major VA programs and activities. A 10G Optical Region Area Network connects CRDC with downtown DC. Opened in an interim location in 2005, CRDC is currently a hosting data center.

MTIs and iEHR & VLER Health - $162 million:

FY2014 Request: Included in the request is $109 million for mandatory sustainment of VA's MTIs and $53M for iEHR &VLER Health.

MTIs: Major Initiatives address VA priorities such as eliminating the Benefits backlog, homelessness, health care access, and emergency preparedness. The FY2014 request for $109 million will cover mandatory sustainment of the following:

- Eliminate Veteran Homelessness: Efforts to provide services and assistance to treat and house Veterans by leveraging the best health care and benefits provided by VA.
- Veterans Benefits Management System (VBMS): Improvement of the Veterans' experience with VA, by allowing them to interact using multiple communications channels and reducing the need to submit paper documents, as well as providing a secure, accessible means to obtain benefits.
- Enhance the Veteran Experience and access to health care: Continued implementation of Bed Management Solutions (BMS), and eliminating disparities in access to care wherever they exist within our system.
- Ensure preparedness to meet emergent national needs: VA's organizations will continue to take on ongoing emergency preparedness responsibilities, including contributing to a Department-wide Comprehensive Emergency Management program that includes All Hazards Emergency Preparedness Planning Program; Continuity of Operations Plan, and a Test, Training and Evaluation Program. The FY2014 request will also allow VA to continuously staff the Information Operations Center (IOC) with subject matter experts from across the Department with analytical skills to predict and analyze as well as operational response experts.

iEHR and VLER Health: The FY2014 request of $53 million for mandatory sustainment will allow the VA to maintain software license agreements for a

Commercial-Off-the-Shelf (COTS) product, professional services, laboratory and pharmacy software, and enable capabilities of a Service Oriented Architecture (SOA) Suite in support of both the Department of Defense (DoD) Military Health System (MHS) and the Department of Veterans Affairs (VA) Electronic Health Records (EHR), and associated information management systems

Information Security

The request of $123 million funds VA IT Security programs and their services and tools. VA must protect the personal and health information of over 26 million Veterans and more than 300,000 VA employees, 24 hours a day and 365 days per year. The programs provide policy, guidance, advice, incident response, general support, and the tools and services necessary to protect IT resources and infrastructure. They address IT security and privacy issues, provide risk management capabilities and incident and data breach response. They also 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 the continuity of operations planning.

An example of the services and tools funded is the continuous monitoring program which is responsible for checking IT systems and watching over 400,000 IT devices attached to the VA network. Funds will also cover staff who works on the remediation of any monitored findings, faults or deficiencies. VA has to keep pace with the evolution of technology and cyber threats and the funding allows VA to maintain up-to-date network security tools like those for intrusion detection. Also funded are the services and tools that manage the response to any intrusion or data breach including tools for forensic analysis. Oversight and coordination of efforts related to identity and access management processes are also funded. The funding enables work to maintain and update the security and privacy policies followed by all VA employees. Work on software security assurance, security for systems architecture and security related systems engineering is also funded. The funding is critical to VA's ability to address the emerging security issues associated with the increasing use of mobile computing devices by Veterans, physicians and employees, both for those issued by the VA and those that are personally owned devices.

The Office of Information Security is 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. Business Continuity is another element of Information Security. It maintains the policies, procedures and plans to minimize the impact on IT operations that may come from an event such as a natural disaster or terrorist attack. VA's mission critical IT systems must be protected and returned to full function in the shortest time possible.

The Network and Security Operation Center (NSOC) provides for incident reporting and response, and also delivers VA network security services such as anti-virus protection, penetration testing, vulnerability scanning, firewall management, forensic analysis, and intrusion detection monitoring. NSOC also uses its network scanning capability to provide information for vulnerability risk assessments which drive decisions for remediation work and security architecture and configuration changes. Field based Information Security Officers participate in this remediation work and are a significant element of the Continuous Readiness in Information Security Program (CRISP) that began in FY 2012. One aspect of CRISP proactively addresses process and policy deficiencies along with architecture and configuration issues. Another aspect of CRISP addresses audit resolution and material weakness remediation, which are a part of corrective active plans stemming from Federal Information Systems Controls Audit Manual and Federal Information Systems Management Act audit reporting. Post audit work also includes review of policies and procedures to assess their adequacy and effectiveness. Software Assurance work is done with internal and external partners so that security standards are defined and met in the software engineering process. This reduces the need for software patches to fix security issues later.

FY 2013

- Launch an effort to address the security concerns associated with the increased use of non-Government Furnished Equipment by employees, physicians and contractors.
- Release an FY 2013 Security Calendar which will highlight when approximately 30 recurring actions, such as the review of facility system menus, must be carried out. This is part of the continuous readiness activity of CRISP.
- Establish a business partner extranet connection to the VA IT network from outside the domain to ensure a secure and maintainable channel for VA business partners.

FY 2014

- Initiate an effort to address the security issues related to the newly emerging projects such as "Clinic in Hand" which are driving an expansion of mobile computing in VA.
- Establish a project that addresses the "Big Data Analytics" component of the Information Security Continuous Monitoring and Risk Management programs. The Big Data effort will use new statistical methods, prediction techniques, modeling, and a multidisciplinary approach. This analytic capability will allow VA to review captured data for evidence of threats or vulnerabilities. It will also provide analysis to judge asset performance and assess configuration planning and management. This effort will require

software tools for advanced analytics, the capability for parallel processing and an enlarged data storage capacity.

National Data Center Program (NDCP)

NDCP's 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. NDCP identified 86 VA data centers, primarily located in medical centers, which will be consolidated as part of the Federal Data Center Consolidation Initiative.

As part of the iEHR program planning, VA is hosting VistA systems at DoD data centers. The end result will be fewer but larger data centers, with increased opportunities for economies of scale and efficiency. The consolidation of VHA VistA systems into DoD-DISA data center space is a foundational element of VA's iEHR strategy.

Deliverables:

- FY 2013 – completion of migrations for Regions 2 & 3; begin migrations of Regions 1 & 4.
- FY 2014 – completion of Regions 1 & 4 resulting in all four VHA regions running VistA in DoD-DISA space, thereby enabling full iEHR connectivity with DoD systems.

Telehealth:

Important for the New Models of Health Care initiative, Telehealth represents a variety of new care models that make care provisioning available to the patient in their home, or closer 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. The three areas are Clinical Video Telehealth, Home Telehealth, and Store and Forward Telehealth. Additionally the Undersecretary for Health has described Telehealth as a "signature" program within VHA because of its world leadership in this new model of health care. All the Telehealth modalities and efforts are heavily dependent on IT infrastructure O&M.

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 becomes critical. The complicated stack of technology that lies between the patient and provider must be reliable 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 through Telehealth

modalities. OIT and VHA collaborate within a joint Telehealth Governance Board to assure the IT resources are available as this Telehealth program expands to serve an estimated 9 million Veterans.

James A. Lovell, Federal Health Care Center, North Chicago – Activation

This project sustains the merger between the existing North Chicago Veterans Affairs Medical Center and the existing Naval Health Clinic Great Lakes facilities. OIT provisions the infrastructure to support the integration of VA and the 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 allows for optimum staffing levels of government full time equivalents (FTE) to transition support from contracted resources. It also provides 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.

Discretionary Sustainment - $337 million

The budget provides $337 million for discretionary sustainment which covers other necessary sustainment activities. Specifically, it includes:

- infrastructure enhancements and O&M support necessary to bring new VA facilities online
- correction of non-critical software defects and/or required system upgrades for operational IT solution
- enhancements to facilitate operational running of the enterprise (e.g. hardware refresh, PBX replacement, VaaS, E-mail Replacement, etc.)
- funding for 5 Components of Operational Excellence such as the National Data Center Program which is designed to enhance service delivery, compliance with service level agreements, enhancing speed of execution for new product releases, and lowering O&M costs.
- funding for infrastructure to support iOS Devices and Completion of the National Wireless Infrastructure Program.

Activations - $180 million

Modernization of aging facilities promotes new efficiencies in service for Veterans healthcare and benefits delivery. Over the past decade, expansion of the VA mission to serve an increasing number of Veterans from two protracted combat operations has lead to an increase in VA staff and a concomitant increase in space where the staff deliver healthcare and benefits services. New and remodeled

space, whether in VA owned or leased facilities, has expanded in parallel to mission expansion. A new VA knowledge worker is highly dependent on IT and therefore the space the knowledge worker occupies must be equipped with the 21st century technology that enables him or her to deliver service to Veterans and their families. OIT uses the ACBM (Activation Cost Budget Model) methodology to predict IT activation costs based on the square footage of each construction project. IT and construction project management of each construction/renovation project leads to a just-in-time acquisition and installation of the required IT equipment and services to coincide with space occupancy.

The FY 2014 funding request will provide acquisition of IT equipment that is necessary to activate new space or renovate existing space as required by lines of business. Over the past six years the VA's space has grown considerably and is now composed of approximately 6700 unique buildings and covers about 155 million square feet of space. Approximately 15-25 million square feet of space are activated or renovated annually.

Deliverables: Major facilities, such as the following from VHA: Health Care Centers in Fayetteville, NC; Charlotte, NC; Winston-Salem, NC; Loma Linda, CA; Butler, PA; an Outpatient Clinic in Tallahassee, FL, along with a significant number of smaller facilities, are expected to come on line and be supported by this request.

Voice as a Service: $116 million

For decades, the VA has furnished local voice communication capabilities by purchasing and installing dedicated private branch exchange (PBX) systems at each medical center, regional office, or other "major" facility. Associated satellite facilities have typically received their voice functionality via a connection to the PBX at their parent facility. This is a costly and highly duplicative approach in terms of equipment, software and support resulting in a patchwork of service provided to Veterans, with some areas not providing the expected level of access and service. Telephony and VaaS will improve the way most Veterans and their families access health and benefits services, especially rural and highly rural Veterans. Newer technologies related to telephony and the supporting infrastructures will provide all of the needed voice features and functions, including those for call centers.

The transition away from traditional PBXs will also allow the VA to provide telephony services with the least cost, least technical risk and least operational risk. Telephony and VaaS will allow for a centrally managed, standardized, interoperable solution that can be used as a foundation for future capabilities including video, unified communications, chat, on-line support and contact and call centers.

Deliverables:

- Pilot program funded in FY 2013 to be completed and outcomes assessed
- Information from Pilot program to be applied to an Acquisition strategy for Government Owned/Contractor Operated model of telephony services
- Implementation of an Enterprise Plan to meet common business drivers:
    - Survivable and scalable voice infrastructure that will support VHA, VBA and NCA missions and requirements for service delivery
    - Efficient call routing to access VA services
    - Call Center capability with a single point of access for services
    - Ability to capture and measure service delivery thru use of reports and statistics
    - Use of video to provide virtual access for Telehealth, real-time chat, and distance learning
    - Ubiquitous access to health and benefit information, records and Veteran data

Hardware and Desktop Refresh (LCM): $37.8 million

Lifecycle management (LCM) has two components - hardware and desktop refresh. LCM aims to maintain both in a useful lifecycle, replacing hardware and desktops once they are no longer useful in order to avoid service disruptions and improve security for the VA user.

LCM enforces standards for hardware and desktops. Each hardware commodity item has defined engineering standards to optimize device configuration and management across the enterprise. In addition, because of the standard buy/replacement strategy for desktop refresh, VA is able to comply with OMB mandates for a single Federal Desktop Standard, make desktop management through automated tools possible, and facilitate future OS upgrades. Because of the single desktop standard, the National Service Desk, a Tier 1 help desk, VA is able to support a high rate of "first call resolution" for trouble tickets related to desktop computing. Finally, by standardizing to a single desktop standard, providing security becomes easier, thereby improving the information security posture of the Department.

Vocational Rehabilitation and Employment – Transition Assistance Program (VRE-TAP): $3 million:

VBA's Vocational Rehabilitation and Employment (VR&E) program provides effective vocational rehabilitation services to veterans with service-connected disabilities. The program enables our injured soldiers, sailors, airmen, and other veterans with disabilities to transition from military service to a successful rehabilitation and on to suitable employment after service to our Nation. VR&E's Transition Assistance Program (TAP) helps service members and their spouses shift from the military to civilian life by offering job-search assistance and related

services, within 6 months of discharge. Due to legislative changes and higher demand, an expansion of TAP programs will take place during FY13-F14 that will hire, train and deploy additional staff to work on TAP claims.

This request will provide the necessary space, tools and equipment to the staff and allow them to perform their tasks. This includes the basic set of desktop technology (computer, phone, access to printing service and video conferencing) and assumes that 20% of workers will require mobile technology (laptop, Blackberry). The assumptions for sustaining this set of new technologies include ongoing costs (recurring HW maintenance, SW licensing, telecommunications, IT support (Tier 1 Help Desk and Tier 2 Desktop support), and other costs associated the program.

MTIs Transitioning to Sustainment

The Strategic Capital Investment Planning (SCIP) Automation Tool (SAT) 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. By the end of FY 2013, the SCIP initiative will be in sustainment and OIT will plan and execute changes to SAT to comply with OMB's Net Zero Mandate.

For the Preparedness initiative, the integration of the IOC and HSPD-12 program allows VA to more effectively and securely address emergent national needs that touch the lives of Veterans and ensures confidence in the suitability of VA's employees, contractors, and affiliates.

The cost accounting analysis system associated with the Systems to Drive Performance and Outcomes (STDP) initiative will provide VA leadership with accurate cost data for budget formulation as well as effective and flexible tools for overall management analyses. This will place the Department in a better position to assess and offer services to Veterans.

The Research and Development initiative will result in better care for Veterans and cost savings for VA. Under this initiative, the genomic medicine program benefits Veterans because it tailors prevention and treatment to each Veteran. Point of care research allows research studies to take place without extra clinic visits for the patients, in turn reducing additional cost for VA.

<u>Improve Veteran Mental Health (IVMH)</u>

The IVMH initiative seeks to develop and maintain a self-regulating, patient-centered mental healthcare system within the larger VA healthcare structure. 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 Metal Health Services. This improved mental health

infrastructure will monitor clinical programs, provide feedback to address problems, ensure clinical services are patient centered, and address mental health needs that emerge in all medical care settings. The new infrastructure will include software to plan treatments and track high risk patients, as well as a pilot to increase use of evidence-based psychopharmacology.

IVMH will expand beyond traditional service delivery to include public health outreach programs and resources to improve the well-being of Veterans in communities. 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 members, Veterans and their families. In addition, IVMH will enhance delivery of evidence-based psychosocial interventions, and inform planning, implementation and operations using a public health model. Technology solutions include real time clinical video-conferences through tele-mental health.

FY 2014 Request: The FY 2014 request of $1.1 million will allow the IVMH initiative to provide an updated tool to identify behavioral risks that require immediate intervention when the Veteran visits a VHA facility. In addition, it will provide an updated tool to assist Veteran Crisis Line staff. The crisis line provides an intervention service to Veterans and their family members.

FY 2013 Deliverables:

- Provide a tool for clinicians to author and distribute assessment instruments for evaluating mental health. This will facilitate implementation of current assessment technologies as well as expanded centralized national data rollup and analysis in order to improve treatment of mental health conditions.
- Provide a tool to identify patients that are missing from VA care, and provide communication across facilities to alert others who may see a patient of this concern.
- Provide a tool for Veterans to track their medications, to establish goals for their own mental health, and to monitor their progress toward those goals within the My Health*e*Vet portal (MHV).

Marginal Sustainment - $76 million

Marginal sustainment includes $36.7 million for the initial marginal sustainment costs associated with deployment of MTI activities implemented in FY 2014, as well as $38.7 million for the iEHR and VLER Health. For more detail on the MTI deliverables, see section "Development, Modernization and Enhancement Subaccount", and see the Interagency Program Office (IPO) section, for a detailed discussion on iEHR and VLER health.

FY 14 Marginal Sustainment by MTI (Dollars in Thousands)	
MI 02 - VBMS	$ 3,648
MI 04 - VLER	$ 2,200
MI 05 - Mental Health	$ 1,095
MI 06 - VRM	$ 21,800
MI 07 - New Models of Care	$ 5,202
MI 08 - EVEAH	$ 2,764
Total	**$ 36,709**

Staffing and Administration Subaccount

Payroll & Administrative Support Highlights
(dollars in thousands)

	2012	2013		2014	
	Actual	Budget Estimate	Continuing Resolution	Estimate	2012-2014 Increase/ Decrease
Full Time Equivalent Employment	7,311	7,580	7,536	7,459	
Direct	7,210	7,435	7,435	7,355	
Reimbursement	101	145	101	104	
Obligations:					
Personal Services & Benefits	814,564	895,231	840,241	869,949	55,385
Travel	12,507	16,000	12,042	14,808	2,301
Comm., Utilities & Rent	13,980	11,929	14,045	14,185	205
Printing & Reproduction	51	60	21	26	-25
Other Services	122,984	110,616	120,148	135,437	12,453
Supplies & Materials	875	1,138	654	654	-221
Equipment	494	4,877	3,876	4,216	3,722
Lands & Structures					0
Other	141	149	20	20	-121
Subtotal	**$965,596**	**$1,040,000**	**$991,047**	**$1,039,295**	**$73,699**
Funding Sources:					
Appropriation	915,000	1,021,000	975,000	1,026,400	111,400
Transfers 1/	-3,669				3,669
Reimbursements (+)	13,519	19,000	12,479	12,895	-624
Available Balance SOY (+)	45,466	0	3,568	0	-45,466
Available Balance EOY (-)	-3,568	0	0	0	3,568
Unobligated Balance					0
(Expiring) Lapse	-859				859
Change in Uncollected Orders	-293				293
Total Obligations	**$965,596**	**$1,040,000**	**$991,047**	**$1,039,295**	**$73,699**

1/ In FY 2012, there was a transfer of 3,669 to the North Chicago facility.

FY 2014 Realignment of Functions

In FY 2014, VA is requesting $1.026 billion for IT staffing and administration, primarily for pay and benefits for its 7,355 FTE. This request reflects a 1 percent pay raise and inflation of 1.7 percent for non-pay contracts. Additionally, the FY2014 request reflects a realignment of FTE between VHA and OIT as follows

- **Austin HR** – The budget reflects a realignment of 53 FTE and $6.346 million from OIT to Medical Support and Compliance. OIT utilized HR specialists but determined that this function is more efficiently aligned within VHA operations. In 2012 and 2013, the staff was supported by OIT on a reimbursable basis, based upon the reassignment that was effective in December 2011.

- **Clinical Application Coordinators (CAC)** – The budget includes a realignment of $6.138 million and 53 CAC FTE to VHA. CACs are a mixture of IT specialists and Title 38 employees who provide direct support to clinical services and coordinate facility efforts in support of VHA's Medical Center Management. These CACs are present in OIT as the result of the 2006 realignment, but should be based in VHA.

- **Information Technology Support Staff** – The budget includes a realignment of $7.989 million and 26 FTE from the VHA Office of Informatics and Analytics in the Medical Support and Compliance Appropriation to the Office of Information Technology. VA has determined through a detailed operational analysis that a portion of its functions are more IT in nature, and should be aligned within OIT.

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.

OIT is the steward of VA's IT assets and resources, and is responsible for ensuring the efficient and effective operation of VA's IT Management System to meet mission requirements of the Secretary, Under Secretaries, Assistant Secretaries, and other key officials. With the requested funding, OIT will continue to provide strategy and technical direction, guidance, and policy to ensure that IT resources are acquired and managed for the Department in a manner that adheres to various Federal laws and regulations.

OIT is composed of eight major organizational components; the table below displays FTE for each component:

	2012 Actual	2013 PB	2013 CR	2014 Estimate
Service Delivery and Engineering	5,473	5,539	5,526	5,473
Product Development	923	998	984	992
Information Security	551	559	559	559
Office of Quality Performance and Oversight	169	175	175	175
IT Resource Management	118	141	124	145
Architecture System Design	63	78	78	78
Interagency Program Office	3	24	24	24
VLER Program Office	11	13	13	13
Other		53	53	-
Total FTE	7,311	7,580	7,536	7,459

Note: Includes reimbursable FTE.

Office of Service Delivery and Engineering
The Service Delivery and Engineering component provides all operational and maintenance activities associated with VA's IT environment on behalf of the AS/IT. This includes the following activities: overseeing and managing the VA regional data centers, the IT network, and telecommunications; conducting production monitoring for all information systems, production services, managing the delivery of operations services to all VA geographic locations, and conducting all Private Branch Exchange management and maintenance.

Product Development
The Product Development component manages all enterprise application development activities. Development consists of planning, developing (or acquiring), and testing applications that meet business requirements. It provides day-to-day direction over all solutions developed by OIT for VA business units.

Information Security
Information Security deals with matters related to information protection including privacy, cyber security, risk management, records management, Freedom of Information Act (FOIA), incident response, critical infrastructure protection and business continuity. The office develops, implements and oversees the policies, procedures, training, communication and operations related to improving how VA and its' partners safeguard the personally identifiable information (PII) of Veterans and VA employees. Its objective is to assure the confidentiality, integrity and availability of information and information systems.

Office of Quality Performance and Oversight
Quality, Performance & Oversight facilitates the establishment of performance measures and metrics related to the full range of IT program responsibilities and

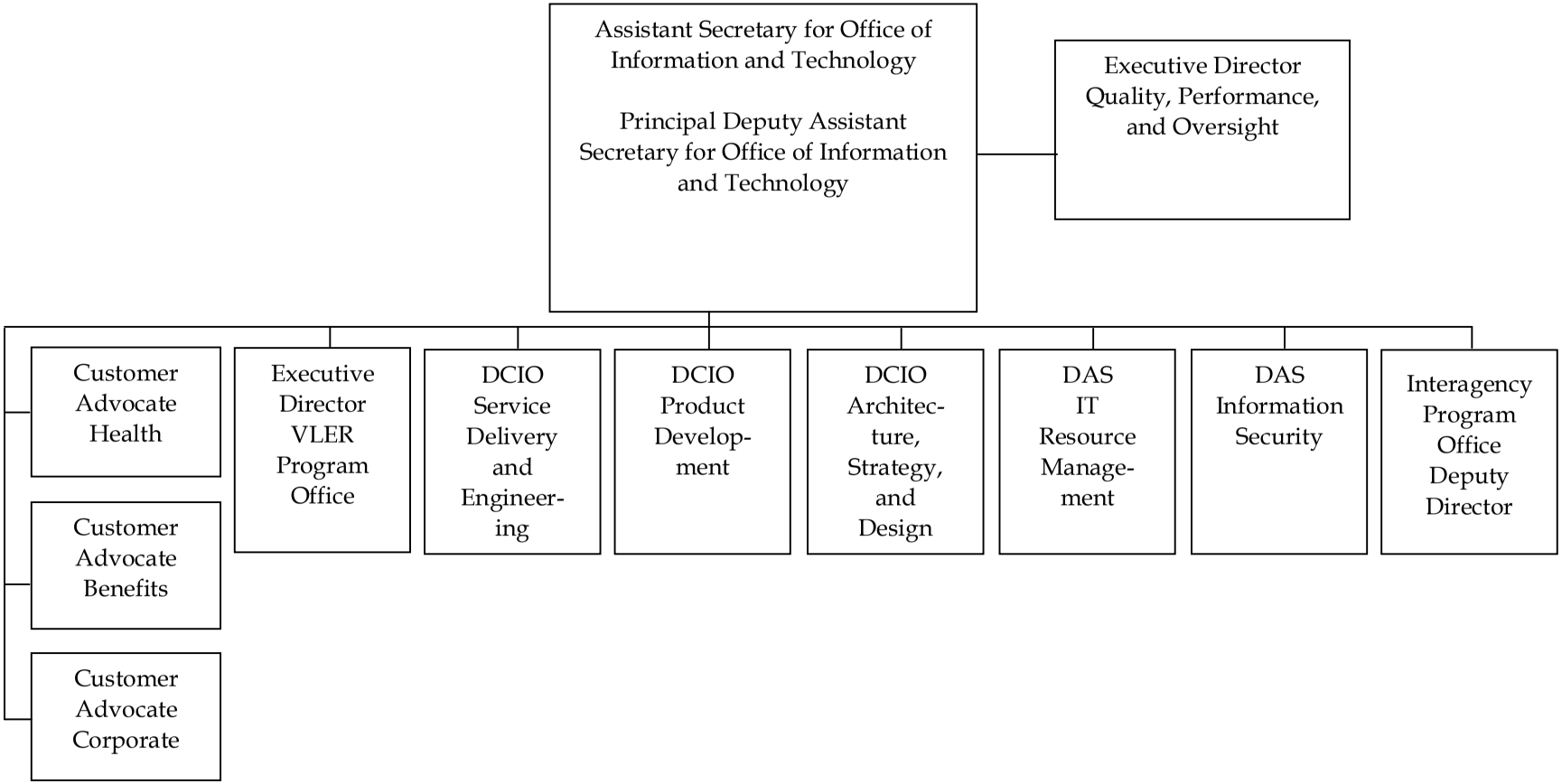
strategic objectives and manages associated measurement efforts. The office has an integrated enterprise-wide risk management framework to identify and manage risk. This framework is designed to anticipate, identify, prioritize, and monitor OIT enterprise risks, ensures information technology investments are managed efficiently and effectively, and provides assurance in the achievement of OIT objectives.

Interagency Program Office (IPO)
The IPO acts as the single point of accountability for the development and implementation of electronic health record systems and capabilities and provides oversight and management of the delivery of interoperability goals and objectives. At the direction of The Wounded, Ill, and Injured Senior Oversight Committee (SOC), the IPO expanded their original focus to include electronic data sharing of personnel and benefits information. Responsibility for development of requirements and execution of IT solutions remain with the respective DoD and VA organizations.

Additional OIT Support Offices
OIT Support includes IT Resource Management (ITRM); Architecture, Strategy and Design (ASD); the VLER office, and customer advocates. ITRM directs the financial management, human capital management, IT asset management and procurement activities of OIT. As such, it has the primary responsibility of linking the budgeting process with IT programs. ASD advises and assists the AS/IT in overseeing and directing the areas of IT strategy, plans, and programs for the Department. The office develops the Enterprise Architecture and IT Strategic Plan, which addresses short and long-term IT goals, objectives and performance measures necessary to support VA business lines. The VLER office supports a visionary, interagency federal initiative created to ensure that health, benefits and personnel information for Service members and Veterans, captured from accession to final rights, are electronically and securely available to efficiently and effectively deliver health and benefits entitlements. The purpose of VLER is to enable the VA and its partners to proactively provide the full continuum of services and benefits to Veterans through Veteran-centric processes made possible by effective, efficient, and secure standards-based information sharing. VLER is neither an IT program nor an information service provider. VLER is a multi-faceted business and technology initiative that includes a portfolio of health, benefits, and personnel information sharing capabilities. Additionally, the OIT support staff includes customer advocates for health, benefits and corporate customers. The customer advocates articulate clients' needs and ensure their voices are heard in the forums where we operate.

Office of Information Technology

Organization Chart



Interagency Program Office (IPO)
VA integrated Electronic Health Record (iEHR)

In the 2014 budget, VA is requesting $343.6 M for the integrated Electronic Health Record (iEHR) and the Virtual Lifetime Electronic Record (VLER) Health, an increase of $145 million above the 2013 continuing resolution. The 2008 National Defense Authorization Act established the DoD/VA Interagency Program Office (IPO) to act as the single point of accountability for DoD and VA in the rapid development and implementation of Electronic Health Record (EHR) systems and VLER Health capabilities.

The IPO was established to deliver affordable, interoperable and time-critical integrated electronic healthcare capability across DoD and VA with the goal of providing complete and seamless electronic exchange and record portability of healthcare information in a secure and private format to ensure effective delivery of healthcare services. The iEHR program represents an integrated, multi-increment effort between the two departments, one that is bound by a common architecture, data model, and presentation layer. The iEHR program will include a mix of Commercial Off the Shelf (COTS), Government Off the Shelf (GOTS), and Open Source capabilities, in addition to reuse of enduring unique capabilities. VLER Health is a portfolio of programs that manage the exchange and use of important health information with private partners, other agencies and the Veteran according to nationally-established standards. This portfolio has been known in VA as the Nationwide Health Information Network or NwHIN. Now known as the eHealth Exchange, information sharing is rapidly spreading across the country and VA is in the lead. In FY2013 – 2014, VLER Health will begin to seamlessly integrate with the new EHR, to seamlessly "serve up" this private sector and other agency, including DoD, data that comes through the eHealth Exchange or via "Direct" secure messaging.

When fully implemented, iEHR and VLER Health will enable DoD, VA, and other public and private sector providers to securely access electronic health information. These projects will establish an integrated environment to facilitate joint DoD and VA capability integration to facilitate data exchange requirements between current systems as well as the path forward towards a common infrastructure, common business processes and common services. The major activity for VLER Health in FY 2014 will be continued maturity of an Adaptor and Gateway that will be used to produce standardized content in HL7 Consolidated Clinical Document Architecture format and provide that information for transport to the eHealth Exchange (formerly the Nationwide Health Information Network) and for secure messaging. Implementation of this project will allow for increased information available for use in the iEHR application in clinical care from data provided by other government and private sector health providers. Through patient matching and secure transport, including the exchange and use

of clinically relevant health information to support clinical encounters, a reduction in costs will be realized through elimination of duplicative procedures, and the exchange of clinically relevant health information used for disability adjudication. Additional use cases are for other clinical treatment, coverage of services, clinical registries and future research.

FY 2014 Request: The FY 2014 request includes $252 million in development; $53M in mandatory sustainment, and $39 million in marginal sustainment. FY 2014 efforts include risk reduction activities and proof of concept in the following initial capability modules: Presentation Layer, Laboratory, Immunization and Pharmacy. This early version of iEHR is planned to roll out in two facilities located in San Antonio, TX, and Hampton Roads, VA. Other key FY 2014 iEHR activities include infrastructure development, Health Data Dictionary mapping, establishment of the Service Oriented Architecture (SOA) Suite, and associated Enterprise Service Bus (ESB) and transition planning.

Fiscal Year 2014 requirements address multiple new and on-going IT investment projects critically aligned to the goals and objectives of the Secretaries of Defense and Veterans Affairs. These projects will establish an integrated environment to facilitate joint DoD and VA capability integration to facilitate data exchange requirements between current systems as well as the path forward towards a common infrastructure, common business processes and common services. This will include defining an overall data strategy that will address how data will be managed, stored, discovered, accessed, and processed through the use of common data schemas, models, and structures. FY 2014 funding will also enable VLER Health to field eHealth Exchange Adaptor/Gateway and Network Direct software and allow for testing and modification of any defects that may be identified during the fielding process. In addition, clinical capability risk reduction will be conducted via demonstrations and technology assessments. DoD and VA, working through the Health Executive Council, are responsible for development and implementation of VLER Health systems, capabilities, and initiatives.

FY 2014 Deliverables: The most critical goal for FY 2014 is to successfully achieve iEHR Initial Operating Capability (IOC). IOC deployment will provide the first subset of clinical capabilities (to include initial lab and immunization) to facilities in two separate locations—San Antonio, TX and Hampton Roads, VA. The joint applications, accessed through a common enhanced GUI, will utilize the respective "EHR cores" from VA and DoD, but will use common standards, infrastructure, and core services to ensure interoperability between the Departments.

Much of the FY 14 effort prior to IOC will focus on the development of the underlying infrastructure capabilities to form the seamless insertion of new capabilities. This infrastructure (to include identity management, single-sign-on,

access control, privacy management, security, and a service oriented architecture (SOA) suite) will also be delivered to the chosen IOC sites. The combination of the clinical and infrastructure capabilities, when released to San Antonio and Hampton Roads, will improve patient safety and clinical outcome, improve diagnostic accuracy, and increase interoperability between the VA and DoD.

Lastly, IOC will play a critical role in resolving the major pharmacy challenges that are currently being experienced at the James A. Lovell Federal Health Care Center (JAL FHCC) in North Chicago. These fixes will reduce the risk of medication errors, improve care transitions, eliminate costs, and improve patient satisfaction.

Legislative Proposals

Legislative Proposals	FY2014 [1/]
Title 38 Pay Authority to Maintain On-Call Pay for Information Technology (IT) Specialists in VA OIT	$8,056
Title 38 Pay Authority to Recruit and Retain Healthcare Professionals in VA OIT:	$365
Legislative Proposals Total ***(cost in thousands)***	**$8,421**

[1/] Discretionary amounts are funded in the request amount.

In a rapidly evolving business and legislative environment, with the number of Veterans eligible for VA benefits and the number and scope of VA programs growing, additional flexibility is needed within the overall VA discretionary budget to meet evolving demands on the IT appropriation. Consequently, VA seeks legislative authority through the following proposals so IT can meet business lines' demands to provide services to Veterans.

Title 38 Pay Authority to Maintain On-Call Pay for Information Technology (IT) Specialists in VA OIT

Proposed Legislative Authority:

Allow the Office of Information and Technology (OI&T) Title 38 Pay Authority, in order to maintain on-call pay for Title 5 IT Specialists responsible for providing IT services incident to direct patient care.

Justification:

The proposed change in Title 38 legislation is to continue to allow Title 5 IT Specialists authority to serve in an "on-call" status and receive "on-call" pay because of the requirement to support VA's healthcare mission 24 hours a day, 7 days a week (24 x 7). When the realignment of OI&T occurred, Title 5 IT staff were transferred out of VHA and the authority to receive "on-call" pay was subsequently lost. This change has resulted in the inability to provide off-tour IT

support for mission-critical IT systems that are in use by VA employees across the country 24 hours a day, 365 days a year. On-call coverage is needed because VA does not staff IT on a 24x7 basis. The decision to not maintain a three-shift schedule is based on both the availability of qualified IT specialists and the cost to maintain a significantly higher FTE ceiling. Even if IT were able to maintain three shifts of on-duty personnel, on-call capability would still be necessary as a means of providing contingency coverage in the event of holidays and workforce shortages.

10- Year Cost Table

Category (cost in thousands)	2014	2015	2016	2017	2018	5 Year
Cost of current OIT Staff receiving on-call pay	$7,181	$7,803	$8,480	$9,215	$10,014	$42,694
Cost of future additional OIT staff to receive on-call pay	$875	$951	$1,033	$1,123	$1,220	$5,202
Total OI&T	$8,056	$8,754	$9,513	$10,338	$11,234	$47,895

Category (cost in thousands)	2019	2020	2021	2022	2023	10 Year
Cost of current OIT Staff receiving on-call pay	$10,882	$11,826	$12,851	$13,965	$15,176	$107,394
Cost of future additional OIT staff to receive on-call pay	$1,326	$1,441	$1,566	$1,701	$1,849	$13,085
Total OI&T	$12,208	$13,267	$14,417	$15,667	$17,025	$120,479

Title 38 Pay Authority to Recruit and Retain Healthcare Professionals in VA OIT

Proposed Legislative Authority:

Allow the Office of Information and Technology (OI&T) Title 38 Pay Authority, in order to recruit and retain healthcare professionals in several of our leadership positions.

Justification:

The current legislative authority allows for Veterans Health Administration (VHA) to recruit and retain healthcare professionals using Title 38 Authority. Title 38 Authority was delegated by the Office of Personnel Management (OPM) based on the clinical duties and medical mission of VHA.

The purpose of the proposed change in Title 38 legislation is to allow OI&T, now operating under a single IT authority, to recruit and retain healthcare professionals in several of our leadership positions. Having senior executives, specifically, in our IT software development and at the IT VISN CIO level that posses both the medical field background and management background is very important. The complexities of the medical field itself require individuals that have both extensive specialized experience and knowledge in this field, and in the IT management field. OI&T must also ensure that the impacts in healthcare systems being planned, developed and executed are fully identified and thoroughly understood as we move forward to improve healthcare delivery systems in VA.

10-Year Cost Table:

cost in thousands	**2014**	**2015**	**2016**	**2017**	**2018**	**5 Year**
Base Salary	$172	$176	$181	$185	$190	$905
Health Care Add On	$115	$118	$121	$124	$127	$604
Subtotal	$287	$294	$302	$309	$317	$1,509
Benefits at 27%	$77	$79	$81	$83	$86	$407
Total	$365	$374	$383	$393	$402	$1,916

(cost in thousands)	**2019**	**2020**	**2021**	**2022**	**2023**	**10 Year**
Base Salary	$195	$200	$205	$210	$215	$1,929
Health Care Add On	$130	$133	$136	$140	$143	$1,286
Subtotal	$325	$333	$341	$350	$358	$3,216
Benefits at 27%	$88	$90	$92	$94	$97	$868
Total	$412	$423	$433	$444	$455	$4,084

FY 2012 Accomplishments

Major Transformational Initiatives (MTI)

MTIs are Department-wide initiatives designed to address VA priorities such as Homelessness, Access to Care, and Eliminating the Benefits Backlog. FY 2012 accomplishments for these initiatives are highlighted below.

- Veteran Benefits Management System: Deployed at four regional offices. The current functionality provides faster, higher quality, and greater consistency in compensation claims decision.
- Virtual Lifetime Electronic Record: Deployed a release of the NwHIN increment 1. This enables secure sharing of Veteran electronic health information between VA and private partners to ensure up-to-date health records. Enable Secure Electronic Communication: fully implemented My Health*e*Vet Secure Messaging within primary care settings at VA facilities nationwide to support non-urgent communication between VA patients and their VA health care team.
- Veterans Relationship Management: Released Veterans Online Application Direct Connect which provides Veterans the ability to apply for VBA benefits by answering guided interview questions through the security of the eBenefits portal.
- New Models of Health Care: Facilitated the redesign of primary care through reengineering of the Primary Care Management Module to create a national database identifying all members of the Patient Aligned Care Team and tracking of all patient care providers.
- Access to Health Care: As a result of deploying Point of Service kiosks software surveys have shown a 97 percent Veteran satisfaction rate. Rural Health piloted a program to provide non-VA healthcare services to eligible Veterans in five VISNs over a three-year period.

Program Management Accountability System (PMAS)

PMAS' most significant FY 2012 accomplishment is achieving 82 percent of planned development and capability delivery. This figure exceeds the FY 2013 President's Budget target of 80 percent. In addition, this success rate is significantly greater than the IT industry standard rate of 42 percent. PMAS is VA's disciplined approach to IT development and capability delivery. With this approach, customers, IT project team, vendors, and all stakeholders engaged in a project focus on a single mission, to achieve on-time delivery of project increments. PMAS uses an incremental product build process for IT projects with delivery of new functionality, tested and accepted by the customer, in cycles of six months or less. Within PMAS, project managers are accountable for meeting

cost, schedule and scope goals. PMAS reduces project development risk, institutes monitoring, establishes accountability, and creates a reporting discipline.

Customer Satisfaction

OIT is committed to improving our customer satisfaction. To measure progress OIT administers an annual IT survey, analyzes survey results, presents those findings and develops recommendations for IT service improvements. The near-term target for customer satisfaction is an American Customer Satisfaction Index (ACSI) score of 75, which marks a level above the average for government organizations. OIT's Business Relation Management Office (BRMO) has also provided a strategic recommendation, accepted by the Chief Information Officer (CIO), of implementing a Service Improvement Plan to drive all individual facility ACSI scores up to a floor of 72. This strategy will enable OIT to reach its goal of an enterprise score of 75 by FY 2015.

There are also a number of efforts underway to measure the performance of various systems and processes. The analysis of newly acquired data from targeted surveys and data calls has been combined with metrics available from the past and current enterprise-wide IT Customer Satisfaction data to better understand what factors most affect improvements in customer satisfaction.

In conjunction with Service Delivery and Engineering, a council of experienced Facility CIOs known as the IT Service Improvement Council was created and is now operational. This Council is focused on service improvements and has produced a "best practices" library to share service improvement successes and other tools and processes that can be implemented at the facility level to improve customer satisfaction with little or no budgetary increases. BRMO has taken the lead in establishing communication channels to bring this content to all Facility CIOs and IT Field Staff across VA.

Operational Excellence

<u>Enterprise Management Framework (EMF)</u>

EMF allows a common view of all critical information on the health of the IT infrastructure. The CIO can see, at a glance and in real time, management reports, dashboards, metrics, intelligent analysis and trending, as well as functionality presenting all IT data from across the enterprise using a single data source. The effort began in FY 2012 and will continue in FY 2013. It will be sustained and expanded in FY 2014. The FY 2014 investments will begin to provide proactive warning of system problems before they become apparent to the end-user. The proactive nature of EMF ultimately improves the level of service OIT can provide VA Administrations and Staff Offices in support of their business functions.

EMF efforts are ongoing to automate the Rigors and Performance report and other significant operational metrics. The goal is to provide real time SLA information to the OIT customer/user so that meaningful IT investment decisions can be made in situations where system performance and availability do not meet business requirements.

Service Lines for IT Field Operations

The service line staffing model was rolled out for national deployment in FY 2012 based upon a pilot program completed in FY 2011 that demonstrated the improved performance of IT service delivery in IT Field Operations. This deployment will be completed during FY 2013 and FY 2014. It aligns staff by skill rather than facility and provides deeper levels of talent, new career ladders for IT specialists and improved service to VA user communities. This is being accomplished within existing OIT staff ceilings.

Accomplishments:

- FY 2012 – all OIT Field Operations Regions finished recruitment of principal, service-line managers and staff in five core disciplines, resulting in recruiting 346 FTE.

National Service Desk

A 2007 study of the help desk function indicated extreme fragmentation and lack of help desk coverage in one third of facilities. Beginning in 2011, the CIO mandated the creation of a National Service Desk organization and the migration of the disparate help desk staffs into a single functional entity with a single tool set. This consolidation and expansion of Tier 1 help for VA users will be completed early in FY 2013 and will be maintained in FY 2014. The call center statistics of time to answer, first call resolution and time to ticket closure all suggest vastly improved customer service for VA IT users.

Accomplishments:

- FY 2012 – consolidation of three of five regions, migration of National Service Desk from Franchise Fund to OIT-SDE; selection of single help desk ticketing tool and beginning migration to that tool.

National Data Center Program (NDCP)

The NDCP program was launched in 2005 with the migration of VHA VistA systems into Tier 3 data centers for IT Regions 1 and 4. During 2011, preparation work was done to begin migrating Regions 2 and 3 into DoD-DISA data center space.

Accomplishments:

- FY 2012 – agreement reached with DoD/DISA for data center space for Region 2 & 3 VistA Systems migration; acquisition of data circuits and hardware for migrations was initiated.

iOS Device Infrastructure

VA IT strategic planning indicates that the ascendancy of mobile/iOS devices is a future trend in health and benefits delivery systems. In FY 2012, OIT launched an iOS device pilot project to demonstrate the required device security and management infrastructure could be built to enable VA business lines to develop mobile applications for facilitated service delivery in their new care models.

Accomplishments:

- FY 2012 – pilot project to support ~1,500 VHA iOS devices. One of the goals of the pilot is to determine whether the infrastructure capabilities are able to manage and support security requirement on iOS devices.

National Wireless Infrastructure Project

A National WiFi Infrastructure project has existed in VA since 2010 and approximately 50 percent of the hospitals have undergone the installation of a ubiquitous modern WiFi system. This project will enable WiFi-LAN connectivity for an entirely new generation of WiFi enabled biomedical devices, such as the VHA RTLS project. Funding in FY 2013 and FY 2014 will allow completion of the project with coverage to all major facilities.

Accomplishments:

- FY 2012 – new WiFi installation contract was awarded and funded to complete infrastructure in three VHA VISNs scheduled to participate in VHA RTLS projects.

21st Century Mobile – Citrix Access Gateway (CAG)

As a consequence of the National Telework Act and other requirements for remote access to VA systems, the CAG project was created in FY 2012 to allow approximately 24,000 users to connect from home or other remote locations and perform their suite of duties on-line.

Accomplishments:

- FY 2012 – Existing CAG server farms were integrated to enable minimum functionality for limited user populations.

Information Security

In FY 2012, VA's information security program expanded its view of the IT network with the "Visibility to Everything" (V2E) effort. This work was completed jointly by IT Operations and Information Security staff. V2E is the next step toward monitoring all the endpoints in the IT network and maintaining their security.

VA's CRISP initiative is an integrated effort to increase the effectiveness of existing protections for both sensitive information and the integrity of the VA systems. CRISP also proactively addresses previously identified weaknesses in security at VA facilities through focused work and increased awareness. CRISP has enlisted everyone in VA to participate and has created a heightened sensitivity to security and privacy within everyday work processes.

IT Governance and Financial Management

VA IT governance ensures the alignment of IT strategy, systems and processes to VA's business strategy. IT investment decisions are no longer autonomous. 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.

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. 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.

OIT created a detailed financial plan for both FY 2012 and FY 2013, known as the Prioritized Budget Operating Plan. This plan has two main purposes:

- First, it created 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 allowed 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 expected from the expenditure.

Amounts Available for Obligation

Information and Technology Systems Appropriation/Obligations
(Dollars in thousands)

Description	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Estimate	2012-2014 Increase/ Decrease
IT Systems Appropriation: FY 2012 (P.L. 112-74)	3,111,376	3,327,444	3,130,949	3,683,344	571,968
Transfers 1/	-6,605				6,605
Total IT Appropriations	**3,104,771**	**3,327,444**	**3,130,949**	**3,683,344**	**578,573**
Reimbursements					
IT Systems Appropriation	58,616	28,000	97,521	173,673	115,057
IT Pay Reimbursements	13,227	19,000	12,479	12,895	-332
Subtotal Reimbursements	**71,843**	**47,000**	**110,000**	**186,568**	**114,725**
Change in Uncollected Orders					
Total Budgetary Resources	**3,176,614**	**3,374,444**	**3,240,949**	**3,869,912**	**693,298**
Adjustments to Obligations					
Unobligated Balance (SOY):	-107,591		33,426		107,591
Unobligated Balance (EOY):	33,426				-33,426
Change in Unobligated Balance (non-add)	**-74,165**		**33,426**		**74,165**
Unobligated Balance Expiring (Lapse)	-1,395				1,395
Adjustments					
Obligations	**3,249,384**	**3,374,444**	**3,274,375**	**3,869,912**	**620,528**
Outlays, Gross	**3,337,910**	**3,763,070**	**3,001,642**	**3,688,785**	**350,875**
Less Collections	-72,143	-47,000	-110,000	-186,568	-114,425
Outlays, Net	**3,265,767**	**3,716,070**	**2,891,642**	**3,502,217**	**236,450**
FTE	7,210	7,435	7,435	7,355	
Reimbursable FTE	101	145	101	104	
Total FTE	**7,311**	**7,580**	**7,536**	**7,459**	

1/ FY 2012 transfer of $6,605 to the North Chicago facility.

Office of Information and Technology
Obligations by Object Class and Funding Sources
(Dollars in Thousands)

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Estimate	2012-2014 Increase/ Decrease
Personal Services	814,564	895,231	840,241	869,949	55,385
Travel	12,588	16,000	12,042	14,808	2,220
Rent, Communications and Utilities	576,917	380,594	403,086	403,226	(173,691)
Printing and Reproduction	81	60	21	26	(55)
Other Services	1,346,579	1,743,346	1,679,772	2,242,384	895,805
Supplies and Materials	7,400	10,064	10,064	10,085	2,685
Equipment	485,592	326,621	326,621	326,906	(158,686)
Lands and Structures	5,522	2,332	2,332	2,332	(3,190)
Other	141	196	196	196	55
Total Obligations	**$3,249,384**	**$3,374,444**	**$3,274,375**	**$3,869,912**	**620,528**
Funding Sources					
Appropriation	**3,111,376**	**3,327,444**	**3,130,949**	**3,683,344**	**571,968**
Across the Board Reduction					
Rescission					
Transfers 1/	-6,605				6,605.00
Reimbursements	71,843	47,000	110,000	186,568	114,725
Non-Pay Reimbursements	58,616	28,000	97,521	173,673	115,057
Pay Reimbursements	13,227	19,000	12,479	12,895	-332
Unobligated balance expiring	-1,395				1,395
Change in uncollected orders					
Unobligated SOY 2/	107,591		33,426		-107,591
Unobligated EOY	-33,426				33,426
Total	**$3,249,384**	**$3,374,444**	**$3,274,375**	**$3,869,912**	**$620,528**

Note: Numbers may not add due to rounding.
1/ FY2012 shows a transfer of 6,605 to the North Chicago facility.

Performance Measures

Categories (See Note at the bottom of this spreadsheet for a list of categories)	Performance Measures Data							
	Measure	Results History				Future Targets		2014 Strategic Target
		2009	2010	2011	2012	2013 PB	2014 Request	
(B) Support Delivery of Services	Number of Material Weaknesses	4	1	1	1	1	1	0
(B) Support Delivery of Services	Percent of milestones achieved towards deployment & implementation of a paperless disability claims processing system. (Supports Agency Priority Goal)	N/Av	N/Av	100%	100%	100%	100%	100%
(B) Support Delivery of Services	Percent of milestones achieved in deploying and implementing the Veterans Relationship Management System (VRMS) (Supports Agency Priority Goal)	N/Av	N/Av	30%	70%	100%	100%	100%
(B) Support Delivery of Services	Percent of milestones achieved in deploying and implementing the Virtual Lifetime Electronic Record (VLER)	N/Av	N/Av	88%	60%	100%	100%	100%
(B) Support Delivery of Services	Percent of VA IT projects delivering functionality on 6-month or less intervals	N/Av	N/Av	80%	80%	80%	80%	100%
(B) Support Delivery of Services	The enterprise VA American Customer Service Index for internal customer satisfaction with VA IT services	N/Av	N/Av	71	73	74	75	76

Performance Measure Supporting Information

KEY OR DEPARTMENTAL MEASURES ONLY

1) Percent of milestones achieved towards deployment & implementation of a Paperless Disability Claims Processing System. (Supports Priority Goal)

a) Means and Strategies:

- VA will complete project initiative actions, specifically creating project management and software development environments
- VA will provide funding, staffing resources, and the authority to proceed with the PDCPS
- VA will complete the following project management activities:
  - Form an Integrated Project Team
  - Create Quality Assurance Plan
  - Create Project Management Plan
- VA will develop the following supporting documents:
  - Configuration Management Plan
  - Disaster Recovery Plan
  - Concept of Operations Plan
  - Contingency Plan
  - Acquisition Plan
  - System Security Plan
  - Privacy Interaction Assessment
  - System Interconnect Agreement
- VA will build the PDCPS incrementally using the "Agile Scrum" method and deliver, per an approved schedule and architecture, product components that have been:
  - Tested as components
  - Tested in an integrated environment
  - Delivered in system "builds"
  - Accepted by the user (VBA) community
- VA will field a mature, tested, and operationally-ready PDCPS with the following release-unique documents:
  - Master schedule
  - Deployment, Implementation, and Training plans
  - National Deployment request
  - Approval document – National Deployment

b) Data Source(s): ProPath and the Program Management Assessment System (PMAS), Milestone Reviews, Business Relationship Meetings, OIT Monthly Performance Reviews.

c) Data Verification: Will include Milestone Reviews documenting adherence to schedule.

d) Measure Validation:

- This measure indicates OIT performance on timely delivery of new functionality to customers. Schedule is validated through the use of internal OIT Product Delivery Measurements

e) Cross-Cutting Activities: None

f) External Factors:

- DoD/VA interoperability is required to minimize technical changes due to concurrent development
- The Veterans Benefit Management System may require schedule changes to meet higher-level VA goals.
- The Virtual Lifetime Electronic Record project may require schedule changes in PDCPS to meet higher-level VA goals

g) Other Supporting Information: None

h) Link to Category, Capability, and Secondary Criteria:

- Category: Support Delivery of Services
- Capability: Controls and Oversight
- Secondary Criteria: Identified with core missions of VA. Of demonstrated high visibility to our stakeholders.

Table 2: Performance Measure Supporting Information

2) Percent of milestones achieved in deploying and implementing the Veterans Relationship Management (VRMS). (Supports Priority Goal)

a) Means and Strategies:

- VA will complete project initiative actions, specifically creating project management and software development environments
- VA will provide funding, staffing resources, and the authority to proceed with the CRMS
- VA will complete the following project management activities:
  - Form an Integrated Project Team
  - Create Quality Assurance Plan
  - Create Project Management Plan
  - Create a Project Schedule
- VA will develop the following supporting documents:
  - Configuration Management Plan
  - Disaster Recovery Plan
  - Concept of Operations Plan
  - Contingency Plan
  - Acquisition Plan
  - System Security Plan
  - Privacy Interaction Assessment
  - System Interconnect Agreement
  - Incident Response Plan
- VA will build the CRMS incrementally using the "Agile Scrum" method and deliver, per an approved schedule and architecture, product components that have been:
  - Tested as components
  - Tested in an integrated environment
  - Delivered in system "builds"
  - Accepted by the user (VBA) community
- VA will field a mature, tested, and operationally-ready CRMS with the following release-unique documents:
  - Master schedule
  - Deployment , Implementation, and Training plans
  - National Deployment request
  - Approval document – National Deployment

b) Data Source(s): 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:

- 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: None

f) External Factors:

- DoD/VA interoperability required to minimize technical changes due to concurrent development
- The Veterans Benefit Management System and Virtual Lifetime Electronic Record project may require schedule changes in CRMS to meet higher-level VA goals

g) Other Supporting Information: None

h) Link to Category, Capability, and Secondary Criteria:

Category: Support Delivery of Services

Capability**:** Controls and Oversight

Secondary Criteria: Identified with core missions of VA. Of demonstrated high visibility to our stakeholders

3) Percent of milestones achieved in deploying and implementing the Virtual Lifetime Electronic Record (VLER). (Supports Priority Goal)

Table 2: Performance Measure Supporting Information

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:

Category: Support Delivery of Services

Capability: Controls and Oversight

Secondary Criteria: Identified with core missions of VA. Of demonstrated high visibility to our stakeholders

4) Number of Material Weaknesses (Departmental Management Measure)

a)Means and Strategies:

- Remediation of the one material weakness is being tracked based on a specific corrective action plan with set milestones and completion dates; these are monitored for completion. The weakness is complex and requires action over several years.

b) Data Source(s):

- Based on findings identified in the annual auditor's report on VA's consolidated financial statements.

c) Data Verification:

- Final Audit Report

d) Measure Validation:

- Final Audit Report

e) Cross-Cutting Activities:

- None

f**) External Factors:**

- Congressional Oversight

g) Other Supporting Information:

- None

h) Link to Category, Capability, and Secondary Criteria:

- Category: Support Delivery of Services
- Capability: Controls and Oversight
- Secondary Criteria: Of demonstrated high visibility to our stakeholders

Information Technology Systems Appropriations History

(Dollars in thousands)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriations	FTE
2009	2,442,066	2,492,066	2,471,166	2,539,391 _1/	6,710
2010	3,307,000	3,307,000	3,307,000	3,307,000	6,853
2011	3,307,000	3,222,000	3,147,000	2,993,604_2/	7,004
2012	3,161,376	3,025,000	3,161,376	3,111,376	7,311
2013	3,327,444	3,327,444	3,327,444	--	7,536
2014	**3,683,344**	--	--	--	7,459

Note: The Information Technology Systems account was established in P.L. 109-114.
1/ Includes $50 million in emergency funding provided in P.L. 111-5.
2/ The FY 11 appropriation was $3.141 billion (including ATB rescission) with an additional $147 million in unobligated balances rescinded.

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2014 Budget Appendices

Appendix 1 Budget Request Detail

Information and Technology
Appendix 1 -- Budget Request Detail
(Dollars in Thousands)

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Estimate	2012-2014 Increase/ Decrease
Total Budget Authority						
Development						
Access to Healthcare	$ 40,071	$ 67,816	$ 23,414	$ -	$ 3,645	$ (36,426)
Healthcare Efficiency	$ 2,456	$ 4,659	$ 8,689	$ -	$ -	$ (2,456)
Homelessness	$ 4,650	$ 3,075	$ 2,792	$ -	$ -	$ (4,650)
Integrated Electronic Health Record (iEHR) & VLER Health	$ 68,833	$ 104,000	$ 133,550	$ 8,125	$ 251,882	$ 183,049
Mental Health	$ 6,476	$ 8,818	$ 5,844	$ -	$ -	$ (6,476)
New Models of Care	$ 24,703	$ 35,724	$ 39,883	$ -	$ 32,647	$ 7,944
Veterans Benefits Management System (VBMS)	$ 104,163	$ 38,525	$ 40,125	$ -	$ 32,834	$ (71,329)
Virtual Lifetime Electronic Record (VLER)	$ 46,191	$ 49,939	$ 45,857	$ -	$ 11,352	$ (34,839)
Veterans Relationship Management (VRM)	$ 68,547	$ 96,218	$ 82,713	$ -	$ 120,157	$ 51,610
Automated GI Bill (Chapter 33)	$ 51,998	$ -	$ 4,400	$ -	$ -	$ (51,998)
Preparedness (PIV)	$ 16,154	$ 3,025	$ 6,485	$ -	$ -	$ (16,154)
Systems to Drive Performance (STDP)	$ -	$ 4,062	$ -	$ -	$ -	$ -
Integrated Operating Model (IOM)	$ 17,516	$ 14,100	$ 17,950	$ -	$ -	$ (17,516)
Human Capital Investment Plan (HCIP)	$ 5,450	$ 14,640	$ 2,720	$ -	$ -	$ (5,450)
Strategic Capital Investement Plan (SCIP)	$ 737	$ 1,000	$ 1,000	$ -	$ -	$ (737)
Health Informatics	$ 7,643	$ 7,500	$ 7,500	$ -	$ 7,774	$ 131
ICD-10	$ 44,119	$ 11,500	$ 14,664	$ -	$ 4,600	$ (39,519)
Other	$ 60,587	$ 29,798	$ 81,375	$ 19,544	$ 30,400	$ (30,187)
Subtotal	$ 570,293	$ 494,399	$ 518,962	$ 27,669	$ 495,291	$ (75,002)
Sustainment/O&M						
Medical Operations and Maintenance	$ 619,707	$ 808,185	$ 649,829	$ -	$ 863,973	$ 244,266
Benefits Operations and Maintenance	$ 187,011	$ 263,300	$ 189,408	$ -	$ 302,301	$ 115,289
Enterprise Operations and Maintenance	$ 736,103	$ 695,632	$ 700,286	$ -	$ 810,660	$ 74,557
Interagency Operations and Maintenance	$ 53,330	$ 44,929	$ 97,464	$ 1,941	$ 184,720	$ 131,390
Subtotal	$ 1,596,151	$ 1,812,046	$ 1,636,987	$ 1,941	$ 2,161,653	$ 565,502
Development	$ 570,293	$ 494,399	$ 518,962	$ 27,669	$ 495,291	$ (75,002)
Sustainment/O&M	$ 1,596,151	$ 1,812,046	$ 1,636,987	$ 1,941	$ 2,161,653	$ 565,502
Staffing and Administration	$ 910,572	$ 1,021,000	$ 975,000	$ 3,568	$ 1,026,400	$ 115,828
H1N1 Supplemental (P.L. 111-32)						
OEF/OIF Supplemental (P.L. 110-28)				$ 248		
Total	$ 3,077,016	$ 3,327,444	$ 3,130,949	$ 33,426	$ 3,683,344	$ 606,328

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Estimate	2012-2014 Increase/ Decrease
Access to Healthcare	**$ 40,071**	**$ 67,816**	**$ 23,414**	**$ -**	**$ 3,645**	**$ (36,426)**
Surgical Quality and Workflow Management Developmental	$ 20,663	$ 27,503	$ 20,302	$ -	$ -	$ (20,663)
Emergency Department Information System Development	$ 7,401	$ 3,700	$ -	$ -	$ -	$ (7,401)
Veterans Benefits Handbook Development	$ 5,416	$ 3,798	$ -	$ -	$ -	$ (5,416)
Bed Management Solution Development	$ 3,131	$ 6,558	$ 3,113	$ -	$ -	$ (3,131)
TeleHealth	$ -	$ 3,939	$ -	$ -	$ -	$ -
National Utilization Management Integration Development	$ 1,760	$ 1,688	$ -	$ -	$ -	$ (1,760)
VPS Kiosk Development	$ 1,700	$ 4,221	$ -	$ -	$ 3,645	$ 1,945
Access IT - Program Management Office	$ -	$ 1,182	$ -	$ -	$ -	$ -
Intensive Care Unit/Anesthesia Record Keeper (ICU/ARK) Analytics System - Development	$ -	$ 5,909	$ -	$ -	$ -	$ -
Veterans Transportation System (VTS) - Development	$ -	$ 4,052	$ -	$ -	$ -	$ -
ASIH Bed Hold - Development	$ -	$ 2,279	$ -	$ -	$ -	$ -
Clinical Flow Management (CDM) Development	$ -	$ 1,688	$ -	$ -	$ -	$ -
Veterans Implant Tracking System (VITAS) - Development	$ -	$ 750	$ -	$ -	$ -	$ -
Annual Surgery Updates - Development	$ -	$ 549	$ -	$ -	$ -	$ -
Healthcare Efficiency	**$ 2,456**	**$ 4,659**	**$ 8,689**	**$ -**	**$ -**	**$ (2,456)**
Real Time Location System (RTLS) National Middleware Data Repository	$ 2,456	$ -	$ 3,500	$ -	$ -	$ (2,456)
Facility Automation - Development	$ -	$ 3,000	$ -		$ -	$ -
Beneficiary Travel - Development	$ -	$ 1,659	$ -		$ -	$ -
Non-VA Care Claims Processing	$ -	$ -	$ 5,189		$ -	$ -
Vet Traveler - Beneficiary Travel - Development	$ -	$ -	$ -		$ -	$ -
Homelessness	**$ 4,650**	**$ 3,075**	**$ 2,792**	**$ -**	**$ -**	**$ (4,650)**
Homelessness Registries	$ 2,038	$ 1,575	$ -	$ -	$ -	$ (2,038)
Homelessness Case Management Development	$ -	$ 1,500	$ -	$ -	$ -	$ -
Homelessness Handheld Devices	$ 2,612	$ -	$ 1,041	$ -	$ -	$ (2,612)
Homeless Management Information System (HIMS)	$ -	$ -	$ 1,752		$ -	$ -
iEHR & VLER Health	**$ 68,833**	**$ 104,000**	**$ 133,550**	**$ 8,125**	**$ 251,882**	**$ 183,049**
Pharmacy	$ -	$ 35,000	$ 13,582		$ 4,000	$ 4,000
Presentation Layer	$ -	$ -	$ 80,037		$ -	$ -
Identity and Access Management	$ -	$ -	$ 8,149		$ -	$ -
iEHR (Interagency 21st Century Core)	$ -	$ 34,000	$ -		$ 197,082	$ 197,082
iEHR - Health Provider Systems	$ -	$ 15,000	$ -		$ -	$ -
iEHR - Scheduling	$ -	$ 10,000	$ -		$ 30,000	$ 30,000
iEHR - Laboratory	$ -	$ 10,000	$ 10,865		$ 5,000	$ 5,000
Immunization Specific Services	$ -	$ -	$ 1,358		$ -	$ -
Access Control Services	$ -	$ -	$ 6,248	$ 8,125	$ -	$ -
VLER Health	$ -	$ -	$ 13,311		$ 15,800	$ 15,800
Mental Health	**$ 6,476**	**$ 8,818**	**$ 5,844**	**$ -**	**$ -**	**$ (6,476)**
Mental Health Systems Development	$ 4,009	$ -	$ 2,905	$ -	$ -	$ (4,009)
My Recovery Plan	$ 2,126	$ -	$ 1,990	$ -	$ -	$ (2,126)
Behavioral Health Lab Software Development	$ 341	$ 1,512	$ 949	$ -	$ -	$ (341)
Pharmacy Legacy (National Clozapine Coordination) - Development	$ -	$ 2,478	$ -		$ -	$ -
Pharmacy Legacy (Methadone Dispensing Tracking, and National Clozapine Coordination) - Development	$ -	$ 2,100	$ -		$ -	$ -
Mental Health Enhancements Outcomes Monitoring - Development	$ -	$ 1,798	$ -		$ -	$ -
Patient Record Flags for Suicide Risk and Missing	$ -	$ 619	$ -		$ -	$ -
Mental Health Clinical Reminders - Development	$ -	$ 311	$ -		$ -	$ -

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Estimate	2012-2014 Increase/ Decrease
New Models of Care	**$ 24,703**	**$ 35,724**	**$ 39,883**	**$ -**	**$ 32,647**	**$ 7,944**
TeleHealth	$ 9,780	$ -	$ 10,620	$ -	$ -	$ (9,780)
VISTA Imaging-Telemedicine Development	$ 5,672	$ 6,633	$ -	$ -	$ -	$ (5,672)
Enterprise Web Applications	$ 4,075	$ -	$ 9,500	$ -	$ -	$ (4,075)
MyHealtheVet	$ -	$ 2,300	$ -	$ -	$ 6,000	$ 6,000
Woman's Health Proposed Projects Development	$ 1,073	$ 950	$ -	$ -	$ -	$ (1,073)
Program Management Office	$ -	$ 1,000	$ -	$ -	$ -	$ -
MyHealtheVet - Health Risk Assessment	$ 4,103	$ -	$ -	$ -	$ -	$ (4,103)
Home Telehealth - Development	$ -	$ 6,016	$ -		$ -	$ -
Patient Health Record (PHR) On-Line Viewing - Development	$ -	$ 4,050	$ -		$ 3,200	$ 3,200
Secure Messaging Development	$ -	$ 2,124	$ -		$ 1,300	$ 1,300
Clinical Video Teleconferencing (General Telehealth) - Development	$ -	$ 2,003	$ -		$ -	$ -
PCMM Re-engineering - Development	$ -	$ 2,000	$ -		$ -	$ -
Health Risk Assessment - Development	$ -	$ 2,000	$ -		$ 3,000	$ 3,000
VA/DoD Image and Scanned Document Sharing Phase I - Development	$ -	$ 1,986	$ -		$ -	$ -
TeleMedicine (Store-Forwards) - Development	$ -	$ 1,962	$ -		$ 1,962	$ 1,962
CRS Notification Abnormal Test Results DME	$ -	$ 950	$ -		$ -	$ -
Breast Cancer Registry DME	$ -	$ 950	$ -		$ -	$ -
e-Move - DME	$ -	$ 800	$ -		$ 1,522	$ 1,522
Care Coordination - Patient Aligned Care Team (PACT) and Women's Health	$ -	$ -	$ 4,532		$ -	$ -
Enterprise Mobile Applications Store	$ -	$ -	$ -		$ -	$ -
My HealtheVet Suite	$ -	$ -	$ 15,231		$ -	$ -
VistA Imaging Storage Infrastructure - Development	$ -	$ -	$ -		$ 4,782	$ 4,782
My HealtheVet Integrations - Development	$ -	$ -	$ -		$ 2,500	$ 2,500
Integrated Veterans Health Library - Development	$ -	$ -	$ -		$ 500	$ 500
Home TeleHealth (HT) Capabilities Enhancements - Development	$ -	$ -	$ -		$ 7,881	$ 7,881
Veterans Benefits Management System (VBMS)	**$ 104,163**	**$ 38,525**	**$ 40,125**	**$ -**	**$ 32,834**	**$ (71,329)**
VBMS	$ 86,320	$ 20,682	$ 22,282	$ -	$ 20,777	$ (65,543)
Veterans Service Network [VETSNET]	$ 17,843	$ 17,843	$ 17,843	$ -	$ 12,057	$ (5,786)
Virtual Lifetime Electronic Record (VLER)	**$ 46,191**	**$ 49,939**	**$ 45,857**	**$ -**	**$ 11,352**	**$ (34,839)**
Memorial/Cemetarial Legacy Development	$ 9,956	$ 11,000	$ -	$ -	$ 11,352	$ 1,396
NHIN Gateway and Adaptor Development	$ 6,439	$ -	$ -	$ -	$ -	$ (6,439)
Warrior Support Federal Case Management Tool	$ 4,669	$ -	$ -	$ -	$ -	$ (4,669)
Warrior Support/Information Sharing Initiative Development	$ 5,000	$ -	$ -	$ -	$ -	$ (5,000)
Warrior Support/VA-DOD Identity Repository Development	$ 3,825	$ -	$ -	$ -	$ -	$ (3,825)
Veteran Authorization and Policies Development	$ 5,224	$ -	$ -	$ -	$ -	$ (5,224)
Bidirectional Health Information Exchange	$ 1,149	$ -	$ -	$ -	$ -	$ (1,149)
VistAWeb Performance & User Interface	$ 600	$ 1,331	$ -	$ -		$ (600)
VLER Data Access Service	$ 3,643	$ -	$ -	$ -	$ -	$ (3,643)
Veteran Authorization and Preferences (VAP) Interface Improvements	$ 3,186	$ -	$ -	$ -	$ -	$ (3,186)
Veteran Authorization and Preferences (VAP2) Interface Improvements	$ 2,500	$ -	$ -	$ -	$ -	$ (2,500)
Federal Information Sharing Technologies (FI	$ -	$ 29,938	$ -		$ -	$ -
VLER IT PMO	$ -	$ 5,500	$ -		$ -	$ -
ITRM	$ -	$ 1,681	$ -		$ -	$ -
Laboratory Data Sharing Initiative (LDSI) - Development	$ -	$ 489	$ -		$ -	$ -
VLER Benefits	$ -	$ -	$ 8,500		$ -	$ -
VLER Core	$ -	$ -	$ 27,057		$ -	$ -
VLER Memorials	$ -	$ -	$ 10,300		$ -	$ -

	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Estimate	2012-2014 Increase/ Decrease
Veterans Relationship Management Development	**$ 68,547**	**$ 96,218**	**$ 82,713**	**$ -**	**$ 120,157**	**$ 51,610**
Chapter 33	**$ 51,998**	**$ -**	**$ 4,400**	**$ -**	**$ -**	**$ (51,998)**
Safety and Security Initiative	**$ 16,154**	**$ 3,025**	**$ 6,485**	**$ -**	**$ -**	**$ (16,154)**
STDP/EWCA (Corporate Core)	**$ -**	**$ 4,062**	**$ -**	**$ -**	**$ -**	**$ -**
Integrated Operating Model	**$ 17,516**	**$ 14,100**	**$ 17,950**	**$ -**	**$ -**	**$ (17,516)**
Human Capital Development	**$ 5,450**	**$ 14,640**	**$ 2,720**	**$ -**	**$ -**	**$ (5,450)**
VA Learning Management Systems Development	$ 3,650	$ 5,540	$ -	$ -	$ -	$ (3,650)
Strategic Capital Investment Planning Database	**$ 737**	**$ 1,000**	**$ 1,000**	**$ -**	**$ -**	**$ (737)**
Health Management Platform Development	**$ 7,643**	**$ 7,500**	**$ 7,500**	**$ -**	**$ 7,774**	**$ 131**
International Classification of Diseases-10	**$ 44,119**	**$ 11,500**	**$ 14,664**	**$ -**	**$ 4,600**	**$ (39,519)**
Other	**$ 60,587**	**$ 29,798**	**$ 81,375**	**$ 19,544**	**$ 30,400**	**$ (30,187)**
VHA Research IT Support Development	$ 17,609	$ 18,521	$ -	$ -	$ -	$ (17,609)
Innovations (VAi2)	$ 11,330	$ -	$ 11,000	$ -	$ -	$ (11,330)
Caregivers Development	$ 6,343	$ -	$ -	$ -	$ -	$ (6,343)
Health Provider Systems Development	$ 3,995	$ -	$ -	$ -	$ -	$ (3,995)
Enrollment System Modernization	$ 3,250	$ 3,221	$ -	$ -	$ -	$ (3,250)
Repositories Development	$ 529	$ -	$ -	$ 2,744	$ -	$ (529)
Enterprise IT Support Development	$ 2,930	$ -	$ 3,500	$ -	$ -	$ (2,930)
Revenue Improvements System Enhancements Development	$ 1,256	$ -	$ -	$ -	$ -	$ (1,256)
Compensation and Pension Records Interlace Development	$ 893	$ -	$ -	$ -	$ 1,100	$ 207
Standards and Terminology Services	$ 775	$ -	$ -	$ -	$ -	$ (775)
Bar Code Expansion	$ 903	$ -	$ 1,900	$ 1,400	$ 1,700	$ 797
Camp Lejeune IT Support	$ -	$ -	$ -	$ 5,200	$ -	$ -
VBA Transformational Initiatives	$ 10,774	$ -	$ -	$ -	$ -	$ (10,774)
Scheduling	$ -	$ -	$ -	$ 7,200	$ -	$ -
ITRM	$ -	$ 3,000	$ -	$ -	$ -	$ -
ASD	$ -	$ 2,835	$ -	$ -	$ -	$ -
E-Gov	$ -	$ 2,091	$ -	$ -	$ -	$ -
Financial Management System (FMS)	$ -	$ 130	$ -	$ -	$ -	$ -
Certififcation of VistA for Meaningful Use	$ -	$ -	$ 1,000	$ -	$ -	$ -
Computerized Patient Records System Version 29 and 30	$ -	$ -	$ 1,373	$ -	$ 4,200	$ 4,200
EDI New Standards Operating Rules - VHA Provider Side Technical Compliance Requirements	$ -	$ -	$ 8,003	$ -	$ -	$ -
eDiscovery	$ -	$ -	$ 1,000	$ -	$ -	$ -
Healthcare Reform/Affordable Care Act	$ -	$ -	$ 1,518	$ 2,400	$ 3,400	$ 3,400
Pharmacy Systems Reengineering Project	$ -	$ -	$ 15,187	$ -	$ -	$ -
Safety updates for medication/prescription Management	$ -	$ -	$ 3,690	$ -	$ -	$ -
SPS Scope Action Plan (ISO-9001)	$ -	$ -	$ 4,393	$ 600	$ -	$ -
VA Medication Reconciliation	$ -	$ -	$ 1,000	$ -	$ -	$ -
VA Website	$ -	$ -	$ 600	$ -	$ -	$ -
Research and Development	$ -	$ -	$ 12,860	$ -	$ -	$ -
Disability Exam and Assessment Program	$ -	$ -	$ 949	$ -	$ -	$ -
VAIQ	$ -	$ -	$ 4,000	$ -	$ -	$ -
Enterprise Integration	$ -	$ -	$ 9,402	$ -	$ -	$ -
EDI Transactions - Mandated Compliance - Development	$ -	$ -		$ -	$ 20,000	$ 20,000
Grand Total	**$ 570,294**	**$ 494,399**	**$ 518,962**	**$ 27,669**	**$ 495,291**	**$ (75,003)**

Note:
Numbers may not add due to rounding.

Appendix 2 Program Level Detail

Information and Technology
Appendix 2 -- Program Level Detail
(Dollars in Thousands)

	2012 Actual 1/	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Budget Estimate
MEDICAL	**$ 811,730**	**$ 1,037,618**	**$ 804,491**	**$ 16,800**	**$ 943,040**
Medical 21st Century Core	**$ 74,287**	**$ 88,636**	**$ 69,048**	**$ 7,800**	**$ 35,469**
Access to Care (Medical Core) (DME)	$ 34,084	$ 41,923	$ 20,302	$ -	$ -
Access to Care (Medical Core) (OM)	$ 7,880	$ 1,064	$ 650	$ -	$ 2,630
Health Informatics (Medical Core) (DME)	$ 7,837	$ 7,500	$ 7,500	$ -	$ 7,774
Health Informatics (Medical Core) (OM)	$ -	$ 1,656	$ 1,185	$ -	$ 1,656
Health Provider Systems (Medical Core) (DME)	$ -	$ -	$ 4,393	$ 600	$ 4,200
Health Provider Systems (Medical Core) (OM)	$ 6,586	$ 7,860	$ 3,950	$ -	$ 15,441
Heatlhcare Efficiency (Medical Core) (DME)	$ 7,456	$ 4,659	$ 8,689	$ -	$ -
Heatlhcare Efficiency (Medical Core) (OM)	$ 1,384	$ 2,000	$ 900	$ -	$ 2,820
Homelessness (Medical Core) (DME)	$ -	$ -	$ -	$ -	$ -
Homelessness (Medical Core) (OM)	$ -	$ -	$ -	$ -	$ -
Scheduling (DME)	$ -	$ 10,000	$ -	$ 7,200	$ -
Scheduling (OM)	$ -	$ -	$ -	$ -	$ -
NMOC (Medical Core) (DME)	$ 5,362	$ 2,000	$ 12,075	$ -	$ -
NMOC (Medical Core) (OM)	$ -	$ -	$ 2,857	$ -	$ 937
VHA Research (Medical Core) (DME)	$ 1,900	$ 7,487	$ 4,543	$ -	$ -
VHA Research (Medical Core) (OM)	$ 1,797	$ 2,487	$ 2,004	$ -	$ 10
Medical 21st Century Schedule Replacement	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Scheduling Replacement (DME)	$ -	$ -	$ -	$ -	$ -
Scheduling Replacement (OM)	$ -	$ -	$ -	$ -	$ -
Medical 21st Century Laboratory	**$ 10,853**	**$ 10,135**	**$ -**	**$ -**	**$ -**
iEHR - Laboratory (DME)	$ -	$ 10,000	$ -	$ -	$ -
iEHR - Laboratory (OM)	$ -	$ -	$ -	$ -	$ -
Laboratory (DME)	$ -	$ -	$ -	$ -	$ -
Laboratory (OM)	$ 10,853	$ 135	$ -	$ -	$ -
Medical 21st Century Pharmacy	**$ 9,379**	**$ 37,235**	**$ 15,187**	**$ -**	**$ -**
iEHR - Pharmacy (DME)	$ 9,379	$ 35,000	$ -	$ -	$ -
iEHR - Pharmacy (OM)	$ -	$ -	$ -	$ -	$ -
Pharmacy (DME)	$ -	$ -	$ 15,187	$ -	$ -
Pharmacy (OM)	$ -	$ 2,235	$ -	$ -	$ -
Medical 21st Century RISE	**$ 1,256**	**$ -**	**$ -**	**$ -**	**$ -**
RISE (DME)	$ 1,256	$ -	$ -	$ -	$ -
RISE (OM)	$ -	$ -	$ -	$ -	$ -
Medical 21st Century CAPRI	**$ 1,477**	**$ 1,500**	**$ 591**	**$ -**	**$ 1,720**
CAPRI (DME)	$ 893	$ -	$ -	$ -	$ 1,100
CAPRI (OM)	$ 584	$ 1,500	$ 591	$ -	$ 620
Medical 21st Century My HealtheVet	**$ 20,892**	**$ 11,784**	**$ 21,055**	**$ -**	**$ 24,758**
Mental Health (Medical My HeV) (DME)	$ 2,126	$ -	$ 1,990	$ -	$ -
Mental Health (Medical My HeV) (OM)	$ -	$ 310	$ -	$ -	$ -
My HealtheVet (DME)	$ -	$ -	$ -	$ -	$ -
My HealtheVet (OM)	$ 5,749	$ -	$ -	$ -	$ -
NMOC (Medical My HeV) (DME)	$ 13,017	$ 11,274	$ 15,231	$ -	$ 18,022
NMOC (Medical My HeV) (OM)	$ -	$ 200	$ 3,834	$ -	$ 6,736
Medical 21st Century Registries	**$ 5,461**	**$ 5,643**	**$ 6,134**	**$ -**	**$ 4,088**
Access to Care (Registries) (DME)	$ 416	$ 750	$ -	$ -	$ -
Access to Care (Registries) (OM)	$ -	$ -	$ -	$ -	$ -
Homelessness (Registries) (DME)	$ 1,843	$ 1,575	$ 1,752	$ -	$ -
Homelessness (Registries) (OM)	$ 851	$ 650	$ 501	$ -	$ 1,232
NMOC (Registries) (DME)	$ 1,073	$ 950	$ 979	$ -	$ -
NMOC (Registries) (OM)	$ -	$ 50	$ 247	$ -	$ -
Registries (DME)	$ -	$ -	$ -	$ -	$ -
Registries (OM)	$ 1,279	$ 1,668	$ 2,655	$ -	$ 2,856
Medical 21st Century TeleHealth	**$ 11,878**	**$ 15,794**	**$ 10,318**	**$ -**	**$ 11,164**
Access to Care (Medical TeleHealth) (DME)	$ -	$ 3,939	$ -	$ -	$ -
Access to Care (Medical TeleHealth) (OM)	$ -	$ 1,013	$ -	$ -	$ -
NMOC (Medical TeleHealth) (DME)	$ 9,780	$ 9,981	$ 9,590	$ -	$ 9,843
NMOC (Medical TeleHealth) (OM)	$ 1,700	$ 361	$ 728	$ -	$ 1,321
Telemedicine (DME)	$ -	$ -	$ -	$ -	$ -
Telemedicine (OM)	$ 398	$ 500	$ -	$ -	$ -
Medical 21st Century Bar Code Expansion	**$ 903**	**$ -**	**$ 2,750**	**$ 1,400**	**$ 1,700**
Bar Code Expansion (DME)	$ 903	$ -	$ 1,900	$ 1,400	$ 1,700
Bar Code Expansion (OM)	$ -	$ -	$ 850	$ -	$ -

Information and Technology
Appendix 2 -- Program Level Detail
(Dollars in Thousands)

	2012 Actual 1/	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Budget Estimate
Medical Legacy	**$ 123,287**	**$ 106,912**	**$ 84,726**	**$ 2,400**	**$ 62,261**
Access to Care (Medical Legacy) (DME)	$ 5,747	$ 21,204	$ 3,113	$ -	$ 3,645
Access to Care (Medical Legacy) (OM)	$ 2,009	$ 1,857	$ 1,000	$ -	$ 4,735
Innovations	$ -	$ -	$ -	$ -	$ -
Caregiver's (DME)	$ 6,353	$ -	$ -	$ -	$ -
Caregiver's (OM)	$ -	$ -	$ -	$ -	$ -
Health Administration (DME)	$ -	$ -	$ -	$ -	$ -
Health Administration (OM)	$ -	$ 1,890	$ -	$ -	$ -
Health Administrative Systems (DME)	$ 44,119	$ 11,500	$ 25,134	$ 2,400	$ 28,000
Health Administrative Systems (OM)	$ 654	$ -	$ 2,592	$ -	$ 5,300
Health Provider Systems (Medical Legacy) (DME)	$ 3,995	$ -	$ 7,063	$ -	$ -
Health Provider Systems (Medical Legacy) (OM)	$ 17,015	$ 18,873	$ 25,570	$ -	$ 10,406
Homelessness (Medical Legacy) (DME)	$ 2,611	$ 1,500	$ 1,041	$ -	$ -
Homelessness (Medical Legacy) (OM)	$ -	$ 229	$ 500	$ -	$ 500
iEHR - Health Provider Systems (DME)	$ 4,940	$ 15,000	$ -	$ -	$ -
iEHR - Health Provider Systems (OM)	$ -	$ -	$ -	$ -	$ -
Mental Health (Medical Legacy) (DME)	$ 4,349	$ 8,818	$ 3,854	$ -	$ -
Mental Health (Medical Legacy) (OM)	$ -	$ -	$ -	$ -	$ 1,095
NMOC (Medical Legacy) (DME)	$ 5,672	$ 11,519	$ 2,009	$ -	$ 4,782
NMOC (Medical Legacy) (OM)	$ 4,876	$ 490	$ 1,047	$ -	$ 462
STDP/EWCA (Medical Legacy) (DME)	$ -	$ -	$ -	$ -	$ -
STDP/EWCA (Medical Legacy) (OM)	$ 2,354	$ -	$ -	$ -	$ -
VHA Legacy Systems (DME)	$ -	$ -	$ -	$ -	$ -
VHA Legacy Systems (OM)	$ -	$ -	$ -	$ -	$ 3,017
VHA Research (Medical Legacy) (DME)	$ 15,709	$ 11,034	$ 8,317	$ -	$ -
VHA Research (Medical Legacy) (OM)	$ 1,217	$ 1,178	$ 3,486	$ -	$ 319
VLER (Medical Legacy) (DME)	$ 1,199	$ 1,820	$ -	$ -	$ -
VLER (Medical Legacy) (OM)	$ 466	$ -	$ -	$ -	$ -
Medical IT Support	**$ 552,057**	**$ 759,979**	**$ 594,682**	**$ 5,200**	**$ 801,880**
Health Administrative Systems (DME)	$ -	$ -	$ -	$ 5,200	$ -
Health Administrative Systems (OM)	$ -	$ -	$ -	$ -	$ -
iEHR (Medical IT Support) (DME)	$ -	$ -	$ -	$ -	$ -
iEHR (Medical IT Support) (OM)	$ 7,190	$ 51,000	$ -	$ -	$ -
VHA Facility Activation (DME)	$ -	$ -	$ -	$ -	$ -
VHA Facility Activation (OM)	$ 53,959	$ 39,100	$ 78,936	$ -	$ 90,082
VHA Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Facility Operations Allowance (OM)	$ -	$ 9,751	$ -	$ -	$ 10,385
VHA Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Hardware Maintenance (OM)	$ 32,808	$ 44,238	$ 29,214	$ -	$ 47,114
VHA IT Infrastructure & Platform Upgrades (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Infrastructure & Platform Upgrades (OM)	$ -	$ -	$ -	$ -	$ -
VHA IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Lifecycle Management (OM)	$ -	$ 49,700	$ -	$ -	$ 58,139
VHA IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
VHA IT Support Contracts (OM)	$ 106,022	$ 58,417	$ 59,804	$ -	$ 64,514
VHA Legacy Systems (DME)	$ -	$ -	$ -	$ -	$ -
VHA Legacy Systems (OM)	$ 196,088	$ 298,095	$ 245,430	$ -	$ 318,435
VHA Research IT Support (DME)	$ -	$ -	$ -	$ -	$ -
VHA Research IT Support (OM)	$ -	$ 18,802	$ 6,370	$ -	$ 14,927
VHA Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VHA Software License Maintenance (OM)	$ 18,599	$ 26,700	$ 20,599	$ -	$ 28,436
VHA Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
VHA Telecommunications (OM)	$ 137,390	$ 164,176	$ 154,329	$ -	$ 169,848
BENEFITS	**$ 357,903**	**$ 312,825**	**$ 244,233**	**$ -**	**$ 346,487**
Benefits 21st Century Paperless Delivery of Veterans Ber	**$ 132,507**	**$ 97,817**	**$ 98,488**	**$ -**	**$ 101,132**
VBMS (DME)	$ 87,147	$ 20,682	$ 22,282	$ -	$ 20,777
VBMS (OM)	$ 45,360	$ 77,135	$ 76,206	$ -	$ 80,355
Benefits 21st Century Education	**$ 64,175**	**$ 11,189**	**$ 12,167**	**$ -**	**$ 27,464**
Chapter 33 (DME)	$ 51,998	$ -	$ 4,400	$ -	$ -
Chapter 33 (OM)	$ 12,177	$ 11,189	$ 7,767	$ -	$ 27,464

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	2012 Actual 1/	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Budget Estimate
Benefits Legacy	**$ 7,695**	**$ 7,660**	**$ 11,984**	**$ -**	**$ 21,760**
Agent Orange (DME)	$ -	$ -	$ -	$ -	$ -
Agent Orange (OM)	$ 1,310	$ -	$ 1,172	$ -	$ -
C&P Application Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
C&P Application Maintenance (OM)	$ -	$ -	$ 7,854	$ -	$ -
Compensation (DME)	$ 2,750	$ -	$ -	$ -	$ -
Compensation (OM)	$ -	$ 2,300	$ 175	$ -	$ 253
Education (DME)	$ -	$ -	$ -	$ -	$ -
Education (OM)	$ 615	$ 3,080	$ 778	$ -	$ 1,627
Insurance (DME)	$ -	$ -	$ -	$ -	$ -
Insurance (OM)	$ -	$ -	$ -	$ -	$ -
Loan Guarantee (DME)	$ -	$ -	$ -	$ -	$ -
Loan Guarantee (OM)	$ -	$ -	$ -	$ -	$ -
VBA Transformational Initiatives (DME)	$ -	$ -	$ -	$ -	$ -
VBA Transformational Initiatives (OM)	$ -	$ -	$ -	$ -	$ -
Vocational Rehabilitation & Employment (DME)	$ 1,197	$ -	$ -	$ -	$ -
Vocational Rehabilitation & Employment (OM)	$ 1,822	$ 2,280	$ 2,005	$ -	$ 19,880
Benefits Legacy VETSNET	**$ 20,225**	**$ 20,696**	**$ 22,077**	**$ -**	**$ 18,320**
VETSNET (DME)	$ 17,843	$ 17,843	$ 17,843	$ -	$ 12,057
VETSNET (OM)	$ 2,382	$ 2,853	$ 4,234	$ -	$ 6,263
Benefits Legacy Memorials Legacy Development Support	**$ 9,956**	**$ 12,000**	**$ 11,300**	**$ -**	**$ 13,552**
Memorials Legacy Development Support (DME)	$ 9,956	$ 11,000	$ 10,300	$ -	$ 11,352
Memorials Legacy Development Support (OM)	$ -	$ 1,000	$ 1,000	$ -	$ 2,200
Benefits IT Support	**$ 123,344**	**$ 163,463**	**$ 88,217**	**$ -**	**$ 164,259**
VBA & NCA Facility Activations (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Facility Activations (OM)	$ -	$ 1,500	$ -	$ -	$ 23,930
VBA & NCA Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Facility Operations Allowance (OM)	$ -	$ 1,182	$ -	$ -	$ 1,259
VBA & NCA Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Hardware Maintenance (OM)	$ 5,674	$ 12,839	$ 12,009	$ -	$ 13,674
VBA & NCA IT Infrastructure & Platform Upgrades (DI	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Infrastructure & Platform Upgrades (OI	$ -	$ 19,000	$ -	$ -	$ -
VBA & NCA IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Lifecycle Management (OM)	$ -	$ 11,200	$ -	$ -	$ -
VBA & NCA IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA IT Support Contracts (OM)	$ 92,045	$ 27,138	$ 45,824	$ -	$ 28,902
VBA & NCA Legacy Systems (DME)	$ -	$ -	$ -	$ -	$ -
VBA & NCA Legacy Systems (OM)	$ 15,721	$ 76,154	$ 17,884	$ -	$ 81,105
VBA & NCA Software License Maintenance (DME)	$ -	$ -		$ -	$ -
VBA & NCA Software License Maintenance (OM)	$ 4,595	$ 4,126	$ 4,729	$ -	$ 4,394
VBA & NCA Telecommunications (DME)	$ -	$ -		$ -	$ -
VBA & NCA Telecommunications (OM)	$ 5,310	$ 10,324	$ 7,771	$ -	$ 10,995
CORPORATE	**$ 774,407**	**$ 739,171**	**$ 754,168**	**$ -**	**$ 810,660**
Corporate 21st Century Core	**$ 49,167**	**$ 54,558**	**$ 62,366**	**$ -**	**$ 19,433**
Corporate 21st Century Core (DME)	$ -	$ -	$ 11,002	$ -	$ -
Corporate 21st Century Core (OM)	$ -	$ 11,548	$ -	$ -	$ -
Human Capital (Corporate Core) (DME)	$ 5,450	$ 9,100	$ 2,720	$ -	$ -
Human Capital (Corporate Core) (OM)	$ 7,235	$ 1,000	$ 12,273	$ -	$ 8,130
Human Resources & Administration (DME)	$ -	$ -	$ -	$ -	$ -
Human Resources & Administration (OM)	$ -	$ -	$ -	$ -	$ -
Innovations (DME)	$ 11,285	$ -	$ 11,000	$ -	$ -
Innovations (OM)	$ -	$ -	$ -	$ -	$ -
IOM (Corporate Core) (DME)	$ 17,516	$ 14,100	$ 17,950	$ -	$ -
IOM (Corporate Core) (OM)	$ 2,286	$ 1,800	$ 2,450	$ -	$ 1,950
SCIP (Corporate Core) (DME)	$ 1,124	$ 1,000	$ 1,000	$ -	$ -
SCIP (Corporate Core) (OM)	$ -	$ 3,162	$ 800	$ -	$ 800
STDP/EWCA (Corporate Core) (DME)	$ -	$ 4,062	$ -	$ -	$ -
STDP/EWCA (Corporate Core) (OM)	$ 4,272	$ 100	$ 3,171	$ -	$ 2,626

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	2012 Actual 1/	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Budget Estimate
VA Learning Management System (DME)	$ -	$ 5,540	$ -	$ -	$ -
VA Learning Management System (OM)	$ -	$ -	$ -	$ -	$ -
VA Talent Management System (DME)	$ -	$ -	$ -	$ -	$ -
VA Talent Management System (OM)	$ -	$ 3,146	$ -	$ -	$ 5,925
Enterprise Risk Management (ERM) (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Risk Management (ERM) (OM)	$ -	$ -	$ -	$ -	$ -
Financial Management System (FMS) Modernization (D	$ -	$ -	$ -	$ -	$ -
Financial Management System (FMS) Modernization (O	$ -	$ -	$ -	$ -	$ -
SCIP Enhancements (DME)	$ -	$ -	$ -	$ -	$ -
SCIP Enhancements (OM)	$ -	$ -	$ -	$ -	$ -
Section 508 Compliance Program (DME)	$ -	$ -	$ -	$ -	$ -
Section 508 Compliance Program (OM)	$ -	$ -	$ -	$ -	$ -
Corporate 21st Century E-Gov	**$ 22,884**	**$ 11,391**	**$ 17,226**	**$ -**	**$ 13,800**
E-Gov (DME)	$ -	$ 2,091	$ -	$ -	$ -
E-Gov (OM)	$ 22,884	$ 9,300	$ 17,226	$ -	$ 13,800
Corporate 21st Century SAM	**$ 925**	**$ 1,608**	**$ -**	**$ -**	**$ -**
SAM (DME)	$ -	$ -	$ -	$ -	$ -
SAM (OM)	$ 925	$ 1,608	$ -	$ -	$ -
Corporate IT Support ASD	**$ -**	**$ 2,835**	**$ 11,500**	**$ -**	**$ -**
ASD (DME)	$ -	$ 2,835	$ 3,500	$ -	$ -
ASD (OM)	$ -	$ -	$ 8,000	$ -	$ -
Enterprise Architecture (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Architecture (OM)	$ -	$ -	$ -	$ -	$ -
ProPath (DME)	$ -	$ -	$ -	$ -	$ -
ProPath (OM)	$ -	$ -	$ -	$ -	$ -
Corporate IT Support Enterprise Cyber Security & Privac	**$ 85,464**	**$ 141,000**	**$ 109,520**	**$ -**	**$ 123,258**
Cyber Security (DME)	$ -	$ -	$ -	$ -	$ -
Cyber Security (OM)	$ 23,498	$ 50,564	$ 45,942	$ -	$ 118,422
iEHR (Corporate IT Support Enterprise Cyber Security &	$ -	$ -	$ -	$ -	$ -
iEHR (Corporate IT Support Enterprise Cyber Security &	$ -	$ 14,000	$ -	$ -	$ -
NSOC (DME)	$ -	$ -	$ -	$ -	$ -
NSOC (OM)	$ 27,143	$ 45,437	$ 58,832	$ -	$ -
Privacy (DME)	$ -	$ -	$ -	$ -	$ -
Privacy (OM)	$ 3,438	$ 2,999	$ 4,746	$ -	$ 4,836
Secure VA (DME)	$ -	$ -	$ -	$ -	$ -
Secure VA (OM)	$ 31,386	$ 28,000	$ -	$ -	$ -
Trusted Internet Connects Refresh (DME)	$ -	$ -	$ -	$ -	$ -
Trusted Internet Connects Refresh (OM)	$ -	$ -	$ -	$ -	$ -
VA Enterprise Intrusion Detection Systems (DME)	$ -	$ -	$ -	$ -	$ -
VA Enterprise Intrusion Detection Systems (OM)	$ -	$ -	$ -	$ -	$ -
Corporate IT Support ITRM	**$ 32,000**	**$ 5,981**	**$ 62,072**	**$ -**	**$ -**
ITRM (DME)	$ -	$ 4,681	$ -	$ -	$ -
ITRM (OM)	$ 32,000	$ 1,300	$ 62,072	$ -	$ -
Corporate IT Support PBX Replacement	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
PBX Replacement (DME)	$ -	$ -	$ -	$ -	$ -
PBX Replacement (OM)	$ -	$ -	$ -	$ -	$ -
Corporate Legacy	**$ 4,493**	**$ 255**	**$ 3,497**	**$ -**	**$ -**
Capital Asset Management System (DME)	$ -	$ -	$ -	$ -	$ -
Capital Asset Management System (OM)	$ -	$ -	$ -	$ -	$ -
Financial Management System (FMS) (DME)	$ -	$ 130	$ -	$ -	$ -
Financial Management System (FMS) (OM)	$ 4,437	$ 125	$ 3,312	$ -	$ -
Payroll/HR System (DME)	$ -	$ -	$ -	$ -	$ -
Payroll/HR System (OM)	$ 56	$ -	$ 185	$ -	$ -

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	2012 Actual 1/	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Budget Estimate
Enterprise IT Support	**$ 579,474**	**$ 521,543**	**$ 487,987**	**$ -**	**$ 538,173**
Enterprise Facility Activations (DME)	$ 2,930	$ -	$ 2,710	$ -	$ -
Enterprise Facility Activations (OM)	$ -	$ 12,890	$ 750	$ -	$ 6,985
Enterprise Hardware Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Hardware Maintenance (OM)	$ 10,848	$ 24,068	$ 11,672	$ -	$ 14,982
Enterprise IT Infrastructure & Platform Upgrades (DME	$ -	$ -	$ -	$ -	$ -
Enterprise IT Infrastructure & Platform Upgrades (OM)	$ -	$ 10,400	$ -	$ -	$ -
Enterprise IT Lifecycle Management (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Lifecycle Management (OM)	$ 49,105	$ 9,100	$ 14,000	$ -	$ 22,305
Enterprise IT Support Contracts (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise IT Support Contracts (OM)	$ 232,809	$ 75,655	$ 80,942	$ -	$ 82,873
Enterprise Legacy Systems (DME)	$ -	$ -	$ 4,000	$ -	$ -
Enterprise Legacy Systems (OM)	$ 90,071	$ 53,557	$ 88,124	$ -	$ 57,038
Enterprise License Expenses (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise License Expenses (OM)	$ 101,008	$ 170,801	$ 112,209	$ -	$ 142,216
Enterprise Software License Maintenance (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Software License Maintenance (OM)	$ 11,521	$ 58,930	$ 27,243	$ -	$ 60,905
Enterprise Telecommunications (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Telecommunications (OM)	$ 64,521	$ 86,750	$ 103,923	$ -	$ 92,389
National Data Processing Center (DME)	$ -	$ -	$ -	$ -	$ -
National Data Processing Center (OM)	$ 16,660	$ 18,497	$ 42,414	$ -	$ 19,699
TAC Fees (DME)	$ -	$ -	$ -	$ -	$ -
TAC Fees (OM)	$ -	$ -	$ -	$ -	$ -
VACO Facility Operations Allowance (DME)	$ -	$ -	$ -	$ -	$ -
VACO Facility Operations Allowance (OM)	$ -	$ 895	$ -	$ -	$ 953
Enterprise Management Framework (DME)	$ -	$ -	$ -	$ -	$ -
Enterprise Management Framework (OM)	$ -	$ -	$ -	$ -	$ -
Product Development Tools (DME)	$ -	$ -	$ -	$ -	$ -
Product Development Tools (OM)	$ -	$ -	$ -	$ -	$ 37,265
SAM (DME)	$ -	$ -	$ -	$ -	$ -
SAM (OM)	$ -	$ -	$ -	$ -	$ 561
Enterprise Telephony Strategy	$ -	$ -	$ -	$ -	**$ 115,996**
Telephony (DME)	$ -	$ -	$ -	$ -	$ -
Telephony (OM)	$ -	$ -	$ -	$ -	$ 115,996
INTERAGENCY	**$ 222,404**	**$ 216,831**	**$ 353,059**	**$ 12,810**	**$ 556,758**
Federal Health Information Exchange	**$ 6,241**	**$ 7,341**	**$ 6,646**	**$ -**	**$ 7,818**
Federal Health Information Exchange (DME)	$ -	$ -	$ -	$ -	$ -
Federal Health Information Exchange (OM)	$ 6,241	$ 7,341	$ 6,646	$ -	$ 7,818
Interagency 21st Century - Veterans Interoperability	**$ 39,132**	**$ 43,826**	**$ 35,844**	**$ 2,744**	**$ 43,386**
Common Services (DME)	$ -	$ -	$ -	$ -	$ -
Common Services (OM)	$ -	$ -	$ -	$ -	$ 2,120
Federal Information Sharing Technologies (FIST) (DME)	$ 20,483	$ 29,938	$ -	$ -	$ -
Federal Information Sharing Technologies (FIST) (OM)	$ 12,651	$ 2,000	$ -	$ -	$ -
ITRM (DME)	$ -	$ -	$ -	$ -	$ -
ITRM (OM)	$ -	$ -	$ -	$ -	$ -
Repositories (DME)	$ 529	$ -	$ -	$ 2,744	$ -
Repositories (OM)	$ -	$ 2,888	$ -	$ -	$ 35,063
Standards and Terminology Services (STS) (DME)	$ 775	$ -	$ -	$ -	$ -
Standards and Terminology Services (STS) (OM)	$ -	$ -	$ 4,803	$ -	$ 4,326
VLER Services (DME)	$ -	$ 5,500	$ 27,057	$ -	$ -
VLER Services (OM)	$ 4,694	$ 3,500	$ 3,984	$ -	$ 1,876

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	2012 Actual 1/	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Budget Estimate
InterAgency 21st Century Core	**$ 22,962**	**$ 35,213**	**$ 170,927**	**$ 8,125**	**$ 343,614**
Common Services (DME)	$ -	$ -	$ -	$ -	$ -
Common Services (OM)	$ 1,870	$ 1,213	$ 1,927	$ -	$ -
iEHR (Interagency 21st Century Core) (DME)	$ 21,091	$ 34,000	$ 133,550	$ 8,125	$ -
iEHR (Interagency 21st Century Core) (OM)	$ -	$ -	$ 35,450	$ -	$ -
iEHR - Health Provider Systems (DME)	$ -	$ -	$ -	$ -	$ -
iEHR - Health Provider Systems (OM)	$ -	$ -	$ -	$ -	$ -
iEHR - Laboratory (DME)	$ -	$ -	$ -	$ -	$ 5,000
iEHR - Laboratory (OM)	$ -	$ -	$ -	$ -	$ 5,584
iEHR - Pharmacy (DME)	$ -	$ -	$ -	$ -	$ 4,000
iEHR - Pharmacy (OM)	$ -	$ -	$ -	$ -	$ 8,775
iEHR - Scheduling (DME)	$ -	$ -	$ -	$ -	$ 30,000
iEHR - Scheduling (OM)	$ -	$ -	$ -	$ -	$ -
iEHR (Corporate IT Support Enterprise Cyber Security &	$ -	$ -	$ -	$ -	$ -
iEHR (Corporate IT Support Enterprise Cyber Security &	$ -	$ -	$ -	$ -	$ -
iEHR (DME)	$ -	$ -	$ -	$ -	$ 197,082
iEHR (OM)	$ -	$ -	$ -	$ -	$ 70,672
VLER Health (DME)	$ -	$ -	$ -	$ -	$ 15,800
VLER Health (OM)	$ -	$ -	$ -	$ -	$ 6,701
InterAgency 21st Century Enrollment System Redesign	**$ 7,140**	**$ 6,445**	**$ -**	**$ -**	**$ -**
Enrollment (DME)	$ -	$ 3,221	$ -	$ -	$ -
Enrollment (OM)	$ -	$ 624	$ -	$ -	$ -
Enrollment System Modernization (DME)	$ 3,250	$ -	$ -	$ -	$ -
Enrollment System Modernization (OM)	$ 3,890	$ 2,600	$ -	$ -	$ -
InterAgency 21st Century One Vet	**$ 124,057**	**$ 114,830**	**$ 131,167**	**$ 1,941**	**$ 155,350**
Veterans Relationship Management (DME)	$ 82,069	$ 96,218	$ 82,713	$ -	$ 120,157
Veterans Relationship Management (OM)	$ 16,487	$ 18,612	$ 38,394	$ 1,941	$ 35,194
E-Authentication (DME)	$ -	$ -	$ -	$ -	$ -
E-Authentication (OM)	$ -	$ -	$ -	$ -	$ -
VBA Transformational Initiatives (DME)	$ -	$ -	$ -	$ -	$ -
VBA Transformational Initiatives (OM)	$ -	$ -	$ -	$ -	$ -
Warrior Support (DME)	$ 24,724	$ -	$ 8,500	$ -	$ -
Warrior Support (OM)	$ 778	$ -	$ 1,560	$ -	$ -
InterAgency 21st Century PIV	**$ 22,872**	**$ 9,176**	**$ 8,475**	**$ -**	**$ 6,590**
Safety & Security Initiative (PIV for HSPD-12) (DME)	$ 16,154	$ 3,025	$ 3,775	$ -	$ -
Safety & Security Initiative (PIV for HSPD-12) (OM)	$ 6,718	$ 6,151	$ 4,700	$ -	$ 6,590
Total IT Activities	**$ 2,166,444**	**$ 2,306,445**	**$ 2,155,949**	**$ 29,610**	**$ 2,656,944**
H1N1 Supplemental (P.L. 111-32)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OEF/OIF Supplemental (P.L. 110-28)	**$ -**	**$ -**	**$ -**	**$ 248**	**$ -**
Staffing and Administration	**$ 910,572**	**$ 1,021,000**	**$ 975,000**	**$ 3,568**	**$ 1,026,400**
Total Budget Authority	**$ 3,077,016**	**$ 3,327,444**	**$ 3,130,949**	**$ 33,426**	**$ 3,683,344**
IT Activities Reimbursements	$ 58,616	$ 28,000	$ 97,521	$ -	$ 173,673
Staffing Reimbursements	$ 13,227	$ 19,000	$ 12,479		$ 12,895
Total Reimbursements	**$ 71,843**	**$ 47,000**	**$ 110,000**	**$ -**	**$ 186,568**
Total BA and Reimbursements	**$ 3,148,859**	**$ 3,374,444**	**$ 3,240,949**	**$ 33,426**	**$ 3,869,912**
Transfers 2/	$ (6,605)	$ -	$ -	$ -	$ -
Net Change in Unobligated Balance 3/	$ 102,515	$ -	$ -	$ -	$ -
Unobligated Balance Expiring (Lapse)	$ (1,395)	$ -	$ -	$ -	$ -
Adjustments	$ 883	$ -	$ -	$ -	$ -
Obligations	**$ 3,244,257**	**$ 3,374,444**	**$ 3,240,949**	**$ 33,426**	**$ 3,869,912**
BA FTE	7,210	7,435	7,435		7,355
Reimbursable FTE	101	145	101		104
Total FTE	**7,311**	**7,580**	**7,536**		**7,459**
DME	**$ 570,293**	**$ 494,399**	**$ 518,962**	**$ 27,670**	**$ 495,291**
OM	**$ 1,596,151**	**$ 1,812,046**	**$ 1,636,987**	**$ 1,941**	**$ 2,161,653**
Total IT Activities	**$ 2,166,444**	**$ 2,306,444**	**$ 2,155,949**	**$ 29,611**	**$ 2,656,944**

Information and Technology
Appendix 2 -- Program Level Detail
(Dollars in Thousands)

	2012 Actual 1/	2013 Budget Estimate	2013 Continuing Resolution	2012 / 2013 2nd Year Carryover	2014 Budget Estimate
Non-Pay Reimbursements	**$ 58,616**	**$ 28,000**	**$ 97,521**	**$ -**	**$ 173,673**
Enrollment Enhancements	$ 3,973	$ 5,000	$ -	$ -	$ -
Enrollment Operations and Maintenance	$ 18	$ 800	$ -	$ -	$ -
Federal Health Information Exchange	$ -	$ -	$ -	$ -	$ -
North Chicago Activations	$ -	$ -	$ -	$ -	$ -
VHA Miscellaneous (Small/Other)	$ -	$ -	$ -	$ -	$ -
Medical and Prosthetic Research	$ -	$ 1,100	$ -	$ -	$ -
BHIE DoD to VA FY 2010 Fund Transfer	$ 6,617	$ 3,400	$ 6,600	$ -	$ 6,600
RB Licensing & Certification	$ -	$ -	$ 157	$ -	$ -
RB On Job Training	$ -	$ -	$ 2,188	$ -	$ -
VRAP Education Training	$ 120	$ -	$ 1,880	$ -	$ 12
Loan Guaranty	$ 12,651	$ 8,500	$ 16,142	$ -	$ 26,502
Insurance	$ 4,196	$ 1,600	$ 6,723	$ -	$ 6,728
IT Support for HR&A	$ -	$ 3,500	$ -	$ -	$ -
IT Support (Housing and Insurance)	$ -	$ -	$ -	$ -	$ -
IT Support for Insurance	$ -	$ 800	$ -	$ -	$ -
Franchise Fund	$ -	$ 3,300	$ -	$ -	$ -
Interagency Program Office	$ 27,832	$ -	$ 60,000	$ -	$ 130,000
VA/Indian Health Services	$ 250	$ -	$ -	$ -	$ -
IT Support of HR&A	$ 2,959		$ 3,831	$ -	$ 3,831

1/ Numbers reflect FY 2012 Actual.

2/ In FY 2012 $6,605 was a transfer to the North Chicago facility.

3/ In FY2012 SF-133 shows $107M for unobligated balance EOY which includes $5M of uncollected orders.

Appendix 3 MTI Funding

Information and Technology
Appendix 3 - Funding for Major Transformational Initiatives FY 2012-2014
(Dollars in Thousands)

Major Transformational Initiatives	2012 Actual	2013 Budget Estimate	2013 Continuing Resolution	2014 Budget Estimate	2012-2014 Increase/ Decrease
Veterans Relationship Management (VRM)	$ 102,617	$ 110,925	$ 95,590	$ 141,957	$ 39,340
Automate GI Bill Benefits	$ 64,175	$ -	$ 4,400	$ -	$ (64,175)
New Models of Health Care (NMHC)	$ 35,904	$ 36,825	$ 45,410	$ 37,849	$ 1,945
Veterans Benefits Management System (VBMS)	$ 149,833	$ 92,253	$ 116,331	$ 36,482	$ (113,351)
Establish strong VA management infrastructure and Integrated Operating Model (IOM)	$ 19,802	$ 33,690	$ 19,900	$ -	$ (19,802)
Virtual Lifetime Electronic Record (VLER)	$ 61,912	$ 52,939	$ 48,733	$ 13,552	$ (48,360)
Transform health care delivery through health informatics	$ 7,952	$ 9,156	$ 8,685	$ 7,774	$ (178)
Health Care Efficiency: Creating Organizational Value by Reducing Cost While Maintaining Quality (HCE)	$ 8,840	$ 6,659	$ 8,689	$ -	$ (8,840)
Enhance the Veteran Experience and Access to Healthcare (EVEAH)	$ 50,446	$ 71,750	$ 24,814	$ 6,409	$ (44,037)
Transform human capital management via Human Capital Investment Plan (HCIP)	$ 10,237	$ 15,640	$ 2,720	$ -	$ (10,237)
Eliminate Veteran Homelessness	$ 5,500	$ 3,954	$ 3,793	$ -	$ (5,500)
Improve Veterans Mental Health	$ 6,476	$ 9,128	$ 5,844	$ 1,095	$ (5,381)
Optimize the utilization of VA's Capital Portfolio by implementing and executing the Strategic Capital Investment Planning (SCIP) process	$ 1,124	$ 4,162	$ 1,800	$ -	$ (1,124)
Ensure Preparedness to meet emergent national needs	$ 19,084	$ 14,515	$ 11,342	$ -	$ (19,084)
Enabling Systems to Drive Performance and Outcomes (STDP)	$ -	$ 4,162	$ -	$ -	$ -
Perform Research & Development (R&D) to enhance the long-term health and well-being of Veterans	$ 20,623	$ 22,186	$ 15,153	$ -	$ (20,623)
TOTAL	**$ 564,525**	**$ 487,944**	**$ 413,203**	**$ 245,118**	**$ (319,407)**

Note: This table represents DME and Marginal Sustainment funding for the MTI's.