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Help a Veteran in Crisis

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.
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 those who served in the military. Whether or not they serve on a committee that directly monitors the Veterans Health Administration (VHA), lawmakers are charged with overseeing, funding, and assuring that the largest publicly-funded U.S. health care system fulfills its service mission. 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 helps elected officials and their legislative aides understand the system that provides health care for millions of veterans, as well as the broader societal impact of the veterans’ health care system.

Often, discussions about the VA health care system revolve around a particular problem or a specific incident or situation. But many are unaware of the complexity, sophistication, and range of services provided in this large health care system designed to serve the often complex needs of America’s veterans. Importantly, it is a comprehensive health care system made up of an intricate web of programs that deliver not only medical and mental health but also public health services. The array of services available at most VA medical centers is vast – from primary care, to hip replacement operations, PTSD treatment, kidney dialysis, dental care, vocational retraining, programs to reduce veteran homelessness, and much more.

As elected representatives attempt to assure that care at the VHA is of the highest quality as well as provide funding and oversight for health care services, they face an environment that is more politicized than ever. Indeed, lawmakers seem to be engaged in a debate over the VHA’s very existence. Although VHA care is consistently rated equal or superior to private sector care, it is jeopardized by the increasing privatization of essential agency services. Observers, including many in the Veterans Service Organization (VSO) community, openly worry the VHA will soon become a shadow of its former self. This will have a negative impact as aging veterans – as well as those who participate in future armed conflicts – need its services.

Members of Congress must be fully briefed on the facts if they are to be good stewards of taxpayer money and provide the care that veterans deserve. In this guide, we dispel common misconceptions and answer frequently asked questions about the agency. Armed with accurate information, Congress can wisely oversee one of the nation’s largest health care systems and ensure the health of the nation’s veterans well into the future.

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Policy Fellow
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The Veterans Healthcare Policy Institute
Letter from the Executive Director

Welcome to the first edition of the Congressional Guide to Veterans’ Health Care. Founded in 2016, our non-partisan non-profit, the Veterans Healthcare Policy Institute, has produced objective, evidence-based research and analysis about veterans and their health care. During conversations with members of Congress and their staff, the media, and even veterans themselves, we have found that veterans’ health care issues and their dedicated health care system are poorly understood.

When compared to every other health care system in the United States, the VA health care system is unparalleled in size and scope and in its array of nationally-recognized veteran-focused programs. At the same time, the proliferation of misleading information published on social media and disseminated by political special interest groups makes it difficult to find accurate information about veterans’ health care and related problems.

That is where this guide comes in. Inside, you will find the topics that most often come up in the media and in House and Senate deliberations. It is not an encyclopedia. Instead, it presents the necessary information required to have a good understanding of who veterans are and how a health care system dedicated to their complex and specific needs actually works. We plan to update this guide annually, although some sections may require more frequent review.

VHPI is committed to helping congressional representatives provide excellent constituent service and effective stewardship of taxpayer dollars while ensuring veterans get the high quality, veteran-centric, and evidence-based health care they deserve. Please do not hesitate to contact me if you ever need assistance digging deeper into a topic that involves veterans’ health care, access to care, or experience on the ground.

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.

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Executive Director
The Veterans Healthcare Policy Institute
@VeteransPolicy on Twitter and Facebook
ExecDirector@veteranspolicy.org | 202-210-8879
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 comprised of sub-agencies, each headed by an undersecretary who reports to the VA Secretary.

The Veterans Health Administration (VHA)

The Veterans Health Administration (VHA) 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 facilities, including acute care hospitals, outpatient clinics, rehabilitation facilities, nursing homes, inpatient residential programs, and campus and community-based centers. The VHA operates 170 medical centers and is organized into a regional network of 22 Veterans Integrated Service Networks (VISN), 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) determines and/or administers a host of veteran benefits, like the GI Bill, housing benefits, vocational rehabilitation and employment, pensions, home loans, life insurance, and disability compensation.

The National Cemetery Administration (NCA)

The National Cemetery Administration provides burials for eligible veterans and maintains the national cemeteries.

The VA Office of Information Technology (OIT)

The VA Office of Information Technology (OIT) is an elevated sub-agency under the VA structure. The OIT tries to assure the seamless sharing of critical information between the sub-agencies. Like the VHA and VBA, OIT is 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 Cerner Corp.
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 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. Many argue that allocations have not been enough to support the surge of post-9/11 veterans.

More about the VA Budget:

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<th>VA's Budget FYs 2015 - 2019</th>
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<tr>
<td>$ in billions</td>
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<tr>
<td>2015: $163.5B</td>
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<td>2016: $166.9B</td>
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<td>2017: $182.1B</td>
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<td>2018: $186.5B</td>
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<td>2019: $198.6B</td>
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### Table: VA's Budget FYs 2009-2019

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<td><strong>182.1</strong></td>
<td><strong>186.5</strong></td>
<td><strong>198.6</strong></td>
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1. 2014 Mandatory includes $15 billion provided by the Veterans Choice Act, and an additional $2.1 billion in 2017 & 2018
2. Totals may not add due to rounding
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 entire world.

Delivering Health Care

The VHA cares for veterans in over 1,255 different sites of care, including 170 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 helping to develop 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.

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. The VHA is a global leader in telehealth and 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 locus of care delivery in the veterans health care system would cause severe disruption to the programs that teach health care professionals in the United States.

Emergency Management

The VHA often responds in emergencies – hurricanes, tornadoes, wildfires, earthquakes, and even volcanic eruptions – to assure that veterans can access health care services during disasters or disruptions of service.

For example, 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 facilities22 during and after Hurricane Maria. The VHA provided crucial health services to veterans in Puerto Rico and throughout the Caribbean.

The VA Workforce

The VA has a salaried staff of roughly 350,000 individuals.24 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.25 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. In December 2018, the agency reported it had nearly 49,000 vacancies26, 42,790 of which were positions within the VHA.

The VHA’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?

A veteran may be eligible for VA care based on any one of a number of factors – including having served in a war zone, having a ‘service-connected’ health problem, having a catastrophic injury, or meeting income criteria set in law.

To be a veteran, per law, one must have completed 24 continuous months of active-duty military service (or the “full period for which they were called to service,” unless a service member is medically retired within that period) and have been discharged or separated under conditions other than ‘dishonorable.’

VA health care is not a mandatory government program like Medicare. VA health care funding is limited to the amount Congress appropriates. Congress has, accordingly, established a system of priorities for VA enrollment. Veterans who have service-connected health conditions (that is, conditions incurred or aggravated in military service), for example, have higher priority than those whose eligibility is based on limited income.

These priority groups are based on awards received (Medal of Honor, Purple Heart), discharge status, the veterans’ income, or a ‘service-connected disability. With multiple exceptions (Purple Heart recipients and veterans of current wars, for example), very high-income veterans with no service connection are not in a high enough priority group to receive VHA care.

Other than Honorable (OTH) Discharges

Discharge status (Honorable, General, Other Than Honorable, Bad Conduct, Dishonorable) is one consideration determining benefit eligibility. Veterans are barred from receiving benefits when, under very restrictive VA regulations, their discharge is deemed to have been issued under dishonorable conditions. Many veterans with an ‘Other than Honorable’ (OTH) discharge have been deemed ineligible for VA health care based on behavior or activities that are classified under VA regulations as “willful and persistent misconduct.”

There are approximately 500,000 veterans with an OTH discharge status. Veterans’ advocates contend that many OTH veterans suffer from mental or physical illnesses arising from their military service. Further, they argue that the veteran’s allegedly less than honorable behavior while on active duty is often triggered by a job-related health condition. Many veterans’ advocates are lobbying for access to benefits for these OTH veterans.

In 2017, former VA Secretary David Shulkin ordered the VHA to provide 90 days of emergency mental health treatment to OTH veterans. The VA must notify OTH veterans of their eligibility to receive care. This mandate has not been accompanied by the hiring of additional staff or the allocation of increased financial resources.

Other Eligibility Exceptions and Recent Changes

On February 26, 2019, Secretary 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.

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 Services**

Establishing eligibility for VA benefits often involves the Veterans Benefits Administration (VBA). This is always the case if veterans seek financial compensation for service-connected disabilities. They may file their application for compensation online, by phone, in-person, or submit it by mail.

Processing a claim for compensation will typically require the veteran to undergo a medical evaluation (referred to as a ‘compensation and pension’ (comp and pen) examination). Veterans often seek help from VSOs or other veterans’ advocacy groups in filing claims or appealing an adverse decision on a claim.

Many comp and pen exams are now conducted by private contractors, which has spurred numerous problems. 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 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 veterans complain about ‘wait times’ or denials of eligibility at the VA, they may be referring to long wait times for a VBA exam or a VBA denial of eligibility – denials which may have been generated by an outside contractor.
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 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 insurance for healthcare. 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.”

According to the Congressional Research Service, the VA-enrolled veteran population has increased by 78 percent from FY2001 to FY2014. Most health care systems in the United States care for a broad range of patients. The VHA cares for some of the oldest, sickest, poorest and medically-complex patients in the nation. A 2016 RAND Corporation study 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.”

These patients include the surviving members of the World War II generation, Korea and Vietnam War veterans, and those who were in the military during and around these conflicts.

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](https://example.com/chor diagram)

**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.
Women Veterans

Although only 7 percent of VHA patients are women, the system has worked diligently (sometimes in response from 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. In 2015, there were 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.
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.

The VHA’s 170 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 among its patients 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 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.

**Telehealth Capacity**

The VHA is a global leader in telehealth. It delivers care via telehealth 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. Patients are also able to receive in-home monitoring via telehealth. In 2016, nearly 12 percent of veterans – or 2.17 million episodes of care – received some of their care via telehealth.

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.

**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. 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. They have been pushing Congress, unsuccessfully, to recognize them and grant them VA benefits and care. A Federal Appeals Court ruling on a suit filed by Blue Water Navy veterans stipulates that the VA cannot deny thousands of these veterans’ disability claims.

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 systematically 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 life-saving, 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), personality disorders, or substance abuse disorders, 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 increasingly delivered 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 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\textsuperscript{88} 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.

**MST Key Statistics**

- At least 25 percent of women\textsuperscript{80} 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\textsuperscript{91} than to be killed in combat.
- In 2017, the DoD received 6,769 reports of sexual assault\textsuperscript{92} involving service members as either victims or subjects of criminal investigation, a nearly 10 percent increase over the previous year.
- The VA states\textsuperscript{93} 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 predictor of 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.

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 sort of 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. Thousands of therapists 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.

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

Suicide rates, which are rising dramatically throughout America, are also rising among the veteran population. On average, twenty veterans die by suicide every day. Of these veterans, the vast majority have had no contact with the VHA. Compared to the rest of the American population, veterans have a higher suicide rate\textsuperscript{109}, particularly among women. 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.

Each of the last two VA Secretaries has prioritized suicide prevention as their top concern. The agency has deployed many programs aimed at lowering the troublingly high rate. Indeed, due to the VA’s suicide prevention efforts, suicide rates\textsuperscript{110} for veterans cared for by the VHA are not rising as rapidly as those in the civilian population.

Identifying At-Risk Veterans

VHA has implemented a predictive analytics program\textsuperscript{111} 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.

Employee Training and Outreach

Each of the 170 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)

Since its launch in 2007, The National Veterans Crisis Line (VCL) operates 24 hours a day and 365 days a year. Initially located in Canandaigua, New York, VCLs also now operate in Atlanta, Georgia, and Topeka, Kansas.

VCL operators have answered more than 3.8 million calls from veterans and their family and friends. Operators have completed more than 640,000 follow-up referrals to local VA SPCs. The VCL has initiated emergency responses nearly 112,000 times and had 439,000 chats and 108,000 texts messages with individuals in crisis.

Care coordination is more effective when a veteran’s provider is in the VHA because the VCL links directly to VHA facilities. When the veteran is not a VHA patient, coordinating with their provider is often hampered by considerable logistical barriers.

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 69 percent of veteran suicides resulted from a firearm injury in 2016. In comparison, the proportion of suicides resulting from a firearm injury among U.S. non-veteran adults was 48 percent. Approximately 71 percent of male veteran suicides and 41 percent of female veteran suicides resulted from a firearm injury.

<table>
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<th>Method of Suicide</th>
<th>% of non-veteran adult suicide deaths</th>
<th>% of veteran adult suicide deaths</th>
<th>% of male non-veteran adult suicide deaths</th>
<th>% of male veteran suicide deaths</th>
<th>% of female non-veteran adult deaths</th>
<th>% of female veteran suicide deaths</th>
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</thead>
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<td>53.9%</td>
<td>70.6%</td>
<td>32.4%</td>
<td>41.2%</td>
</tr>
</tbody>
</table>

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. Many veterans believe that guns must remain in their homes no matter what the circumstance. In response, the VHA launched the first-of-its-kind open innovation challenge for safe gun storage in 2018. That challenge led to the creation of numerous life-saving product designs.
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 are working to develop a program that will empower communities to engage in safe firearm-storage practices. The program will include information to help communities create coalitions around promoting and sustaining firearm safety with an emphasis on service members, veterans, and their families. This is perhaps the nation’s most successful effort to forge common ground on an issue where polarization has interfered with life-saving initiatives.

Myriad VHA programs and support groups help veterans cope and decrease social isolation, thus mitigating the risk of suicide.

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 or the PREVENTS Initiative. It creates a cabinet-level taskforce to work at the national, state, and local government level, as well as with the private sector, to better address and understand veteran suicide. Leaders will 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).

President Trump said his administration would work with Congress to secure grants that would be made available to the private sector and communities to increase suicide prevention efforts, but did not call for a dedicated funding stream for the initiative.

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.

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.

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.

“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)\textsuperscript{153} 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\textsuperscript{154} 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 \textit{not common among the civilian, often female, residents}\textsuperscript{155} in private sector nursing homes. They suffer from more mental health problems, more chronic pain, and traumatic injuries.\textsuperscript{156} 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, \textit{studies document}\textsuperscript{157}, 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.

\textit{“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.”}

\textit{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 include 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.

Broad Problems in Measuring Quality

These measures evaluate criteria such as acute care hospital morbidity, 30-day readmission rates, 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. As discussed below, SAIL scores are not comprehensive gauges of the quality of VA care, and their import is often misunderstood.

It is difficult to accurately measure the quality of some health care services whether they are delivered in the private or public sector. As a VHPI report on quality points out, there are few to no direct quality metrics over many diagnoses. Moreover, most private sector providers do not consistently report quality and wait time data.

As the VA states in its March 2019 Report to Congress on Health Care Standards for Quality (MISSION Act, Section 104) “Even where quality metrics exist for comparing VA to community care, there still is a need to account for population differences. A community provider excellent outcomes with patients that have straightforward medical conditions and a strong support system; however, that may not guarantee the same outcomes if a provider sees a Veteran with complex needs such as homelessness or co-existing mental illness.”

SAIL Ratings and the Bell Curve Controversy

The SAIL methodology grades facilities with star ratings distributed on a bell curve. Ratings go from one to five, with one being the lowest and five the highest. It is often assumed that a one-star VHA medical center or nursing home scores lower than private sector facilities in the city or region. This is not the case.

As many studies have documented (see the section “The VHA Compared to the Private Sector”), VHA care is usually equal, and often superior, to care in the private sector. A one-star VHA facility may be far superior to other hospitals or health care institutions in the surrounding area. As VHPI has reported, this is particularly true of VHA nursing homes.

Bell Curves Inevitably Skew Performance Data

Bell curves inevitably slot individuals or institutions as winners or losers. They artificially place those scored on a curve, positioning some on the lower end and some on the higher end. Bell curves are always a zero-sum game.
For one facility to improve, another facility has to decline in the ratings. If there is broad institutional improvement throughout a system, as is true in the VHA, those on the low end will remain on the low end of the curve. It will seem that there is no improvement in the system when the precise opposite is true.

If Congress were to shutter the 20 percent of facilities on the lower end of the curve, those above them would automatically be placed on the lower end of the curve. This would eventually threaten every VHA facility with closure.

**SAIL ratings often fail 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 not only 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.

Some areas measured in the SAIL scoring system may not be indicative of problems in the quality of the clinical care provided by a particular facility. For example, SAIL measures include patient and employee satisfaction, which may reflect concerns wholly unrelated to care-quality. Employee satisfaction may be influenced by negative portrayals of VA, such as in the media, or by conditions they cannot influence such as hiring freezes. While the agency’s [2018 employee survey](#) showed an uptick in morale, the agency is still grappling with serious retention problems, and many talented staffers are leaving for private sector work.

Employees may also be demoralized by federal hiring freezes. They may be disheartened because they often receive lower salaries than those offered in the private sector. Congress has also [frozen performance bonuses](#) (which are a fraction of those offered in the private sector) and reduced [retirement pay](#).

Patient satisfaction, while an important measure, may also be influenced by failure to adequately fund and staff the VHA or by former service members’ distrust of government and sense of [moral injury](#). Patients may even express dissatisfaction because they want more services from a system with which they are extremely satisfied.

For all of these reasons, SAIL ratings may generate an inaccurate picture of the quality of care of a particular facility or even the system as a whole.
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 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 February 2019, VA published a proposed rule for the community care program that set out its proposed access standards. If adopted, the proposed access standards would exponentially increase 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.

In an economic analysis accompanying the publication of its proposed rule, 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 have expressed concern (https://www.regulations.gov/document?D=VA-2019-VHA-0008-22751) that VA Secretary Robert Wilkie, President Trump’s second VA secretary, has failed to consult with both veterans advocates and political representatives during the rulemaking process.
Recent reports from the VA, testimony at Senate and House Committees on Veterans’ Affairs hearings, and comments from some veterans service organizations highlight problems with assuring that veterans will get high quality, coordinated care in the private sector. Some have suggested delaying the VCCP rollout.

The VA has stated that it intends to begin implementation of that program in June 2019, despite the many concerns lawmakers, veterans service organizations, health care professional organizations, advocates, and individual veterans have raised about VA’s proposed implementation of a Veterans Community Care Program.

**Cost and Funding**

The [Congressional Budget Office estimates](#) that the MISSION Act would result in 640,000 additional veterans seeking private care in the first few years after its implementation. The agency’s current annual allocation of $9 billion for private care would increase substantially. It’s not clear by how much, however, as agency officials have offered lawmakers conflicting estimates.

VA has projected that the proposed veterans community care program would cost $322 million in FY2019 and $17.2 billion over five years according to a February 15, 2019, Impact Analysis drafted by the Office of Community Care at the Veterans Health Administration.

[Stars & Stripes](#) reports that “at one briefing, lawmakers were told [MISSION] would cost $21.4 billion for five years. At another, the cost estimate was $1 billion for the first year.” According to cost estimates for private sector care compiled for the VA Commission on Care, the cost could escalate much higher. The Commission considered a range of options for increasing veterans’ access to community care, but the one closest in design to VA’s proposal was projected to result in total costs as high as $179 billion per year. The report states that “the estimate for the less-managed, broader network scenario is $106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

![Cost and Funding Graph](#)

Source: “[Projected Costs of Recommended Option](#) from the Commission on Care, 2016.”
With no accurate estimates of how much private sector care will be delivered or what it will cost, the VA MISSION Act could deplete the VHA of needed resources. Every dollar spent on private sector care would likely be taken from the VA budget, with private sector providers having payment priority even over VA staff.

Because private sector care is fragmented and therefore generally more expensive[^180], and relies more heavily on specialist services than highly-monitored VHA care, the agency risks being starved of needed resources. Should the VHA lose these resources, it would be difficult to make infrastructure improvements and fill the approximately 49,000 staffing vacancies that plague agency facilities all over the country. Moreover, hospital directors may have to shift their limited resources and staff from direct caregiving roles to ones managing and coordinating care in the private sector. Shifting more care to the private sector will also result in under-utilization of VHA facilities and programs.

### National 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)[^181] warns that the U.S., which already has a shortage of primary care physicians, will need 52,000 more[^182] by 2025. However, not enough physicians in training are choosing to enter primary care[^183]. 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[^184] has designated many primary care shortage areas[^185]. There is not only a shortage of primary care in rural areas but also specialist and acute care. Between 2010 and 2019, 104 rural hospitals have closed[^186] and it is estimated[^187] that another 700 will close in the next decade.

In its report for Congress under the Choice Act, an Independent Assessment by the RAND Corporation[^188] 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[^189] 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[^190], 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 2020. In a hearing on February 27, 2019, VA Secretary Robert Wilkie said the agency could potentially move up the timeline[^191] on the BRAC-style review of VA facilities.
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. 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 an up or down vote. If decisions on facility closures are made from inaccurate quality data and underutilization that results from inappropriate eligibility standards, this guarantees the shuttering of facilities that offer high-quality care. Under the guise of offering veterans greater choice, the choice of the VHA will be eliminated.
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. Many studies have found the VHA generally outperforms the private sector on key quality metrics.

- 2018: A RAND Corporation\textsuperscript{193} study found that private providers are woefully unprepared to treat the often unique and challenging veteran patient population.
- 2018: A RAND Corporation\textsuperscript{194} 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\textsuperscript{195}, 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\textsuperscript{196} 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.

Wait Times

Data shows\textsuperscript{197} 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\textsuperscript{198}, 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\textsuperscript{199} 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\textsuperscript{200}. 
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).

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 studies have documented, clinicians are more effective when they understand how to diagnose and treat problems and the cultural and social issues that impact their patients. However, studies have also shown that the majority of private sector providers know very little about military culture or military-related health conditions.

Veterans Prefer the VA to Non-VA Care

Polls have 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 2017 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.”
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
PSI: 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
Endnotes

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