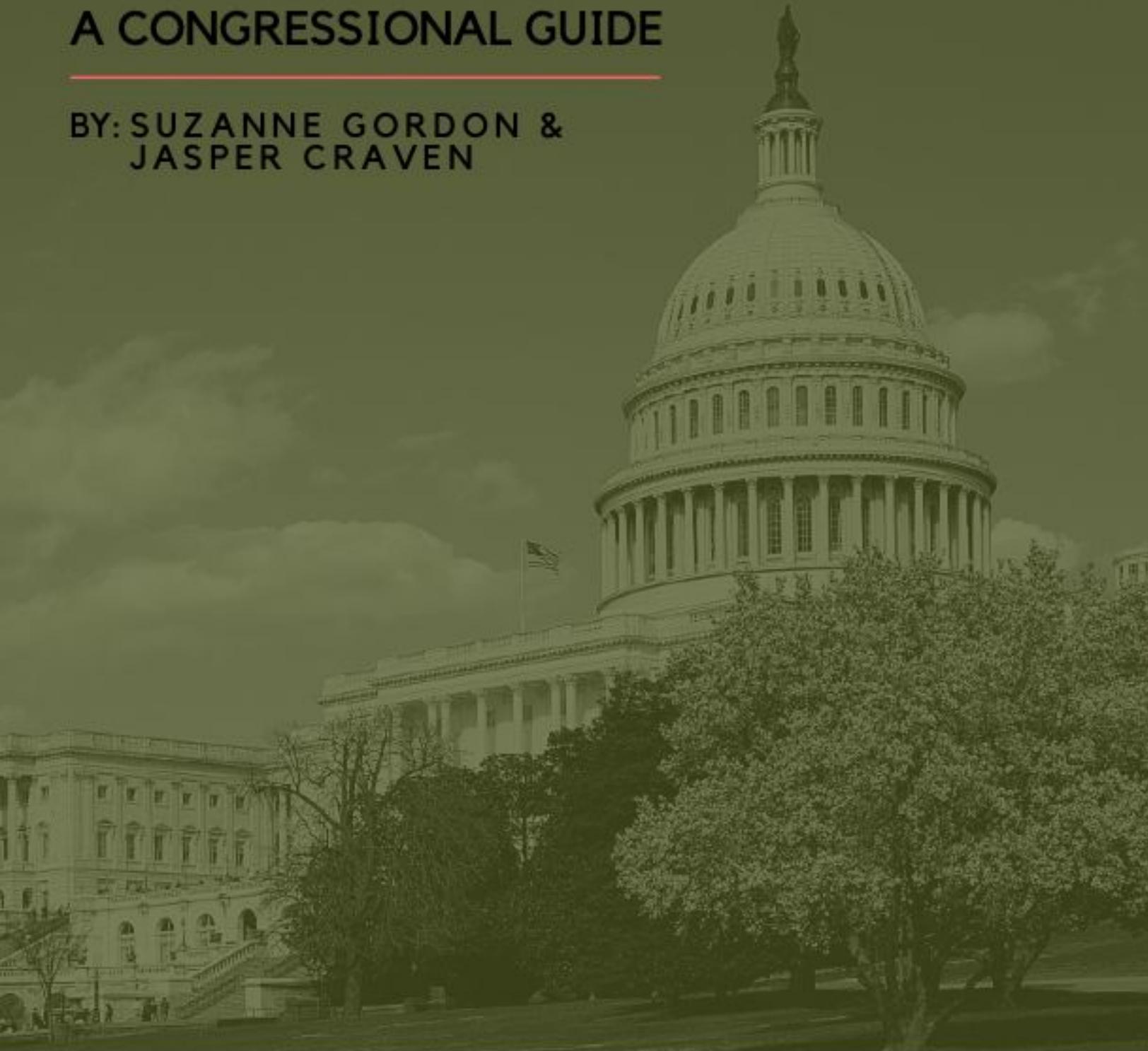


VETERANS HEALTHCARE

A CONGRESSIONAL GUIDE

BY: SUZANNE GORDON &
JASPER CRAVEN



Veterans
Healthcare
Policy
Institute

Strengthening Care for Veterans and the Nation

A 501(C)3 non-partisan non-profit

2021

www.veteranspolicy.org

Table of Contents

Letter from the Authors	5
Letter from the VHPI President	6
About the Department of Veterans Affairs (VA)	7
The Veterans Health Administration (VHA)	7
The Veterans Benefits Administration (VBA)	7
The National Cemetery Administration (NCA)	8
The VA Office of Information Technology (OIT)	8
	9
How the VA is Funded	10
The Four Missions of the Veterans Health Administration	11
Delivering Health Care	11
Research	11
Teaching	11
The VA's Fourth Mission – Emergency Management	12
	12
The VA Workforce	13
Who is eligible for VHA Care?	14
VA Care and Claim Appeals	16
VHA Enrollment Exceptions	17
Discharge Status	17
Other Eligibility Exceptions and Recent Changes	18
Establishing Eligibility for VHA Care	18
The VHA's Patient Profile	20
Veterans and Chronic Pain	21
Other Common Conditions Among Veterans	21
VHA's Enhanced Access to Services and its Integrated Health Care Model	22
	25
Women Veterans	26
Three Models of VHA Care for Women Veterans	26
VHA's Integrated Health Care Model	28
Telehealth Capacity	28
Pioneering the Primary Care Model	28
Primary Care and Mental Health	30

Rehabilitation Services	30
VHA's Electronic Health Record	31
VA Mental Health Services	31
Providing Mental Health Care for Chronic Conditions	32
VHA Mental Health Care vs. Non-VA Mental Health Care	33
Military Sexual Trauma (MST)	33
MST Key Statistics	33
Post-Traumatic Stress Disorder (PTSD)	34
Common PTSD Symptoms	34
PTSD Key Statistics	34
The VA's National Center for PTSD	34
Identifying, Diagnosing, and Treating PTSD	35
	36
Veteran Suicide and Prevention	37
Identifying At-Risk Veterans	37
Employee Training and Outreach	37
Veterans Crisis Line (VCL)	38
Mobile Apps and Other Programs	38
Firearm Safety and Suicide Prevention	39
The PREVENTS Initiative	40
Veterans' Health Care and Opioids	40
VHA Compared to the Private Sector	41
Readjustment to Civilian Life	43
Vet Centers	43
Veterans Integration to Academic Leadership (VITAL)	43
Veterans Justice Outreach Program	43
Homelessness	43
Centers of Excellence and Other Innovations	45
Geriatric Care	45
Palliative Care	46
How the VHA Rates its Facilities	47
Residual Problems from the Star Rating System	47
SAIL ratings often failed to include critical areas of performance	47

Focus of the SAIL Metrics	48
Impact of COVID-19 on VA Metrics	48
The Choice Program	49
The VA MISSION Act	51
The John Scott Hannon Mental Health Care Act	54
Health Care Shortages	56
Facility Closures	57
The VHA Compared to the Private Sector	58
Quality	58
Wait Times	58
Salaried Employees vs. Fee-for-Service	59
Availability, Access, and Duration of Service	59
Best Practices	59
Specialized Treatment Programs for PTSD	59
Military Cultural Competency	59
Best Practices During Covid-19 Pandemic	60
Veterans Prefer the VA to Non-VA Care	62
Acronyms	63



If you are a veteran in crisis or know a veteran in crisis:

Dial 1-800-273-8255

Press 1 to talk to someone

Or:

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

Or:

Visit www.VeteransCrisisLine.net¹ for additional resources (*Learn more about the Veterans Crisis Line on page 23 of this guide. Another fantastic resource is the Academy Award winning HBO film: “Veterans Press 1.”*)

VA Topic	Phone	Website
Homeless Veterans	877-424-3838	https://www.va.gov/HOMELESS/NationalCallCenter.asp
Vet Center Counseling	877-927-8387	https://www.vetcenter.va.gov/
Women Veterans	855-829-6636	https://www.va.gov/womenvet/
Healthcare Enrollment	877-222-8387	https://www.vets.gov/health-care/eligibility/
Minority Veterans	202-461-6191	https://www.va.gov/centerforminorityveterans/

¹ "Support for Veterans and Servicemembers | Veterans Crisis Line." <https://www.veteranscrisisline.net/Resources/>. Accessed 29 Apr. 2019.

Letter from the Authors

Lawmakers are faced with critical and complex issues when they are assigned to the House or Senate Committees on Veterans Affairs or serve on other committees that oversee matters pertaining to the health and well-being of former military members. Whether or not they serve on a committee that directly monitors the VA, all lawmakers must vote on bills that affect oversight and impact funding over the largest publicly funded U.S. healthcare system. Legislative staff are also asked to help veteran constituents navigate the VA benefits and healthcare systems.

An accurate understanding of how the VA works is critical if political representatives are to pass needed legislation and effectively monitor and oversee its implementation and impact. This guide provides essential facts, dispels common misconceptions and answers frequently asked questions about the Veterans Health Administration (VHA), the system that provides healthcare for millions of veterans, and the Veterans Benefits Administration (VBA), the agency within VA that processes benefit claims.

In most instances, a veteran must file and win a disability benefit claim with VBA before obtaining free VHA medical care. That's why most of the initial calls from veterans and families in your district or state focus on veteran challenges with VBA delays and errors. The information in this guide is designed to provide you with a general overview of VBA's compensation benefits. Easy-to-access links are provided to VBA's other benefits, as the laws for the benefits are frequently updated by Congress and the regulations are regularly updated by VA.

Often, discussions about the VA revolve around a particular problem or a specific incident or situation. But many are unaware of the complexity, sophistication, and range of high-quality services the VA provides. The VA's comprehensive health care and benefits system features a vast array of services, which is why the VHA is the only healthcare system in America to focus on what are known as social determinants of health and [healthcare inequities](#).

As elected representatives work to assure that the VA effectively serves the nation's veterans today and into the future, they face an environment that is more politicized than ever. Although for the last several decades, VHA care has consistently been rated or equal or superior to private sector care, it is jeopardized by the increasing privatization of essential agency services. This will have negative impacts on today's veterans -- old and young -- as well as those who participate in future armed conflicts. Efforts to dismantle and outsource VA services also jeopardize non-veterans who, as we have seen during the Covid-19 pandemic, depend on the VA's Fourth Mission as backup to the nation's civilian sector healthcare facilities.

We hope this guide will help members of Congress provide the care and advice that veterans need and deserve.

Suzanne Gordon
Senior Policy Analyst

Jasper Craven
Policy Fellow and Interim Executive Director



The Veterans Healthcare Policy Institute



Letter from the VHPI President

Welcome to the 2021 edition of the Congressional Guide to Veterans' Health Care. Founded in 2016, our non-partisan, non-profit think produces objective, evidence-based research and analysis about veterans and their health care and other benefits. During conversations with members of Congress and their staff, members of the media, and many veterans, we've found that veterans' health care issues are often misunderstood.

That is where this guide comes in. In it, you will find the topics that most often come up in the media and in House and Senate deliberations. It is not an exhaustive encyclopedia. Instead, it presents the necessary information required to gain a good understanding of who veterans are and how the health care and benefit systems dedicated to their complex and specific needs actually works.

VHPI is committed to helping congressional representatives provide excellent constituent services and effective stewardship of taxpayer dollars while ensuring veterans get the high quality, veteran-centric, and evidence-based care they deserve. Please do not hesitate to contact us at ExecDirector@VeteransPolicy.org if you ever need assistance digging deeper into a topic or analyzing legislative initiatives that come across your desk.

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

Paul Cox
President
The Veterans Healthcare Policy Institute

About the Department of Veterans Affairs (VA)

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

The Veterans Health Administration (VHA)

The [Veterans Health Administration \(VHA\)](#)² is the largest of the agencies in the VA. It resembles the health care systems of almost all other industrialized nations: a full-service health care system that both pays for and delivers all types of care to those it serves.

The VHA delivers care to roughly nine million eligible veterans at over 1,255 facilities³, including acute care hospitals, outpatient clinics, rehabilitation facilities, nursing homes, inpatient residential programs, and campus and community-based centers. The VHA operates 171 medical centers and is organized into a regional network of 22 Veterans Integrated Service Networks (VISNs), each with a regional director. Each medical center or health care system, which comprises a medical center and affiliated Community Based Outpatient Clinics (CBOCs), also has a director.

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

The Veterans Benefits Administration (VBA)

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

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

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

- [Disability Compensation](#)
- [Pension](#)

² "Veterans Health Administration - VA.gov." <https://www.va.gov/health/>. Accessed 29 Apr. 2019.

³ "Veterans Health Administration - Locations - VA.gov." <https://www.va.gov/directory/guide/division.asp?dnum=1>. Accessed 29 Apr. 2019.

- [Education & Training](#) ~ often called the “GI Bill”
- [Readiness & Employment](#) ~ formerly known as Vocational Rehabilitation and Employment
- [Home Loans](#) ~ formerly known as Loan Guaranty and part of the “GI Bill”
- [Life Insurance](#)

Eligibility and entitlement to veteran benefits are also determined by VA, in part, by the type of discharge each veteran receives when discharged from the military. This is discussed separately on Page 11.

The National Cemetery Administration (NCA)

The [National Cemetery Administration](#)⁴ provides burials for eligible veterans and maintains the national cemeteries. The NCA also provides grants to support 118 state-owned veteran cemeteries in 48 states and several territories.

The VA Office of Information Technology (OIT)

The [VA Office of Information Technology \(OIT\)](#)⁵ is an elevated sub-agency under the VA structure. The OIT works to ensure the seamless sharing of critical information between the sub-agencies. Unlike the VHA and VBA, OIT is not led by an undersecretary. OIT is primarily responsible for VistA, the VA’s legacy health-record system, and the new Electronic Health Record Modernization project with the Cerner Corporation.

 VA Benefits & Health Care Utilization	
Updated 1/22/2021	
Number of Veterans Receiving VA Disability Compensation (as of 12/31/2020):	5.11 M
Number of Veterans Rated 100% Disabled (as of 12/31/2020):	884,178
Number of Veterans Receiving VA Pension (as of 12/31/2020):	212,177
Number of Spouses Receiving DIC (as of 12/31/2020):	430,345
Number of Total Enrollees in VA Health Care System (FY 20):	9.16 M¹
Number of Total Unique Patients Treated (FY 20):	6.45 M¹
Number of Veterans Compensated for PTSD (as of 12/31/2020):	1,199,098
Number of Veterans in Receipt of IU Benefits (as of 12/31/2020):	373,896
Number of VA Education Beneficiaries (FY 20):	875,060
Number of Life Insurance Policies Supervised and Administered by VA (as of 12/31/2020):	5.63 M
Face Amount of Insurance Policies Supervised and Administered by VA (as of 12/31/2020):	1.18 T
Number of Veterans Participating in Voc Rehab (Chapter 31) (FY 20):	123,490³
Number of Active VA Home Loan Participants (as of 12/31/2020):	3.47 M
Number of Health Care Professionals Rotating Through VA (Academic Year (AY) 19-20):	117,993
Number of Veterans with Major/Minor Amputations Utilizing VA Health Care (FY 20):	96,681²
<small>Source: VBA Office of Performance Analysis and Integrity; Health Services Training Report; VBA Education Service; ¹ VHA OAABI and VSSC (10E2A); ² VA VSSC Amputation Cube; ³ Includes 1,362 Veterans in interrupted case status over one year. Produced by the National Center for Veterans Analysis and Statistics. http://www.va.gov/vetdata/pocketcard/index.asp</small>	

⁴ "National Cemetery Administration - VA.gov." <https://www.cem.va.gov/>. Accessed 29 Apr. 2019.

⁵ "VA OIT - VA.gov." 6 Jan. 2019, <https://www.oit.va.gov/>. Accessed 29 Apr. 2019.

Veterans Demographics

Projected U.S. Veterans Population:	19,541,961	{Female 2,030,586 10.4%}
Projected Number of Living WW II Veterans:		325,574
Estimated Number of WW II Veterans Pass Away Per Day:		296
Percentage of Veteran Population 65 or Older:		46.1%
Veteran Population by Race:	White 80.5%	Black 12.7%
	Asian/Pacific Islander 2.1%	Other 3.9%
	American Indian/Alaska Natives 0.8%	Hispanic 8.2%

About VA

Number of Full Time VA Employees Employees in Pay Status:	396,841 424,939
Number of VA Medical Centers (VAMC):	171
VAMC with Acute Inpatient Care Services:	145
Number of VA Outpatient Sites:	1,283¹
Number of VA Vet Centers:	300
Number of VBA Regional Offices:	56
Number of VA National Cemeteries:	153

FY2019 Appropriations (enacted)²	FY2020 Appropriations (requested)^{2/5}	FY2021 Appropriations (enacted)²
VA: \$197.97B	VA: \$218.43B	VA: \$246.17B
VHA: \$77.67B³	VHA: \$84.10B³	VHA: \$95.26B³
VBA-GOE: \$2.96B⁴	VBA-GOE: \$3.00B⁴	VBA-GOE: \$3.16B⁴
NCA: \$316M	NCA: \$329M	NCA: \$397M
OIT: \$4.10B	OIT: \$4.34B	OIT: \$4.88B

Source: Veteran Population (VP2018) as of 9/30/2020; VA Employ Pay Status Count 12/31/2020; Veterans Affairs Site Tracking (VAST) 12/31/2020 ¹(Does not include temporarily deactivated sites); NCA as of 12/31/2020; Office of Budget; Health Services Training Report AY18-19; ² Includes MCCF; ³ Medical Care w/ MCCF, joint, medical research; ⁴ Discretionary Spending Only; ⁵ Does not include COVID supplemental funding received via P.L. 116-127/116-36.



How the VA is Funded

Each year, the President submits an [annual budget request](#) to Congress that includes an itemization of the funding the Administration seeks to provide veterans' needed care. Submission of the VA budget request begins a complex process of funding veterans' care that also includes three different committees in both the House and Senate: the Veterans' Affairs, Budget, and Appropriations Committees. In addition, a group of Veterans Service Organizations (VSOs) release their own [independent budget](#) recommendations.

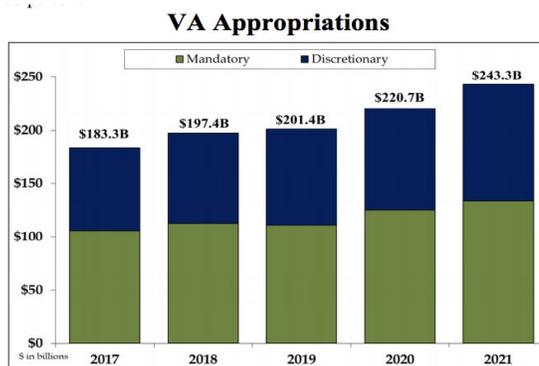
The VHA budget takes account of both the number of veterans its facilities serve as well as the complexity of patients' clinical needs. In general, if fewer – and less complex – veterans are served, the budget allocation is reduced. If more – and more complex – veterans are served, it is increased.

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

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

While Congress has continued to increase the VA budget steadily in recent years, some crucial programs have experienced cuts, and much new money is going out to private sector care, raising serious concerns that taxpayer dollars will be shifted from a successful public program to private sector providers whose services may be of lower quality and whose costs are often excessive. Many also argue that current allocations are not enough to support the surge of post-9/11 veterans as well as those veterans who experience unemployment and loss of health insurance due to the Covid-19 pandemic.

More about the [VA Budget](#)⁶:



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Mandatory	66.4	65.5	74.8	102.4	95.1	92.5	105.5	112.3	110.9	124.7	133.8
Discretionary	56.3	58.5	61.4	63.4	65.1	70.9	74.3	81.6	86.6	92.0	105.0
Medical Collections (MCCF)	2.8	2.8	2.9	3.1	3.2	3.5	3.5	3.5	3.9	3.9	4.5
Total VA	125.5	126.8	139.1	168.9	163.5	166.9	183.3	197.4	201.4	220.6	243.3

Mandatory amounts include \$15 billion provided by the Veterans Choice Act in 2014, \$2.1 billion in 2017 and \$7.3 billion in 2018. Totals may not add due to rounding.

⁶ "VA Plans, Budget, and Performance - VA.gov." <https://www.va.gov/performance/>. Accessed 29 Apr. 2019.

The Four Missions of the Veterans Health Administration

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

Delivering Health Care

The VHA cares for veterans in over 1,255 different sites of care, including 171 medical centers, 740 CBOCs, and other facilities that assist more than [230,000 people every day](#). To increase its capacity and improve access, the VHA has become a global leader in telehealth. Care providers can conduct appointments in everything from physical therapy and audiology to mental health and primary care via the telehealth program.

Research

The [VHA is a research powerhouse](#) uniquely positioned to conduct [innovative studies](#) because it has more patients it can track consistently over a longer period of time than any other health care system. VHA [research](#) innovations have included the shingles vaccine, the nicotine patch, the first implantable cardiac pacemaker, and the use of beta blockers to reduce postoperative mortality rates. The VA's [Million Veteran Program](#), which is investigating how genes impact health, has established the largest genomic database in the world.

Teaching

The VHA is affiliated with more than 1,800 educational institutions. The agency invests \$900 million annually to provide education and instruction to health care professionals in training. More than [70 percent of the nation's doctors](#) have received training in the VA. The VA also trains many healthcare professionals, including psychologists, social workers, nurses, and physical therapists.

At the VHA, future health care professionals learn how to perform concrete tasks, like – among many others – taking a patient's history, doing a physical exam, making the correct diagnosis, determining the best treatment plan, or educating patients about how to take medications, exercise, or lose weight. The cutting-edge training includes lessons in interprofessional teamwork and the use of telehealth, in which the VA is a global leader. The VHA also runs one of the largest U.S. medical simulation centers – [The VHA SimLEARN National Simulation Center](#).

VHA training is far broader than that provided in civilian sector health care training institutions. The VHA considers a patient's non-medical concerns like housing, employment, and legal issues. Significant changes in the veterans' health care system would cause severe disruption to the programs that teach health care professionals in the United States.

The VA's Fourth Mission – Emergency Management

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

To cite only a few examples: VHA facilities created command posts and conducted outreach to thousands of veterans in fire zones during the 2018 California wildfires. Employees made sure veterans had needed medications and medical equipment, were able to get to or reschedule appointments, and had access to services when the disaster was over. In Puerto Rico, the [VHA hospital was one of the only functioning facilities](#) during and after Hurricane Maria. The VHA provided crucial health services to veterans in Puerto Rico and throughout the Caribbean.

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

As we will discuss below, the VA's Fourth Mission was successfully implemented during the Covid-19 pandemic and will be ongoing as the nation recovers from the economic and healthcare impacts of a situation we have not encountered for over a century.



The VA Workforce

The VA has a salaried staff of roughly [350,000 individuals](#). Of these, an estimated 300,000 work at the VHA, including physicians, nurses, psychologists, and other health care professionals. Clerks, coders, transport workers, housekeepers, and many others also support and enhance the care of veterans.

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

One of the agency's chronic problems is staff shortages, which are detailed quarterly at this [link](#). In late 2020, the agency reported it had nearly 33,000 vacancies. VHPI has written [a detailed report](#) on the extent and causes of the VA vacancy crisis.

The department's many vacancies are, in part, due to the nationwide health care worker shortage. However, the agency faces more acute issues in recruitment and retention of staff than the private sector. The VA is generally prohibited from offering the same competitive wages as many top private facilities across the country. Moreover, many potential recruits are lost because of frustration with the federal government's complex, lengthy, and inconsistent hiring processes.



Who is eligible for VHA Care?

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

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

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

Due to the barriers and the complexities of the enrollment and claim processes, veterans should be encouraged to seek assistance from a [VSO accredited by VA](#) to make sure the veteran submits the correct VA form to the correct VA agency – VHA or VBA. Veterans should be discouraged from seeking assistance from for-profit companies that charge fees and are not accredited by VA.

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

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

1. Apply to VHA using [VA Form 10-10EZ](#). This is VHA's *enrollment* form that, when approved by VHA, opens the door only to VHA care. Veterans should pay close attention to Section II, "Military Service Information," because there are ten different items that, when checked "yes," may expedite care or lower costs. For example, [VHA provides free care for up to five years after discharge to veterans who deployed to a war zone since 1998](#).
2. Apply to VBA using [VA Form 21-526EZ](#). This is a VBA disability *compensation* claim form that, when approved by VBA, opens the door to both VHA care and VBA compensation payments. VBA pays compensation to veterans for medical conditions associated with military service.

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

VA recently created a website to search for the [correct VA forms](#) for each benefit.

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

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

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

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

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

A veteran’s VBA compensation claim status, referred to by VBA as “service connection,” is a [percentage rating, from zero to 100 percent](#). As of December 2, 2020, a single veteran with a 10 percent rating receives \$144.14 per month. VBA pays a single veteran with a 100 percent rating \$3,146.42 per month.

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

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

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

VA Care and Claim Appeals

Because of lack of adequate training VHA and VBA often make errors determining eligibility for care or when deciding a disability benefit claim. Because of lack of sufficient staff, delays are also common. Between 2004 and 2013, VBA faced a massive backlog of disability claims and high VA error rates. Thus, veterans often waited years for a decision, especially if a veteran filed an appeal.

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

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

Board of Veterans' Appeals: If VHA or VBA continue to deny a veteran benefits or access to care, then a veteran can file an appeal with VA's [Board of Veterans' Appeals](#) (Board), located

in Washington, DC. Veterans are encouraged to seek out a VSO so that the correct VA form is submitted to the Board within the appeal period, usually one year from the date of the VBA or VHA decision. The Board also considers appeals for all of VBA's other benefits, including education benefits under the GI Bill.

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

VHA Enrollment Exceptions

There are two significant exceptions to the VHA enrollment rule for a veteran.

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

The second exception is outpatient counseling from a VA Vet Center.

Learn more about the unique rules obtaining [Vet Center care](#) by visiting their web site or by calling 877-927-8387. See page 36 for additional details.

Discharge Status

“Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans, active duty service members, including National Guard and Reserve components, and their families.”

-VetCenter.VA.Gov
www.vetcenter.va.gov

A former service member's discharge status (Honorable, General, Other Than Honorable, Bad Conduct, Dishonorable) is one consideration determining VBA benefit eligibility and is a common barrier to care and benefits.

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

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

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

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

Some veterans' advocates are asking Congress and VA to expand care to this group of veterans. Former [VA Secretary David Shulkin ordered VHA to provide 90 days of emergency mental health treatment to veterans with bad paper](#). VA is also required to inform veterans with "bad paper" about these new eligibility rules. However, this mandate has not been uniformly implemented as of this writing. Swords to Plowshares and several other groups have asked the VA to revise the way it deals with Character of Discharge Reviews. So far the VA has not responded positively to this [petition for a rule-making change](#).

Other Eligibility Exceptions and Recent Changes

On February 26, 2019, former VA Secretary Robert Wilkie announced that veterans with a Purple Heart medal be [in the top-priority category](#) for disability claims starting in April 2019.

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

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

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

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

Establishing Eligibility for VHA Care

Establishing eligibility for VA benefits requires the veteran to file a specific form for each benefit with VBA. This is always the case if veterans seek financial compensation for service-connected disabilities. When a veteran files a claim, VBA scans all of the documents into a computer system for processing, as VBA rarely uses paper claim files. Although a veteran may live in one state and file a claim in that state, VBA's "National Work Queue" allows VBA to process any claim, in whole or in part, at any VBA Regional Office. Also see Page 13 for details on claims.

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

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

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

Most C&P exams are conducted VHA or by private, for-profit contractors. Evidence suggests that C&P exams conducted by private contractors often cause numerous problems for veterans. For example, veterans were routinely subjected to long wait times by the five major contractors who performed these examinations.

[A 2018 Government Accountability Office Report](#) found that for-profit contractors also made significant errors in exam reports. In 2015, the [Tampa Bay Times](#) reported that one of the contractors, [Veterans Evaluation Services](#), sent dozens of veterans to a Tampa doctor under federal investigation.

In some instances, when a veteran complains about "waiting" or a "denial" of VHA care, a veteran may be referring to months of waiting for a C&P exam, a VBA decision, or an appeal. The best way

to determine a veteran's status is to ask a veteran for the letter or decision sent by VHA, VBA, the Board, or the Court. Shortly before leaving office, [Donald Trump privatized](#) all compensation and pension exams, a highly controversial decision in the veterans' community that many are now seeking to reverse.



The VHA's Patient Profile

Nine million veterans are enrolled in the VHA. Of that number, some 6.5 million use VA health care services in any given year. According to the [Congressional Research Service](#), the VA-enrolled veteran population increased by 78 percent from FY2001 to FY2014. These patients include those who served in and around World War II, the Korean, Vietnam, and Gulf Wars, as well as many from the post-9/11 generation. The veteran population is shifting geographically, with more veterans living in the South and West and fewer in the Northeast and Upper Midwest.

According to a [2017 survey](#), some enrollees use the VHA to provide care or services that are not provided or are more costly (like prescription drugs) even though they primarily use other health insurance. Thirty percent of enrollees depend entirely on the VHA for their health care needs. As one recent study reported, “Veterans who used VA services were more likely to be black, younger, female, unmarried, and less educated and to have lower household incomes.” A [RAND study](#) explained that, “Although, as a group VA patients tend to be older than other veterans, those who rely most on the VA for their health care are younger... and lack other sources of coverage.”

The VHA cares for some of the oldest, sickest, poorest and medically complex patients in the nation. [RAND](#) found that “VA providers are likely to be treating a sicker population with more chronic conditions, such as cancer, diabetes, and chronic obstructive pulmonary disease (COPD) than the population expected by civilian providers.” Because of their age and deployment histories, veterans who are cared for by the VHA have more chronic physical and mental health conditions than other veterans.

As studies point out, demand for VA care is likely to increase as younger veterans age and experience more health problems. According to [RAND](#), by 2024, “the VA patient population will become less healthy. Owing partly to an aging population and the increasing share of Iraq and Afghanistan veterans, the future veteran population will have a higher prevalence of chronic conditions (such as diabetes and hypertension) and mental health conditions (such as depression and posttraumatic stress disorder.)”

“U.S. engagement in a military conflict in the next ten years would increase the number of newly eligible veterans, many of whom would have combat exposure.

Across a range of conflict scenarios of different levels of scale and intensity, our analysis predicts that a future conflict would add between 500,000 and 925,000 new VA patients.”

**-Balancing Demand and Supply
for Veterans' Health Care (RAND)**

Another significant variable that will impact demand for VA healthcare is job loss due to the Covid-19 pandemic. Because of the pandemic, veteran unemployment skyrocketed from three to over 12 percent in the spring of 2020, though it has since [come down](#) substantially. Even so, deep

economic precarity remains in this community. And as we know from the past, when veterans lose their jobs and health insurance, most reach out to the VA as a safety net.

Comparison of Chronic Conditions of Veterans and Non-Veterans

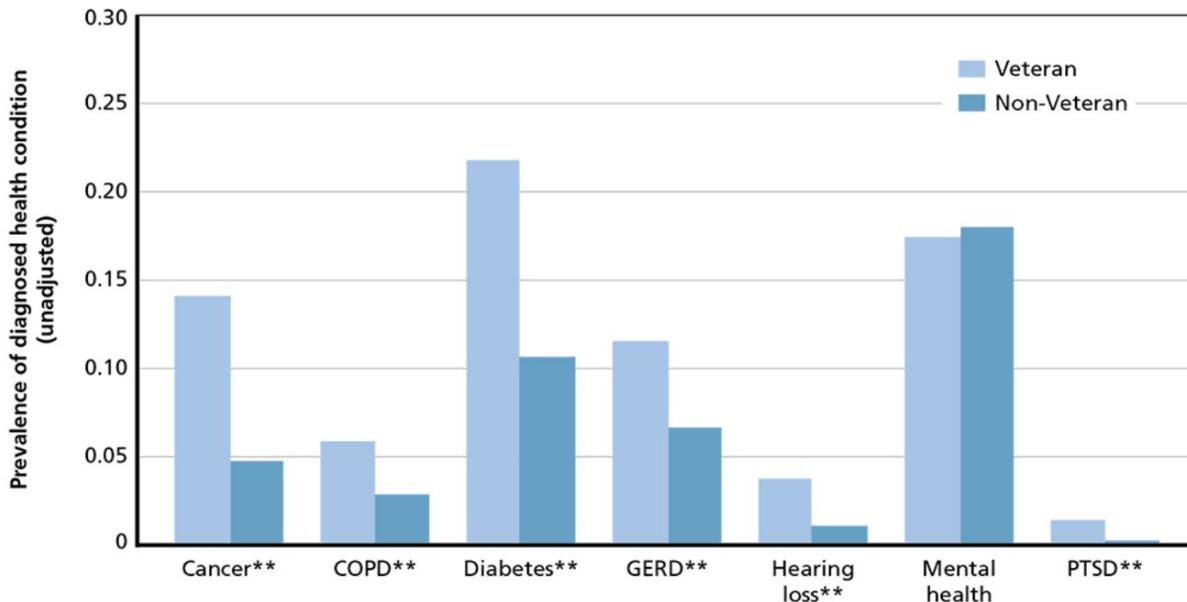


Chart from 'Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs' at RAND.org

**Chronic Obstructive Pulmonary Disease (COPD)

**Gastroesophageal reflux disease (GERD)

**Post Traumatic Stress Disorder (PTSD)

Veterans and Chronic Pain

Military training and deployments often involve hauling around 60 to 100-pound packs that place an excessive burden on the bodies of service members. It can [lead to chronic musculoskeletal diseases](#) and problems with chronic pain. That's why veterans of younger ages suffer from more chronic pain than their civilian counterparts.

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

Chronic pain also increases the risk of suicide and can spur substance abuse. The rate of opioid overdose deaths among veterans [is twice as high](#) as in the civilian population.

Other Common Conditions Among Veterans

Hearing loss and tinnitus are the most common ailments that bring people to VHA care. Almost every branch of the military exposes personnel to high levels of noise. Veterans are 30 percent more likely to suffer severe hearing impairment than non-VA patients because of exposure to toxic levels of noise. According to the VA, [2.7 million veterans](#) currently receive compensation for hearing loss or tinnitus. The VHA has established [the National Center for Rehabilitative Auditory Research \(NCRAR\)](#), a VA-funded research facility in Portland, Oregon. The NCRAR has done pioneering [research](#) on veterans' hearing problems, tinnitus management, and helped develop effective hearing aids.

Diabetes, some gastrointestinal problems, COPD, and cancers are more commonly diagnosed in [veterans than non-veterans](#).

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

Signature injuries and contaminants unique to each U.S. conflict, including:

- Agent Orange exposure for Vietnam veterans
- Chemical warfare agent experiments and nuclear weapons testing and cleanup during the Cold War
- Gulf War syndrome
- Exposure to toxic burn pits in Iraq and Afghanistan.

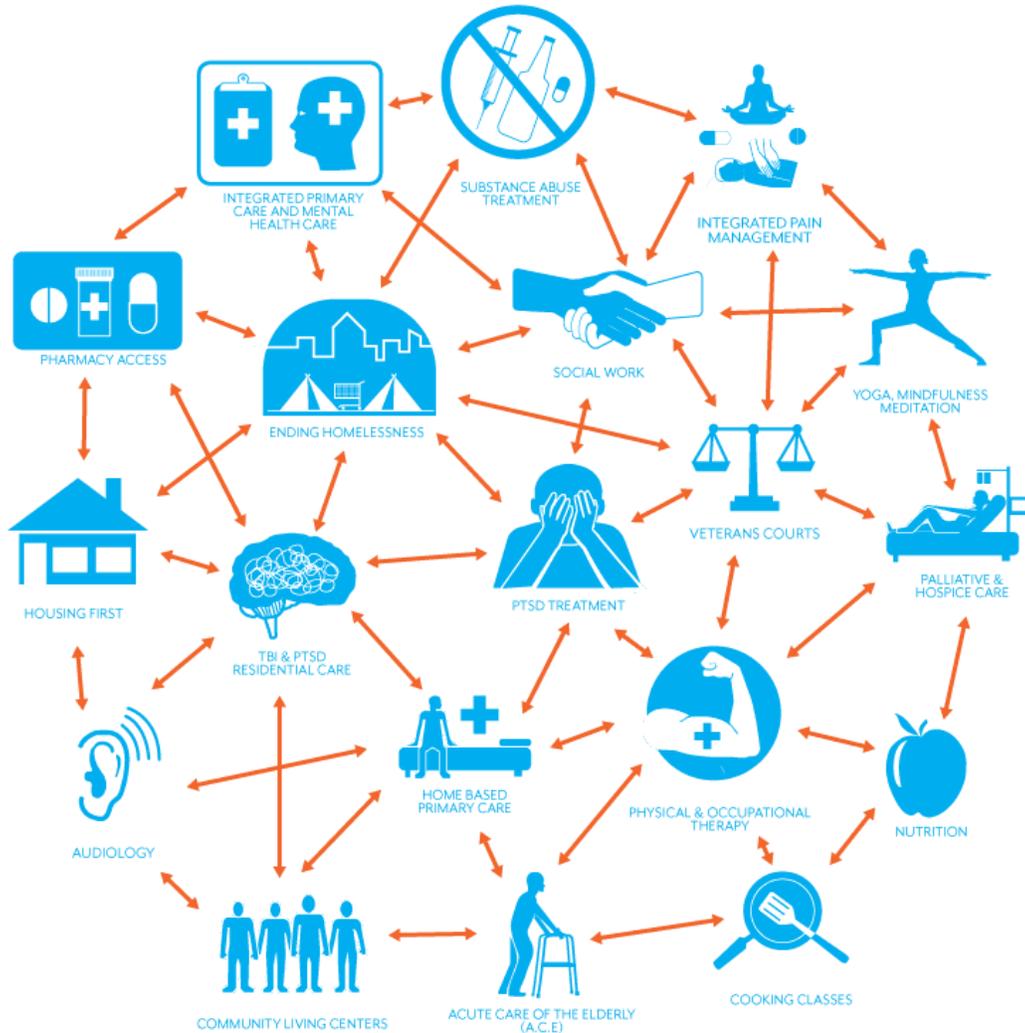
Infectious disease risks like [visceral leishmaniasis](#), West Nile virus, and [Mycobacterium tuberculosis](#) (TB), to name only a few.

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

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

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

The VHA's 171 medical centers offer a full range of surgical services – everything from general to specialized surgery to transplantation at designated sites – and patient care. The VHA also delivers outpatient care – primary care, optometry, audiology, [dental](#), and mental and behavioral health services, among many others.



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

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

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

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

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

One recent [study](#) compared the treatment of older male veterans in VA with cancer with that received by older men under traditional, fee-for-service Medicare. The study found that VA offered care that was at least as good and often better than that offered by non-VA doctors. According to an author of the study, Nancy Keating, an associate professor of health care policy at Harvard Medical School and the lead author of the study, a key factor accounting for this result is that care at VA "is much better coordinated than in most other settings." She also explained that VA "has a good, integrated medical record. Their doctors all work together and communicate more effectively." ⁹

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

A 2019 [study](#) on patients who had end-stage renal disease and were receiving dialysis found that, "among members of this national cohort of veterans who initiated dialysis between 2008 and 2011, we found that 2-year mortality rates were lower for those receiving dialysis exclusively in VA dialysis facilities and for those dialyzing in more than one setting than for those who received dialysis exclusively through Medicare." The authors of this study asked, "What might explain more favorable survival rates in cohort members who used VA dialysis or received dialysis in a dual setting compared with those who received dialysis under Medicare?" Their answer: "Compared with veterans receiving dialysis exclusively under Medicare, those who dialyze exclusively within the VA likely have more ready access to comprehensive care benefits, care coordination due to colocation of

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

GWEN SHEPARD
VETERAN, AIR FORCE RESERVE

dialysis and non-dialysis services, and informational continuity stemming from VA's seamless electronic medical record."

The VA often (but not always) performs better than or similarly to other systems of care with regard to the safety and effectiveness of care.

-O'Hanlon et al,
2017 Journal of
General Internal Medicine

One study about the importance of access to care was published in the journal [Circulation](#). It compared the incidence of coronary heart disease and strokes for a large group of African American and white veterans cared for by the VHA and those given treatment outside of agency walls. The study found that although "blacks experience higher mortality than their white peers" in the general population, African Americans cared for in the VA actually fared better than white veterans. The authors speculated that this was because the VA

provided "unhindered access to healthcare," which patients in the broader healthcare system rarely enjoy. Outcomes may also be enhanced by the fact that the VHA offers patient-coordinated care.

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



Women Veterans

Veteran demographics are changing significantly. For example, after World War II, less than one percent of the veteran population was women. According to the VA, [10 percent](#) of veterans are now women and represent 7 percent of the VHA's patient population.

As this number continues to grow, the system has worked diligently (sometimes in response to pressure from women veterans' groups like the [Service Women's Action Network \(SWAN\)](#) or advocates like the Vietnam Veterans of America) to address the needs of women veterans. Increasing numbers of women have served in the Armed Forces since World War II. By 1994, when a ban on women serving in military combat roles was instituted, [roughly 10 percent of enlisted military personnel](#) were women. President Barack H. Obama officially [lifted that ban](#) in January 2013.

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

There are today roughly [2 million women veterans](#) in the United States and Puerto Rico. They represent 9.4 percent of the total veteran population. Of that 2 million women veterans, 35.9 percent were enrolled in the VHA. Not all enrolled women veterans use VHA services.

Many of these women have experienced Military Sexual Trauma (MST). Some do not want to have any contact with the VHA or with male veterans and bristle that, inevitably, VHA facilities will be filled with men who make up the majority of its patients. The VA has established a [Women Veterans Health Strategic Health Care Group \(Women's Health\)](#) and has women veterans program managers and field directors in every major medical center.

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

Three Models of VHA Care for Women Veterans

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

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

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

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

Under the leadership of Iraq veteran Kayla Williams, the VA's Center for Women's Veterans worked to make the department more welcoming to women. The Center launched numerous initiatives to educate staff and patients about the needs of female veterans. The Center created a pioneering digital communications outreach program that sent out emails, newsletters, news roundups, health research roundups, and more to female veterans.

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

Unfortunately, many women veterans still face challenges when they go to the VHA. Some of these encounters, which range from crude comments to [sexual misconduct](#), stem from long-held stereotypes and toxic attitudes developed in the military and sustained in smoky VSO posts. Also common are irritating encounters in which a female veteran who sits down with a VHA clerk is mistaken for the wife, partner, or daughter of a male veteran. Although the VA is trying to counter these stereotypes, this culture change, like any other, may take years to accomplish.

“Most providers in the private sector don't even know what Military Sexual Trauma is, much less know what kinds of treatments are evidence-based to provide mental healthcare for it.” The VA, on the other hand, understands women's specific military experiences and risks and is able to give women veterans the support and services they need - at lower cost.

-Kayla Williams

VHA's Integrated Health Care Model

Telehealth Capacity

The VA's expertise with telemedicine dates back to the 1960s, when the department first communicated with patients through crude telecommunication technology. Decades later, as the internet ushered in fast speeds and accessibility, the VA took telehealth to new levels. Today, the VA runs the largest telehealth system in America, with millions of appointments done remotely each and every year. This care covers 38 clinical areas and is wildly popular among VA patients, 45 percent of whom live in rural areas and sometimes find it difficult to make the trek to their nearest facility.

Some may assume that telehealth is a much-degraded quality of care, but this is not the case. The VA can now take vital signs and extract other health data through medical tools given to the veteran at home. There are now many independent case studies attesting to the value of this virtual network and its ability to improve health outcomes. This is supremely true for telemental health services, which, in recent years, have reduced acute psychiatric VA inpatient admissions by an impressive 32 percent and days of care by 39 percent.

The VHA is a global leader in [telehealth](#) that delivers this sort of care at over 900 locations. Making use of continually evolving communication and information technology, patients separated from providers by geographical location are able to receive high-fidelity services in their homes or in VHA facilities.

Here are only a few examples:

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

As the coronavirus pandemic hit American shores last March, the VA was, thus, supremely positioned to ensure continuity of care with the 9 million veterans who rely on the system. According to the department, phone or video appointments skyrocketed by more than 800% in the early weeks of the pandemic. VA recently announced that telehealth visits have continued to

increase as this crisis has dragged. While 10,000 or so patients had telehealth appointments each month before the pandemic, that number has now jumped to nearly 120,000.

Pioneering the Primary Care Model

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

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

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

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

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

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

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

SOURCE:

"QUALITY OF CARE FOR OLDER PATIENTS WITH CANCER IN THE VETERANS HEALTH ADMINISTRATION VERSUS THE PRIVATE SECTOR: A COHORT STUDY"
N.L. KEATING, ET AL., | JUNE 2011

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

Many veterans' unique conditions would not have been recognized and treated if veterans had been scattered throughout a civilian sector health care system where data on their conditions is not systematically collected. One of the dangers of channeling more veterans into private sector care is that critical information on military-related exposures and/or newly emerging health problems will not be recognized or rigorously explored. This will impact not only veterans' health, but their ability to get well-deserved compensation for their occupational injuries and health conditions.

Primary Care and Mental Health

One of VHA's most significant achievements is the kind of integration of primary and mental health care that is almost impossible to produce in the private sector. In the VHA, mental health professionals are co-located in primary care practices. Every veteran in primary care at the VHA is screened for PTSD, depression, and alcohol and substance abuse. They are also screened at least once a year for MST.

In most private sector practices, patients who tell a primary care provider or specialist about a mental or behavioral health problem are given a referral to a mental or behavioral health provider. The patient is expected to make – and show up for – an initial appointment following that referral. Because of the stigma of mental health problems, many patients never schedule the first appointment or, if they do, actually go to it.

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

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

Rehabilitation Services

The VHA is unusual in its focus on restoration of function for patients who have hard-to-manage chronic conditions that cannot be cured. VA facilities offer highly regarded, specialized residential

inpatient and outpatient rehabilitation programs. These programs may also care for active-duty service members.

They include:

- [Blind Rehabilitation Centers](#) that help veterans with vision problems.
- [Centers for Spinal Cord Injuries and Disorders of Care](#).
- [Polytrauma/TBI System of Care](#), which includes five Polytrauma Rehabilitation Centers as well as Polytrauma Network Sites and Support Clinic Teams.
- The [VA's Domiciliary Residential Treatment Programs](#) have a total of 8,000 inpatient beds for patients whose length of stay varies from one to six months. Like the San Diego VA Health Care System's [ASPIRE Center](#), some of these programs help prevent veteran homelessness. Others include intensive substance abuse residential rehabilitation. The Post-Deployment Assessment Treatment Program (PDAT) at the Martinez California VA Community Outpatient Clinic provides cognitive rehabilitation.



VHA's Electronic Health Record

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

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

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

Although VHA's electronic health record still receives high ratings for its usability, some in the agency and the private sector contend that it is 'antiquated.' They prefer that it be replaced by an off-the-shelf system developed in the private sector. Because of this, Cerner Corp. was awarded the ten-year, multi-billion dollar contract to overhaul the system. VA leadership has promised that Cerner, which is used by the DoD, will provide seamless record-keeping between DoD and VA care in the future. The company has experienced a number of failures and budget overruns since it began VA work in 2018.



VA Mental Health Services

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

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

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

These treatments include:

- Traditional psychiatric medications
- Individual and group psychotherapy sessions
- Methods like Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT) for PTSD

These various therapies are also offered via telehealth, which is of particular help to those rural veterans who live in mental health deserts. The VHA also uses and researches integrative therapies like [yoga](#), mindfulness meditation, therapeutic touch, and massage, among many others.

Providing Mental Health Care for Chronic Conditions

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

One of VHA's most important innovations is its extended care program. This program targets aging veterans through geriatrics, home-based primary care, VHA nursing homes, and palliative care. VHA mental health programs also connect younger veterans to housing and employment support and help with the kind of readjustment problems they have when they return to higher education following separation from service.

The VA also [employs](#) scores of anthropologists to study the complex interaction between culture and illness. VA anthropologists have

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

SOURCE:

ANTHROPOLOGISTS IN THE VA:
A GENERATIVE FORCE
ELISA J. SOBO | SEPTEMBER 2014

studied how families and communities understand PTSD; how to create secure messaging; or respect and maintain the dignity of patients with spinal cord injuries.



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

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

Military Sexual Trauma (MST)

The VHA has now recognized Military Sexual Trauma (MST) as a serious service-related condition and has established a variety of programs to deal with it among both male and female veterans.

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

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

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

NORRISSA MCLORIN
U.S. MARINE CORPS VETERAN

MST Key Statistics

- At least [25 percent of women](#) serving in the U.S. military say they have been sexually assaulted, and up to 80 percent have been sexually harassed.
- In 2011, women in the military [were more likely to be raped by fellow soldiers](#) than to be killed in combat.
- In 2017, the [DoD received 6,769 reports of sexual assault](#) involving service members as either victims or subjects of criminal investigation, a nearly 10 percent increase over the previous year.

- The [VA states](#) that “although rates of MST are higher among women, because there are so many more men than women in the military, there are actually a significant number of women and men in VA treated for MST.”



Post-Traumatic Stress Disorder (PTSD)

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

Common PTSD Symptoms

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

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

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

"I felt helpless. I couldn't sleep, I kept making all these foolish decisions. All that has changed. I have done a total 180 about the value of the VA. You can walk in the VA clinic and unless you walk in with a chip on your shoulder about something, if you just walk in and look around, it will almost bring you to tears. The staff is so dedicated, and you can just see it."

LOUIS KERN
VIETNAM VETERAN

PTSD Key Statistics

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

The VA's National Center for PTSD

The Veterans Health Care Act of 1984 created the [VA's National Center for PTSD](#). The center's mission is to "promote the training of health care and related personnel in, and research into, the causes and diagnosis of PTSD and the treatment of Veterans for PTSD."

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

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

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

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

Identifying, Diagnosing, and Treating PTSD

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

The VHA's [Clinician-Administered PTSD Scale](#) provides a standardized interview for clinicians and researchers so they can accurately diagnose and quantify the severity of PTSD symptoms. The center has produced the [PTSD Checklist](#), a self-report questionnaire that allows veterans to record their symptoms and facilitates monitoring of the ongoing effectiveness of treatment. The center has also created the easily accessible [PTSD Coach](#) mobile app.

Systematic research by VHA scientists helped evaluate and spread two of the gold-standard treatments for PTSD: [Cognitive Processing Therapy \(CPT\)](#) and [Prolonged Exposure Therapy \(PE\)](#). VHA Mental Health leadership has established some of the most sophisticated and large-scale training programs in evidence-based mental health treatments ever created to ensure that research affects practice.

The VHA has developed a sustainable capacity to train mental health clinicians in PTSD treatment. Over 8,500 VHA mental health providers have attended multi-day training workshops in CPT and PE. They then receive consultation and support from expert trainers and consultants who, over about six months, coach each trainee as they work with two veterans who receive CPT or PE. Therapists can then turn theory into effective practice because experts monitor quality control and

assess the training's impact. This kind of educational capacity is rarely available outside the VA or DoD health care systems.

In contrast, it's been [widely documented](#) that community-based providers are not practicing in ways consistent with best practices as laid out in formal Clinical Practice Guidelines including those focusing on treatment of PTSD

Most importantly, they have not been trained to deliver the evidence-based treatments that have received the most research support for effectiveness.

The National Center for PTSD has also produced important resources on the [relationship between PTSD and suicide](#) that is critical in helping understand and prevent suicide.



Veteran Suicide and Prevention

According to the most recent VA data [available](#), U.S. veterans die by suicide at a rate 1.5 times higher than the non-veteran adult population. Over 6,400 veterans died by suicide in 2018, [17.6](#) each day. The rate of veterans dying by suicide between 2005-2017 remained fairly steady. During this period, suicide rates among veterans not using VA care (and U.S. adults in general) continued to escalate. However, the suicide rate for veterans who use VA for their healthcare was dramatically [slowed](#) and then reversed. Between 2017-2018, suicide rates for veterans who use VA for their care decreased by 2.4%, while rising 2.5% among veterans receiving their healthcare in the community. That success was in spite of the fact that the cohort of veterans who use the VA have greater risk factors for suicide.

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

Identifying At-Risk Veterans

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

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

Some of these ultra-high-risk veterans might not have been identified based only on clinical signs. This is a crucial distinction because many veterans who die by suicide do not have a history of suicide attempts or recently documented suicidal ideation.

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

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

IRAQ WAR VETERAN

**IN A LETTER TO THE COMMISSION ON CARE
APRIL 17, 2016**

Employee Training and Outreach

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

Veterans Crisis Line (VCL)

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

VA's crisis line often expedites access to care for a Veteran. This is evidenced by the nearly [900,000 annual appointment referrals plus the more than 167,000 dispatches of emergency services](#) that often prevent veteran suicide.

In 2007, in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA, part of the U.S. Department of Health and Human Services), a "Press 1" feature was added to an existing nationwide suicide prevention hotline.

Incoming calls are transferred by SAMHSA to VHA. The calls were answered 24 hours a day and 365 days a year by a single VHA's medical center in Canandaigua, New York. As Veteran demand rose due to increased awareness and decreased stigma, VA changed the name to the Veterans Crisis Line and added two more VHA call centers in Atlanta, Georgia and Topeka, Kansas.

Trained mental health professionals have received nearly [7 million communications](#) from Veterans, service members, and family members from all over the globe. The contacts include:

- More than 5 million calls
- More than 585,000 chats
- More than 184,000 texts
- More than 897,000 referrals
- Leading to more than 167,000 dispatches of emergency services.

Mobile Apps and Other Programs

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

Firearm Safety and Suicide Prevention

Approximately 68 percent of veteran suicides resulted from a firearm injury in 2018. In comparison, the proportion of suicides resulting from a firearm injury among U.S. non-veteran adults was 48 percent. Approximately 69 percent of male veteran suicides and 42 percent of female veteran suicides resulted from a firearm injury.

Method of Suicide	% of non-veteran adult suicide deaths	% of veteran adult suicide deaths	% of male non-veteran adult suicide deaths	% of male veteran suicide deaths	% of female non-veteran adult deaths	% of female veteran suicide deaths
Firearm	48.2%	68.2%	53.5%	69.4%	31.7%	41.9%

A comprehensive breakdown of veteran suicide rates is [available here](#).

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

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

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

The PREVENTS Initiative

In February 2018, President Trump signed an executive order that created the ['President's Roadmap to Empower Veterans and End the National Tragedy of Suicide' Initiative](#) (PREVENTS).

It created a cabinet-level taskforce to work at the national, state, and local government levels, as well as with the private sector, to better address and understand veteran suicide. Leaders are supposed to work in collaboration with the VA, DoD, Health and Human Services, and Homeland Security. The VA Secretary serves as the primary point person for this initiative.

The effort builds on the VA's [National Strategy for Preventing Veteran Suicide](#). It explicitly acknowledges that VHA care and its suicide prevention programs should lead the prevention initiative. Suicide rates for veterans are lower for those who receive VA care than for those who do not.

Those looking for a more comprehensive analysis of the VA's mental health programs and some of the potential pitfalls of policymaking that shifts care to the private sector without adequate safeguards are invited to read VHPI's comprehensive [2021 report](#) on these topics.



Veterans' Health Care and Opioids

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

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

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

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

[More than 90 percent](#) of VA facilities offer some type of supplemental therapy for pain management. VHA's integrated pain management program helps wean patients from opioids and utilizes different pain management techniques. The VHA provides non-opioid medications as well as occupational, physical and recreational therapy, chiropractic, pain classes, Tai Chi, mindfulness meditation, acupuncture, and yoga – all of which are free of charge. The [VA's MOVE!](#) Weight Management Program also encourages veterans to exercise and helps coach them with an easily accessible [mobile app](#).

“Interdisciplinary pain management continues to grow in the VA (as well as internationally) but is rare in the U.S. private sector where healthcare tends to be fragmented and truncated. VHA accounts for 40 percent of U.S. interdisciplinary pain programs even though it serves 8 percent of the adult population.”

SOURCE:
VETERANS HEALTH ADMINISTRATION MENTAL
HEALTH PROGRAM EVALUATION
RAND CORPORATION | 2011

VHA Compared to the Private Sector

[A 2017 VA Office of the Inspector General \(OIG\) report](#) compared opioid prescribing to veterans in the VA and those treated by Veterans Choice providers outside the VA. There was an increased risk of overdose deaths among veterans prescribed opioids by community providers. Veterans with chronic pain and mental health disorders are at particularly high-risk. Veterans treated in the

private sector were more at-risk because private sector facilities have not implemented the same kind of stringent prescribing and monitoring guidelines that the VHA has mobilized to deal with this critical problem. Additionally, there was little information-sharing between the VA and private sector providers.

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



Readjustment to Civilian Life

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

Vet Centers

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

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

Veterans Integration to Academic Leadership (VITAL)

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

Veterans Justice Outreach Program

The [Veterans Justice Outreach Program](#), founded in 2009, is designed to avoid the incarceration of mentally ill veterans. Every VAMC has a veterans justice outreach specialist who "serves as a liaison with the local criminal justice system." These specialists "reach out to veterans in jails or the courts and work as case managers trying to engage them in treatment." They also assist veterans with eligibility claims and connect veterans to the VA or community services. Specialists also provide training to law enforcement personnel about issues that are specifically relevant to veterans, such as how PTSD or TBI may be connected to their history of legal problems. These specialists play a critical role in the system of over 220 [Veterans Treatment Courts](#) that exist around the United States. While VA plays no role in their administration or operation, these special courts generally aim to place non-violent veteran offenders into VA treatment instead of incarcerating them.

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

JOSHUA WILDER OAKLEY

U.S. ARMY MEDIC, VETERAN

Homelessness

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

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

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

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

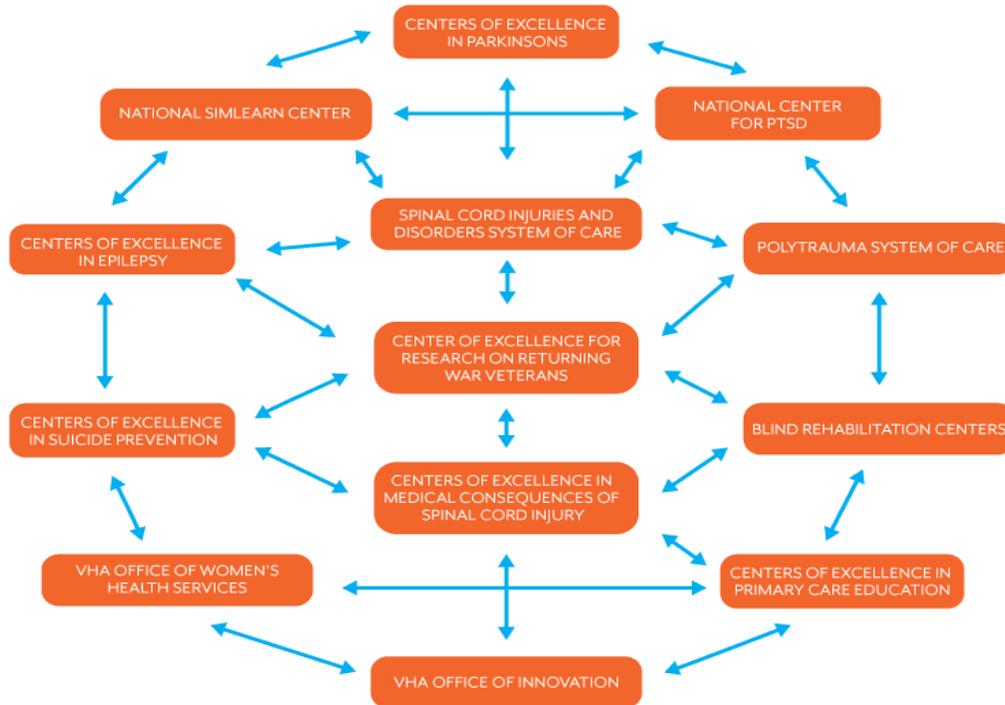
One of the most innovative policies that stemmed from the Obama era came out of Los Angeles, the American city with the largest number of unhoused residents. The plan was simple but not easily accomplished. That's because it involved creating [thousands of housing units](#) on the sprawling VA campus in Brentwood, one of the most posh zip codes in the country. Following years of bureaucratic and legal fights, a bold master plan was drafted, finalized, and is now being implemented. President Joe Biden has publicly supported replicating this housing experiment across the country, a necessary move as the COVID-19 pandemic threatens to undo much of the progress accomplished in veteran housing over the past decade.

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

MICHAEL BLECKER
EXECUTIVE DIRECTOR
SWORDS TO PLOWSHARES

Centers of Excellence and Other Innovations

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



Geriatric Care

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

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

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

The VA also has 135 nursing homes called [Community Living Centers \(CLCs\)](#) in the United States and Puerto Rico. These facilities are available to veterans for short-term stays or for the rest of their lives. The [1999 Millennium Act](#) mandated that the VA pay for nursing home care if veterans have a 70 to 100 percent service-connected condition or if they are 60 percent service-connected and unemployable. Some residents may use CLCs but make co-pays. VA also places veterans who have undergone VA hospitalization and need follow-up care in community nursing homes.

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

Palliative Care

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

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

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

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

CHARLENE HARRINGTON, PH.D., RN
PROFESSOR EMERITUS
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

How the VHA Rates its Facilities

In 2012, the VHA released its Strategic Analytics for Improvement and Learning (SAIL) Value Model for evaluating performance. The SAIL model utilizes a scorecard made up of 28 measures from ten different areas that are intended to “measure, evaluate, and benchmark quality and efficiency at VA Medical Centers (VAMC).”

These measures included things like acute care hospital morbidity, 30-day readmission rates, nurse turnover, as well as employee and patient satisfaction. SAIL measures were designed to be an internal tool to help facilities improve and do not compare VHA facilities to the private sector.

However, by 2020, it was clear that the SAIL system was a useful one but the process of rating the VA Medical Centers with stars did not prove to be helpful. At that time, VA changed the focus to enabling a comparison of care at the local VA facilities with care provided in hospitals in the community. VA releases publicly data such as quality of care metrics, patient satisfaction, and waiting times for specific categories of care. Public facing websites for such data include:

<https://www.accesstocare.va.gov>.

This site has options to review timely access, patient satisfaction, comparison of care with local facilities, how VA is doing with access nationally, and local providers of care for Veterans. There is also a link for more specific data by facility.

Residual Problems from the Star Rating System

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

SAIL ratings often failed to include critical areas of performance

SAIL ratings focus heavily on inpatient hospital metrics. The VHA system is, however, unique in its provision of a wide variety of services as well as its collaboration with the VBA and other government agencies. This network of care coordination and integration considers what is known as the 'social determinants of health.' This broad approach has helped to reduce veteran homelessness and assist veterans deal with legal and employment issues. These intertwined efforts have also positively impacted veterans' physical and mental health.

Focus of the SAIL Metrics

VA is especially focused on measures tied to prevention of serious illness. Veterans are enrolled and VA has a longitudinal relationship with those veterans. VA pays special attention to monitoring the preventive metrics, which has contributed to the overall quality improvement seen. In addition, VA has a strong focus on promoting the mental health of veterans. Preventing suicide remains among VA Secretary Denis McDonough's top priorities. The SAIL metrics for mental health have focused on easily measurable items and the resulting scores are "Z scores." Z scores represent the ratio of the facility score minus the mean for that score, all divided by the standard deviation. Z scores can overemphasize small differences when standard deviations are small (i.e, when facilities trend toward the mean.)

Impact of COVID-19 on VA Metrics

During the emergence of COVID, VA necessarily prioritized care of those infected, and chose to support the fourth mission in supporting the public health of the community. VA communicated well with patients, and VA's trust scores climbed significantly during this era.

However, regular face to face appointments were sometimes delayed, both in house and in the private sector, due to shifting of resources. Frequently, VA used video appointments and other telehealth means to support the care of veterans, but the concern is what could have been missed with the switch to video appointments or the rescheduling of appointments. Treatment and prevention of COVID-19 will likely negatively impact some of the quality metrics both for VA and for the private sector, although there are now significant efforts underway to assess veterans whose appointments were changed or delayed.

The Choice Program

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

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

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

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

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

This left the VHA underfunded by some \$14 billion. VSOs and VA leadership had earlier determined that the VHA needed \$21 billion to hire needed staff and make necessary improvements. The Choice Act was extended repeatedly at an additional cost of more [than \\$9 billion](#), which went to private sector providers and third-party administrators.

Following a rushed bidding process, the two federal contractors hired to implement Choice fumbled while transferring medical records from the VA to private providers. The two companies, Health Net Federal Services and TriWest Healthcare Alliance, had only a 13 percent success rate in scheduling out-of-network appointments in the first year of the program.

When contractors did schedule appointments successfully, they often bungled the details. The [Office of Inspector General](#) found a number of egregious scheduling mistakes. Among them: A veteran in Idaho with a herniated disk was given an appointment with a primary care doctor in New York. Another veteran in south Texas was set up for wrist surgery with a specialist who was not trained to perform the procedure.

Two VA OIG reports documented that the third-party administrators (TPAs) made significant errors in the payment process. A [2017 report](#) states that “As a result, we estimate that OCC overpaid the TPAs tens of millions of dollars from November 1, 2014, through September 30, 2016, for claims processed through FBCS.” A [2018 report](#) documents “253,641 duplicate payments on 4,758,759 claims (5.3 percent) through the bulk payment process from March 4, 2016, through March 31, 2017.”

[Additional issues arose](#) when the scheduling contractors were not held to strict payment standards by the VA, resulting in many veterans being billed directly for some or all of their care. In some cases, those bills hurt veterans' credit reports, and collection agencies came knocking. The Choice Act also escalated the amount of taxpayer dollars going to the private sector rather than to improve VA's in-house programs and services. [In 2002, according to the RAND corporation](#), the VA spent \$890 million to serve 7.8% of veterans in the private sector. In 2014, that figure had increased almost six times to \$5.57 billion to pay for 21.2% of veterans whose care was shifted to the private sector. The Choice Program further boosted this trend, infusing [roughly \\$20 billion](#) into private sector care.



The VA MISSION Act

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, signed into law on June 6, 2018, consolidated several mechanisms through which VA purchased care to augment its own service-delivery. It also expanded the circumstances under which veterans could receive private sector care.

The MISSION Act established the framework for a Veterans Community Care Program (VCCP), and set the criteria under which veterans could participate in that program. These criteria include:

1. When the VA can't offer a specific service,
2. When VA doesn't operate a full-service medical center in a state
3. When a veteran was previously eligible for non-VA care under the Choice program
4. When private care "would be in the best medical interest of the covered veteran based upon criteria developed by the [VA Secretary],"
5. When the VA does not meet access standards established by the VA Secretary, a veteran can choose to be treated by a non-VA provider.

Even if a community provider is reliably shown to have superior quality for a specific medical service (e.g. cardiac surgery), fragmentation of care between VA and non-VA providers creates new risks for harm.

In June 2019, VA published its [final rules](#) for the community care program that set out its proposed access standards. These access [standards](#) exponentially increased the number of veterans eligible for private care. Any enrolled veteran deemed to have an 'average drive time' of more than 30 minutes for a primary care or mental health appointment, or 60 minutes for a specialty appointment, could choose to be treated in the private sector under the proposed access rules.

That choice would also be open to a veteran who has to wait more than 20 days for VA mental health or primary care, or 28 days for specialty care. In many heavily trafficked urban areas, as well as sparsely populated rural areas, drive times can easily exceed 30 or 60 minutes.

SOURCE:

DEPARTMENT OF VETERANS AFFAIRS,
REPORT TO CONGRESS
HEALTH CARE STANDARDS AND QUALITY,
MISSION ACT, SECTION 104
MARCH 2019

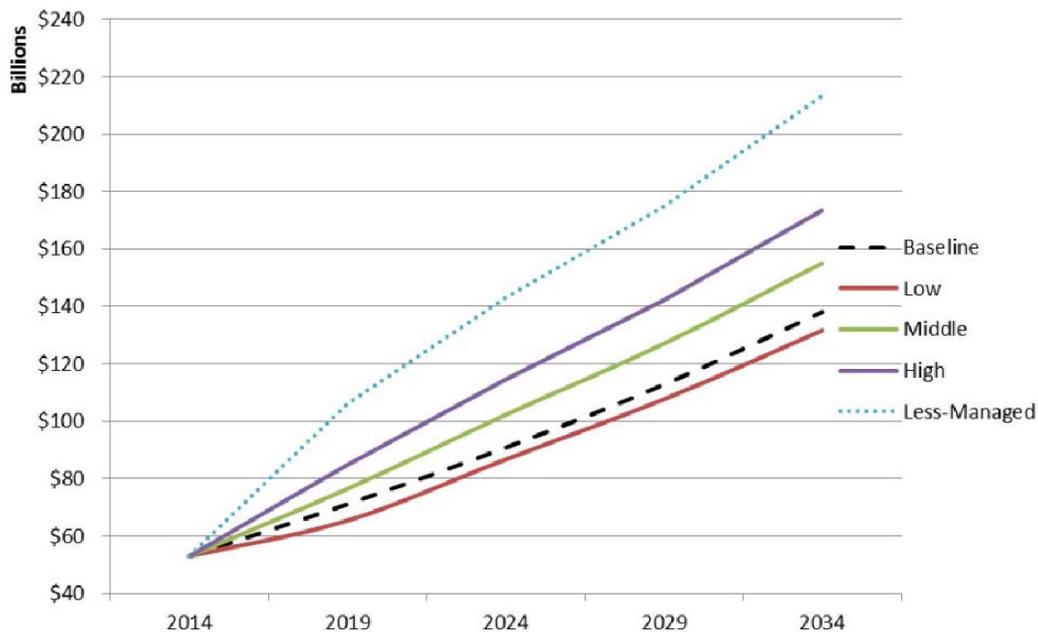
In an economic analysis accompanying the publication of its rules, VA indicated that adoption of the drive-time criteria alone would increase the numbers eligible for community care from around 8 percent to approximately 40 percent. In private communications, VA leaders around the country have estimated that 63 percent of patients would be eligible for private sector care based on drive time alone. In reality, there is little clear basis for reliably projecting how many veterans will choose private sector care, and estimates presented by the VA leadership are often contradictory and just that – estimates.

A number of federal lawmakers who voted in favor of the MISSION Act subsequently [expressed concern](#) that former VA Secretary Robert Wilkie failed to consult with both veterans' advocates and political representatives during the rulemaking process. One of them was Senate Veterans Affairs

Committee Chairman Jon Tester, D-MT., who expressed worries that VA's "primary focus is supplanting in-house care, as opposed to supplementing that care when it makes the most sense for veterans."

On June 6, 2019 -- the first day of the Mission Act rollout -- the House Committee on Veterans' Affairs deployed seven staffers to five veterans' hospitals across the country to monitor this new private care program in action. But according to an internal Congressional report, these staff faced "coordinated and unprecedented obstruction" by national VA staff in these oversight efforts. Importantly, these officials were denied access to VA's then-new Decision Support Tool, a software program that is used by an authorized staff member to determine a veterans' eligibility for private sector care. This sort of obstruction around MISSION was indicative throughout Trump's tenure, and has made it incredibly difficult to understand how many patients and taxpayer dollars have been funneled into private sector pockets.

In 2018, the year before Mission was implemented, 6.2 million veterans accessed community care and 1.8 million of them were accessing community care for the first time. The Congressional Budget Office initially estimated that the MISSION Act would result in 640,000 additional veterans seeking private care in the first few years after its implementation. VA has estimated that it will spend \$17.8 billion on community care in 2021. This is almost as much as the VA spent on private sector care during the three years of the MISSION Act, and a hike of about 20 percent from 2018 numbers.



Source: [*“Projected Costs of Recommended Option” from the Commission on Care, 2016.*](#)

The Trump administration offered little insight into how much private sector care was actually costing, and whether it was adequately serving veteran patients. [Private sector care, after all, is fragmented and therefore generally more expensive](#) than at the VHA. Many advocates have argued

for prioritizing funds to make infrastructure improvements and fill the tens of thousands of staffing vacancies that plague agency facilities all over the country. Moreover, advocates have expressed concerns that hospital directors are shifting their limited resources and staff from direct caregiving roles to ones managing and coordinating care in the private sector.

As private sector care has expanded through Mission, other pressing issues have come to light. In February 2021, for instance, the [Government Accountability Office](#) reported that the VA's community care network did not appear to be consistently denying access to providers who've lost licenses or faced other concerns over care quality. There also remain issues of private providers and contractors [over-billing the VA for care](#) and sending veterans in the age of COVID-19 to private telehealth appointments, rather than stay with the VA, which is a world leader in this virtual form of medicine.

Veterans advocates have raised concerns that VA staff are being diverted from providing direct clinical care to veterans in order to manage and coordinate the care veterans receive from the private sector. They also worry that the MISSION Act is fragmenting care for veterans with complex healthcare conditions where positive outcomes depend on care coordination. In one instance, the VA Office of Inspector General conducted an [investigation](#) of the suicide of a veteran in Memphis and found that failures in care coordination between the VA and the private sector were factors that negatively affected this tragic outcome. More recently, the [Government Accountability Office](#) found that oversight lapses likely allowed non-licensed private providers to see VA patients.

The creation of multiple lanes of care, which are not connected and coordinated, can result in serious problems for veterans. Studies consistently document that increasing the number of care transitions and lack of coordination between care providers is a problem in the non-VA U.S. healthcare system. It is a particularly acute issue for those with mental health and substance abuse problems and those who are at high risk for suicide. To cite [one analysis](#), the “costs of fragmentation” include “uncoordinated care, low adherence rates, and variations in sources of care.” Fragmented care also has increased dangers of duplicative over-prescribing and redundant diagnostic testing.

As a [September 2020 JAMA article](#) notes: “Without well-defined mechanisms for 2-way flow of information, it is unclear how easier access to private sector care, potentially at the expense of increased fragmentation, could translate into safer higher-quality care, regardless of the cost implications.” A 2018 [study](#) found that, “recent federal policy changes attempt to expand veterans' access to providers outside the Department of Veterans Affairs (VA). Receipt of prescription medications across unconnected systems of care may increase the risk for unsafe prescribing, particularly in persons with dementia.”

The John Scott Hannon Mental Health Care Act

In the months before the 2020 election, lawmakers passed and Trump signed the [John Scott Hannon Act](#), a law that took major steps towards privatizing veterans' mental health care. That's because it gives the VA Secretary broad authority to award \$174 million in grants up to \$750,000 in size to private sector programs that ostensibly enhance veterans' mental health and reduce veteran suicide. The problem is that the private sector is largely unaccountable and ill-trained to treat the invisible wounds of war. In some cases, [private entities offer PTSD treatments that haven't shown efficacy](#).

The overarching goal behind this law is a positive one: to improve access to mental health care for veterans. The bill's namesake, [Commander John Scott Hannon](#), was a platoon leader for various Navy SEAL Teams with a track-record of meritorious service that earned him numerous awards, including the Bronze Star.

Once he came home, Hannon was diagnosed with Post-Traumatic Stress Disorder, a Traumatic Brain Injury, severe depression and bipolar disorder. He sought and received help from the VA in his home state of Montana, and also found healing in nature, where, among other activities, he rescued and rehabilitated injured wild animals and worked with a local land trust to get veterans onto hiking trails. Despite this mix of therapies, Hannon couldn't overcome the invisible wounds he'd suffered. On February 25, 2018, he died by a firearm suicide.

The legislation was [introduced](#) by Hannon's home-state senator, Jon Tester, who serves as the Democratic leader of the Senate Committee on Veterans Affairs. Tester quickly found an ally for the bill in his Republican counterpart, Jerry Moran, who is closely tied to the Koch-backed, pro-privatization group Concerned Veterans for America.

In promising to improve veterans' access to mental health treatment and reduce veteran suicide, this law set up pilot programs and grant opportunities to private sector providers that purport to improve veterans on a series of metrics, including well-being, financial health, and suicide risk. And it's likely that much of the nearly \$200 million in grants will go to providing veterans the same sort of intangible relief that Hannon found in nature.

Yet the VA will have no real role in coordinating or supervising this care. There are no competency, training, or qualification standards for these providers, which are offering critical services. Even worse, although many will treat veterans with PTSD or who are suicidal, none are required to have any specialized training in PTSD or suicide prevention.

Undergirding this law, which has been hailed by a [flurry of powerful veteran groups](#), is a fundamentally false assumption: that the private sector is better at addressing mental health care than the VA.

In fact, the VA has been found to outperform the private sector in treating a broad swath of mental health conditions, including [each](#) and [every one](#) that Hannon suffered from. As the most [recent data shows](#), veterans outside the VA are far more likely to die by suicide than those who receive care inside departmental walls. A comprehensive [study](#) released last month similarly found that veterans far prefer VA mental health care to what's being offered in the private sector.

Not only does the act endorse the inaccurate notion that the private sector can easily care for veteran's complex conditions, it sets an extraordinary precedent for veterans' mental healthcare. For the first time, the law mandates that the government pay for care and other social services for veterans, regardless of their eligibility for VA care. Because family problems often influence veterans' mental health, the bill would also, for the first time, pay for private sector care for veterans' families.

The intention behind these proposed changes is laudable. Today, a major roadblock preventing progress on the veteran suicide crisis is that millions of veterans are simply ineligible for VA help. That's because VA eligibility is determined by the nature of a veteran's military discharge as well as, with some exceptions, whether or not the veteran has a proven service-related disability and/or low income.

More than 1.2 million veterans are [permanently excluded](#) from some or all VA benefits and aren't even defined as veterans for VA purposes. That's because they've been separated from the military with so called "Other Than Honorable" or "General" discharges, a designation known more commonly by its shorthand: "bad paper."

More than 125,000 of these bad paper discharges have been assigned during the Forever Wars. [Most veterans received these discharges for minor infractions](#) — getting drunk, taking drugs, getting into fights, being "insubordinate", showing up late for formation, etc. Much of this "bad behavior" is directly due to military-related mental health conditions. Women who have had the courage to report sexual assaults or harassment have also been retaliated against with these discharges. Because veterans with "Other Than Honorable" discharges have no access to the VA, they are doubly punished: they are kicked out of the military and then denied care for the problems the military created or exacerbated from the only system that understands and is competent to address these problems.

In short, the decision to divert VA dollars into the private sector from existing, underfunded VA care makes no clinical sense. As a [2018](#) paper from the National Academies of Science, Engineering and Medicine, the VA runs the best mental healthcare network in America. This paper also reported that many veterans don't seek VA mental healthcare because they don't know how to apply for VA benefits, aren't sure whether they are eligible for services, or don't feel deserving of help.

While the Hannon law pledges to also improve VA mental care, there's no money attached to address these efforts by, for instance, increasing PR efforts to make veterans' aware of their benefits. There's also no new funding to bolster internal capacity and provide VA care to all veterans regardless of discharge status.

Health Care Shortages

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

The nation has been plagued by a persistent shortage of primary care physicians. A study by the [American Association of Medical Colleges \(AAMC\)](#) warns that the U.S., which already has a shortage of primary care physicians, will need [52,000 more](#) by 2025. However, not enough physicians in training are [choosing to enter primary care](#). The supply of nurse practitioners and physician assistants is not sufficient to make up for this shortfall because many of these providers choose to enter more lucrative specialty care areas of practice.

The delivery of health care to rural populations is a particular challenge in our country. [The Health Resources and Services Administration](#) has designated many [primary care shortage areas](#). According to [one survey](#) of primary-care doctors, nearly a fifth had temporarily closed their practices, owing to the pandemic, and two in five had laid off or furloughed staff.

Because of the coronavirus crisis, thousands of hospitals are furloughing staff, and between 20 and 40% of American hospitals face serious financial difficulties and may not survive in their current form.

There is not only a shortage of primary care in rural areas but also specialist and acute care, as well as hospital capacity. Between 2005 and the 2014, [176 rural hospitals have closed](#) and the coronavirus pandemic is, according to some [reports](#), threatening the financial stability and survival of one in four rural hospitals.

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

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

Facility Closures

A provision in the MISSION Act mandates that the president, after consulting with Congress, appoint a nine-member Asset and Infrastructure Review (AIR) Commission in 2022.

The legislation stipulates that three members of the commission must be from VSOs. A series of other interests, including those from the private health care sector, must also secure seats. As soon as he signed the bill into law, however, [President Trump announced](#) that he was under no mandate to consult with Congress or set aside seats for VSOs on the commission. Before he left office, Trump sought to appoint a number of controversial commissioners, including Jason Beardsley, a former special operator who [allegedly became involved](#) in a disastrously planned [coup attempt in Venezuela](#).

President Biden may be more cautious in his selection of commissioners. However, the AIR Commission's mandate still remains problematic.

The money for this commission, as well as to finance facility closures, will be taken from the VHA care budget. Any final recommendations on facility closures will largely be insulated from action by congressional representatives and will, in their entirety, be subject to a simple up or down vote. If decisions on facility closures are made from inaccurate quality data and underutilization that results from inappropriate eligibility standards under the VA MISSION Act, this guarantees the shuttering of facilities that offer high-quality care. Under the guise of offering veterans greater choice, the option of the VHA will be eliminated. Such closures would also impact local economies and thousands of VA employees, a third of whom are veterans themselves. Many have seen their lives significantly stabilized through work thanks to programs like [compensated work therapy](#).

The closing of small or large VHA facilities would greatly compromise the government's pledge to care for veterans and cause severe economic, healthcare, benefits, training, and research harm to veterans, families, VSOs, VHA employees, and healthcare professionals in communities across America.

Even in areas where the veteran demographics have shifted, it is highly unlikely that the veteran population — or the broader community — will be better served by closure of a facility. It is critical to understand the vital role these medical facilities play in their communities and the breadth and depth of services they deliver to veterans and the nation. Strong safeguards are needed to ensure that changes in the VHA's distribution of services do not degrade its ability to provide the comprehensive and high-quality care veterans deserve. Concerns over closings are particularly salient as the VHA continues to fulfill its Fourth Mission to serve as a backup to civilian

Any decisions on the AIR commission must account for an honest truth, that peace in this world is far too fleeting. Accordingly, today's underutilized facilities will surely become newly populated as new conflicts erupt, and as the many tolls of war catch up to the post-9/11 generation.

healthcare facilities during the Covid-19 pandemic, whose impacts will continue for many years.

For a more detailed analysis of the problems of the AIR Commission please [visit our website](#).

The VHA Compared to the Private Sector

Quality

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

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

Wait Times

[Data shows](#) that one in five VA patients is seen on the same day they make an appointment. Even though roughly 16 percent of VA primary care facilities are operating at over 100 percent of capacity, for the system as a whole, the average wait time to see a VA primary care doctor is five days, and nine days for appointments with VA specialists. Waits to see a mental health professional average four days. No other U.S. health care system of equal or comparable size posts data for clinical appointments.

The industry consulting firm [Merritt Hawkins](#), in its latest survey of 15 major metropolitan areas, found that the wait time to get the first appointment with a physician averages 24 days. In many

parts of the country, the wait times are far worse, especially to see certain kinds of doctors. This is especially true in rural areas, but long wait times can also occur in cities, including ones with renowned medical schools and hospitals. People living in the Boston area, for example, require an average of 109 days to find a family physician who is still taking new patients and up to a year to get the first appointment with a cardiologist. Wait times generally have increased 30 percent since 2014, according to the study. A 2019 [JAMA Network study](#) found wait times in the VA are comparable or better than wait times in the private sector.

Salaried Employees vs. Fee-for-Service

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

Availability, Access, and Duration of Service

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

Best Practices

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

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

MOE ARMSTRONG

VIETNAM VETERAN
FORMER LEAD PEER SPECIALIST,
ERRERRA COMMUNITY CARE CENTER, WEST HAVEN VA

Specialized Treatment Programs for PTSD

VHA has a national network of specialized PTSD services that include outpatient and residential programs. Veterans experiencing PTSD may be treated in a range of settings varying in intensity and matched to the level of need, including primary care, outpatient clinics, and residential PTSD programs. Staff members in these programs are offered training in evidence-based PTSD treatments and develop a specialized knowledge of PTSD and familiarity with the needs and experiences of Veterans with PTSD. The disorder remains relatively unfamiliar to many non-VA mental health providers.

Military Cultural Competency

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



Best Practices During Covid-19 Pandemic

As soon as this pandemic took hold, [VHA staff embedded with the Centers for Disease Control](#) and are today largely running the country's 65 emergency coordinating centers. The department has also deployed nurses to screen American soldiers coming home; built a [website landing page](#) to inform veterans of updates through the crisis and restricted non-essential hospital visits across the country.

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

The VA also quickly utilized its vast telehealth network to substitute virtual for face-to-face visits--not only for medical, but also for mental health visits. The VA has also pioneered the use of [tele-ICUs](#), in which doctors and nurses can consult over video chat and help with intensive care patients in other locations. The VA has three ICU centers located in Minneapolis, Chicago, and Iowa City where doctors and nurses can consult, via telehealth, and help with intensive care patients in other locations. As of 2018, 17 VA medical centers had equipped ICU rooms with TV screens, cameras, and other telehealth equipment. Using telehealth ICUs cannot solve the problems of a shortage of ICU beds or ventilators if a VHA facility is inundated with severely ill COVID-19 patients. But it can help with any staff shortages that result if nurses and doctors are put in quarantine because they're at risk of developing the disease themselves.

“I feel very lucky to be working in the VA today. I’m already on a hair trigger to cancel total knee replacements or other elective surgeries. When I talk to colleagues in the for-profit sector, they are much more reluctant to do this because they will lose money.”

**-VA Medical Center Director
April 2020**

“Providers had inconsistent knowledge about the military population, admitting that they never learned about veterans or the military during their medical training, and so had limited exposure. Providers discussed that a lack of information, lack of available services (particularly in rural areas), and uncertainty about veterans’ insurance coverage reduce their ability to care for veteran patients.”

SOURCE:

“CARING FOR VETERANS IN U.S. CIVILIAN PRIMARY CARE: QUALITATIVE INTERVIEWS WITH PRIMARY CARE PROVIDERS”
FAMILY PRACTICE | OCTOBER 2018

As a [report](#) in the New England Journal of Medicine noted, “the Veterans Health Administration (VHA) offers a blueprint for rapid expansion of telehealth services during the COVID-19 pandemic that can be used to maintain those advances after the pandemic.” The article went on to describe how the VHA faced the “unique challenges” of dealing with a population with serious underlying healthcare problems, as well as serving as the backup system to the private sector in times of national emergency. The article praised the VA for its ability, through telehealth, to continue with the provision of essential non-COVID care, stem the spread of

COVID-19 within its facilities, and quickly deploy staff and resources to COVID-19 hotspots.

Because the VHA is a highly coordinated system, agency staff rejiggered its supply chain to get necessary equipment to hospitals in hardest hit areas and set up command centers to assist with this national emergency. The department was ready to contribute 16,5000 acute care beds, 1,000 isolation rooms, 3,000 ventilators, six mobile nutrition units capable of churning out 1,200 meals a day, 12 mobile command units, and a network of nearly 4,000 deployable volunteers known as Disaster Emergency Medical Personnel.

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

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

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

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

“In a room in VA headquarters we could watch the entire VA system in real time. We have been able track the evolution of a pandemic not only in the VA but state by state, county by county, monitoring the civilian and veteran population, and determining how many diagnoses there were as well as bed capacity, and burn rate of PPE and supplies.”

-VA official

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

A critical but little noted fact is that the VA's system of coordinated and integrated care has also meant that there have been far fewer healthcare disparities during the Coronavirus crisis. Initial [reports](#) suggest that fewer African American veterans and veterans of color have died or suffered devastating health consequences from coronavirus than has been true outside of the VA. Experts believe this is because the VHA manages chronic health problems more effectively than our fragmented, private sector healthcare system.

The VA has also been aggressively reaching out to veterans to educate them about the mental health risks of COVID-19 and also working to help them avoid infection through mask-wearing. The department even developed a calming phone application called [“COVID Coach”](#) that's available to all.

The problems the VA has had with lack of personal protective equipment (PPE) has stemmed from broader societal failures to prepare for pandemics, [past decisions to shutter VA supply depots](#), FEMA failures to deliver PPE to the VA, as well as [Trump administration decisions](#) to hamper VHA outreach to veterans designed to help them feel more comfortable [wearing masks](#) to prevent the spread of disease.

Veterans Prefer the VA to Non-VA Care

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

The results from the most recent [VA enrollee survey](#) indicate:

- 81 percent of enrollees expressed positive views on ease of access to VA facilities
- 86 percent reported that personnel were welcoming and helpful during their visit
- 72 percent indicated that they either “strongly agreed” or “somewhat agreed” that they trusted VA to fulfill our country's commitment to veterans, an increase from 68 percent in 2016

Many VSOs have conducted similar polls and found similar sentiments. In 2017, after the Veterans of Foreign Wars [released a survey](#) showing their members' support of the agency. VFW National Commander Brian Duffy said, “The most important takeaway is the overwhelming majority of

respondents said they want to fix, not dismantle, the VA health care system.” In their [2020 report](#), VFW again found that the department was incredibly popular, with roughly 82 percent of veterans reporting being satisfied with their VA health care experiences.



Acronyms

AAMC: American Association of Medical Colleges

AED: Automated external defibrillator

AIR: Asset and Infrastructure Review Commission

BRAC: Base Realignment and Closure

CBOC: Community-Based Outpatient Clinic

CLCs: Community Living Centers

COPD: Chronic Obstructive Pulmonary Disease

CMS: Centers for Medicare and Medicaid Services

CPT: Cognitive Processing Therapy

DoD: Department of Defense

FY: Fiscal Year

GERD: Gastroesophageal Reflux Disease

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

MDD: Major Depressive Disorder

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

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

NCRAR: National Center for Rehabilitative Auditory Research

NSSF: The National Shooting Sports Foundation

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

PACT: Patient Aligned Care Team

PE: Prolonged Exposure Therapy

PIM: PACT Intensive Management

PSCI: Patient Centers of Inquiry

PTSD: Post Traumatic Stress Disorder

OEF: Operation Enduring Freedom

OIF: Operation Iraqi Freedom

OIG: Office of Inspector General

OIT: Office of Information Technology

PAO: Public Affairs Officer

SAIL: Strategic Analytics for Improvement and Learning

SAMSHA: Substance Abuse and Mental Health Services Administration

SPC: Suicide Prevention Coordinator

SSVF: Supportive Services for Veteran Families Program

SWAN: Service Women's Action Network

TB: [Mycobacterium tuberculosis](#)

TBI: Traumatic Brain Injury

TPA: Third Party Administrators

VA: Department of Veterans Affairs

VAHCS: Veterans Administration Health Care System

VAMC: VA Medical Center

VANCA: VA National Cemetery Administration

VBA: Veterans Benefits Administration

VCCP: Veterans Community Care Program

VERA: Veterans Equitable Resource Allocation

VHA: Veterans Health Administration

VISN: Veterans Integrated Service Network

VistA: Veterans Health Information System and Technology Architecture

VITAL: Veterans Integration to Academic Leadership program

VSO: Veteran Service Organization