Description of document:	Responses to Questions for the Record (QFR) provided to Congress by the Department of Veterans Affairs (VA), 2011-2012
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VA | U.S. Department of Veterans Affairs

Department of Veterans Affairs
Office of Congressional and Legislative Affairs
Washington DC 20420

August 12, 2014

This letter is to acknowledge receipt of your Freedom of Information Act (FOIA) request received by mail to the VA FOIA Office, June 19, 2014. Your request was forwarded to the Office of Congressional and Legislative Affairs and received June 26, 2014 in which you asked for documents pursuant to the Freedom of Information Act (FOIA), 5 U.S.C. §552 et seq.

Specifically you requested:

"Copy of each response to a "Question for the Record (QFR) provided to Congress by the Department of Veterans or its components. (By responses to QFRs, I mean the responses to formal questions posed in association with testimony before a congressional committee.) These records are most likely maintenance in the Office of Congressional Affairs, Office of Legislative Affairs, Office of Intergovernmental Affairs, or equivalent, or in the executive secretariat."

The records you requested are attached to this letter.

Also, once a hearing is completed, a transcript of the hearing (to include Questions for the Record – QFRs) is available to the public on the U.S. Government Printing Office Website: You can click on the link below, which will take you directly to the page for transcripts:

http://www.gpo.gov/congressional/

Please be advised that the Office of Congressional & Legislative Affairs did not refer your request to any other offices in the Department of Veterans Affairs.

This request was processed by the undersigned. You may appeal the determinations made in this response to:

Department of Veterans Affairs
General Counsel Office (024)
810 Vermont Avenue, N.W.
Washington, DC 20420

Please refer to FOIA 14-06084-F in your response. Be sure to include a copy of this letter, your request, and the reason for your appeal. You may also include a daytime phone in case the General Counsel needs additional information.

Sincerely,

Pamela C. Balsley
FOIA Officer
Office of Congressional
and Legislative Affairs

Attachments:

1. September 9, 2013 – A Matter of Life and Death: Examining Preventable Deaths...Who Oversaw Them
2. January 15, 2014 – Vendors in the OR – VA's Failed Oversight of Surgical Implants
3. February 5, 2014 – Beyond Transformation: Reviewing Current Status and Secondary Effects of VBA Technology
4. February 26, 2014 – To Receive Testimony on the Relationships-.....Victims of Sexual Trauma
5. February 26, 2014 – VA Accountability: Assessing actions Taken in Response to Subcommittee Oversight
6. February 26, 2014 – A Review of the Effectiveness of VA's Vocational Rehabilitation and Employment Program
7. April 2, 2014 – VA and Human Tissue: Improvements Needed for Veterans Safety
8. April 3, 2014 – Trails in Transparency II: is VA Responding to Congressional Request in a Timely Manner?
9. April 9, 2014 – A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths
10. April 11, 2014 – Post Hearing QFR – HVAC Minority, VA's FY14 Budget Submission

Questions for the Record
Committee on Veterans' Affairs
U.S. House of Representatives
Full Committee Hearing
Held on September 9, 2013
At Pittsburgh, PA
"A Matter of Life and Death: Examining Preventable Deaths, Patient-Safety Issues and Bonuses for VA Execs Who Oversaw Them"

Questions for the Record from the Honorable Jeff Miller, Chairman

1. During the field hearing, VA Under Secretary for Health Robert Petzel testified that, "I would agree that reviewing performance awards is appropriate" in response to a question I asked about the need for a "top to bottom" review of VA's bonus system. When will this "top to bottom" review begin? Who will be in charge of it? When do you expect the review to be completed? Please provide the results of the review to the Committee upon completion.

VA Response: The Department of Veterans Affairs (VA) acknowledges the importance and significance of a comprehensive review of its performance awards.
In April 2013, VA's Corporate Senior Executive Management Office (CSEMO) completed an agency-wide review of VA's Senior Executive Service (SES) performance management system as part of VA's request to the Office of Personnel Management (OPM) for recertification. OPM's certification criteria for SES performance management system includes a review of all aspects of the system, including executive training, alignment of expectations with the strategic plan, individual and organizational performance measures, oversight, rating distinctions, award differentiation, and transparency throughout the process. OPM, with the concurrence of the Office of Management and Budget (OMB), determined that VA's SES performance management system warranted full certification, which was granted on May 6, 2013, and continues through May 6, 2015.

VA is required to report annually to OPM about the application of VA's SES performance management system. OPM annually reviews VA's distribution of ratings and awards in an effort to ensure that VA is making meaningful distinctions in ratings and providing awards that reflect performance. The attached letter from Ms. Elaine Kaplan, Acting OPM Director, transmits OPM's formal certification of VA's SES performance management system.

VA SES Full Cert
Signed 05-06-2013.pd

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

The Director

MAY - 6 2013

The Honorable W. Scott Gould
Deputy Secretary
Department of Veterans Affairs
Washington, DC 20420

Dear Mr. Gould:

This is in response to Mr. John R. Gingrich's request of January 3, 2013, for full certification of the U.S. Department of Veterans Affairs (VA) Senior Executive Service (SES) performance appraisal system – a new system issued on January 4, 2012, by the U.S. Office of Personnel Management (OPM) and the U.S. Office of Management and Budget (OMB) and approved by OPM for implementation. OPM has reviewed your request and determined your system warrants full certification, and OMB concurs. The certification period begins the date of this letter and continues for 24 months. Certification authorizes pay above the rate for level III of the Executive Schedule, up to the rate for level II of the Executive Schedule, and use of the higher aggregate pay limit.

VA must continue to report annually to OPM the data that result from the application of this certified system, and VA's compliance with the established report submission deadlines may affect continued certification. OPM will review this data to determine whether VA's awards for all VA SES members involve meaningful distinctions based on performance – a prerequisite to receiving continued certification. VA should also reapply for certification six months prior to the expiration date in order to continue applying a higher maximum rate of basic pay and the higher aggregate limitation on pay beyond the expiration date; this request must result in certification of the appraisal system by OPM and OMB by the end of the two-year certification period to avoid any gap in authority to apply the higher maximum rate of pay and higher aggregate limit. When submitting a certification request in 2015, VA should use the revised certification process created for agencies using the standard SES appraisal system.

Thank you for your attention to this matter. If you have any questions regarding VA's certification status or requirements, please contact Ms. Karen Lebing, Manager for Performance Management Implementation, Senior Executive Service and Performance Management, by telephone at (202) 606-1633, or by e-mail at karen.lebing@opm.gov.

Sincerely,

Elaine Kaplan
Acting Director

Questions for the Record
Senate Armed Services Committee
Subcommittee on Personnel
Hearing #14-09
"To receive testimony on the relationships between military sexual assault, posttraumatic stress disorder and suicide, and on Department of Defense and Department of Veterans Affairs medical treatment and management of victims of sexual trauma."

February 26, 2014

Questions for the Record from Senator Kirsten Gillibrand

Military Sexual Trauma

Question 1: Dr. McCutcheon, you stated in your testimony that: (1) recovery is possible for those who have been diagnosed with Military Sexual Trauma (MST); (2) MST services are provided free of charge at the Department of Veterans Affairs (VA); and (3) there are MST coordinators at every VA Medical Center. Please provide information on the total number of MST coordinators nationwide and the description of their responsibilities.

VA Response: VHA Directive 2010-033, *Military Sexual Trauma (MST) Programming*, provides information about the MST Coordinator role and specifies that every VA health care system must appoint an MST Coordinator. Some health care systems choose to split the MST Coordinator duties among multiple appointees. For example, some health care systems may have one MST Coordinator for the VA Medical Center but another for the Community-Based Outpatient Clinics (CBOC) associated with the health care system. In March 2014, there were 163 staff members serving in MST Coordinator roles across the VA health care system.

MST Coordinators have five primary areas of responsibility:

1. *Implementation of national, Veterans Integrated Service Network (VISN), and local-level screening and treatment policies.* MST Coordinators help ensure that Veterans being seen for care at the facility are screened for experiences of MST, that Veterans have access to needed MST-related services, and that the care is provided free of charge. Coordinators monitor local MST-related programming and make efforts as needed to expand the scope of available services.

2. *Implementation of national, VISN, and local-level staff education policies.* MST Coordinators help ensure that local staff members receive mandated MST education and training and provide training as needed in clinics throughout the health care system to ensure that staff members have the needed knowledge and skills to work effectively with MST Survivors.

3. *Implementation of national, VISN, and local-level informational outreach policies.* MST Coordinators engage in outreach to Veterans to raise awareness of the availability of MST-related services and to facilitate engagement in care.

4. *Serving as local point person for MST-related issues.* MST Coordinators serve as local points of contact, sources of information, and problem solvers regarding MST-related issues for both Veterans and VA staff. They engage in consultation with local offices and services, serve as advocates for Veterans in working with the system, and address systems issues that may create barriers to care.

5. *Communicating with national, VISN, and facility-level leadership.* MST Coordinators stay in regular contact with leadership, stakeholders, their VISN-level points of contact, and other MST Coordinators in their VISN, in order to stay apprised of polices and trends related to MST. MST Coordinators also respond to requests for information about local MST programming from VA Central Office.

Question 2: Dr. McCutcheon, you stated that these MST coordinators are the single point of contact for every veteran who screens positive for MST. What is the average workload for each of these coordinators? Please include the number of veterans seen annually by these coordinators.

VA Response: To clarify, MST Coordinators serve as point people for MST-related issues within their facility. They serve as sources of information and problem-solvers both for Veterans and for staff. When needed on a case-by-case basis, MST Coordinators consult on care-related issues for particular Veterans or serve as advocates to assist particular Veterans with navigating the system. Although individual facilities may choose to set up a process wherein the MST Coordinator has personal contact with every Veteran who screens positive for MST, this is not a model required by national policy.

With respect to MST Coordinator workload, VHA Directive 2010-033 permits facilities to designate the MST Coordinator as a collateral position, performed in addition to other roles. It is an administrative position in that direct clinical care and case management responsibilities are not part of the role. However, most staff in the MST Coordinator position do provide clinical care to MST Survivors as part of other roles. The Directive requires facility leadership to ensure that MST Coordinators have adequate protected administrative time to fulfill the responsibilities of the position. Currently, no specific amount of protected time is required, as facilities vary widely in their size, complexity, number of Veterans seeking MST-related care, and other factors relevant to the MST Coordinator role. Facility leadership is encouraged to consider these factors when determining how much protected time is needed.

VA has recent survey data that provide some information about how much protected time MST Coordinators are allocated. As part of the Department of Defense (DoD)/VA Integrated Mental Health Strategy (IMHS) Strategic Action #28, a survey of practice was disseminated to VA health care facilities. Among other areas, facility leadership were asked to indicate whether the local MST Coordinator had been given protected time for

the duties of that role. The majority of facilities (82 percent) reported that the MST Coordinator has protected time to devote to MST-related training and administrative activities, although there was wide variability in the amount of protected time per week. Among facilities who provided data, the mean number of hours of protected time per week was 6.2 hours.

Question 3: Dr. McCutcheon, during your testimony you indicated there is mandatory training for VA mental health providers and other health care personnel which includes the MST coordinators. What does that training entail?

VA Response: VHA Directive 2012-004, *Mandatory Training of VHA Mental Health and Primary Care Providers on Provision of Care to Veterans Who Experienced Military Sexual Trauma (MST)*, established an MST-mandatory training requirement for all VA mental health and primary care providers. This one-time training requirement was established to ensure that all clinicians receive a consistent baseline level of training on MST. Mental health providers fulfill the requirement by completing a comprehensive web-based independent study course that focuses on the treatment of mental health sequelae associated with MST, including an overview of empirically-based treatments for posttraumatic stress disorder (PTSD), depression, and substance use. Mental health providers also have the option to "test-out" of the course by passing an MST knowledge assessment test that demonstrates significant pre-existing expertise in mental health issues related to MST.

Primary care providers must complete the mandatory training requirement by completing a web-based training on "MST for Medical Providers." This training covers information about health conditions associated with MST; issues related to screening for MST; how MST can affect a Veteran's experience of health care; how to appropriately adapt care to address the needs of MST Survivors; and VA documentation requirements.

Additionally, trainees in health professions which provide clinical services at VA facilities are required to complete the web-based course *Mandatory Training for Trainees* in their first year and a refresher version of the course each year thereafter. VHA's Office of Academic Affiliations has included information on MST in both the initial and refresher courses to ensure that all trainees have a baseline level of knowledge about MST. In addition, regular close supervision that trainees receive from licensed, VA-credentialed clinicians ensures that all trainees receive training and consultation about MST and Veterans' clinical needs on an ongoing basis.

For many years, VHA has also offered a range of voluntary MST-related training programs for continuing education. These allow both providers and trainees the opportunity to develop MST-related knowledge and skills above the baseline provided by the mandatory training described above. Continuing education courses include a monthly teleconference training series on MST-related topics and an annual training conference designed primarily for MST Coordinators.

Question 4: Dr. McCutcheon, as we heard from the two survivors at the hearing, they did not appear to be aware of their mental health options available through the VA. What information is supposed to be provided to each veteran who screens positive for MST or who meets with an MST coordinator?

VA Response: VA screens all Veterans seen for health care for experiences of MST via a clinical reminder in the electronic medical record. The MST Clinical Reminder alerts providers of the need to screen the Veteran, provides language to use in asking the Veteran about MST, and documents the Veteran's response to the screening. Upcoming revisions to the MST Clinical Reminder will capitalize on screening as an opportunity to provide all Veterans with information about VHA's MST-related services, regardless of whether or not they disclose having experienced MST. This will be achieved by the addition of an introductory script that notifies all Veterans that VHA provides free MST-related care. Revisions will also provide additional information to those who disclose having experienced MST. Providers will be instructed to offer every Veteran who reports experiencing MST a fact sheet which reviews the definition and prevalence of MST, the impact of MST, VA's services for MST, and how to access care. The revised MST Clinical Reminder will also include a mental health services referral question, which will streamline access to care for Veterans who express interest in MST-related treatment. It will also facilitate national monitoring of referrals for this care. Individual facilities will decide how this referral will operate locally. Some facilities may decide to route all referrals through the MST Coordinator, but many will route referrals to their general mental health service and consult with the MST Coordinator, as needed.

In addition, MST Coordinators conduct outreach activities year round to help ensure that information about VA's MST services is readily available. For example, MST Coordinators arrange for outreach posters to be displayed in visible locations and for outreach brochures to be available in clinic waiting rooms. These materials discuss the availability of MST-related services and provide contact information for the MST Coordinator. MST Coordinators also often work with local Veterans Service Organizations and other community groups to make information available to the Veterans they serve. MST Coordinators also engage in staff educational activities to help ensure that providers and frontline staff who work with Veterans are aware of local MST services, know how to contact the MST Coordinator, and are able to make appropriate referrals for care when needed. Facilities often capitalize on Sexual Assault Awareness Month (every April) to host a range of informational and awareness-raising events. These local efforts complement the national MST Support Team's initiatives to disseminate information about VA's MST-related services, some of which are described later in this document.

Question 5: Dr. McCutcheon, what mechanisms are in place to ensure MST coordinators are providing all required information to the veterans they meet with?

VA Response: MST Coordinators represent one important source of information for Veterans interested in MST-related services, but VA disseminates information about its services broadly to ensure that even Veterans who do not come in contact with the MST

Coordinator are aware of available services. For example, as noted in the previous question, upcoming revisions to the MST Clinical Reminder will standardize the information provided to all Veterans during the screening process. For Veterans and family members looking for information on the Internet, VA has a Web site on MST (http://www.mentalhealth.va.gov/msthome.asp) with basic information about MST, descriptions of programs and services, and links to other online resources. Also, as described in question 18 below, VA has disseminated information about MST services to key DoD staff members who work with sexual assault Survivors, as well as DoD online resources like the Safe Helpline, in order to provide additional avenues for Servicemembers to access this information.

Not all Veterans interested in MST-related services will necessarily have contact with the facility MST Coordinator. However, MST Coordinators are well-prepared to address the MST-specific needs of Veterans with whom they do meet. VHA Directive 2010-033 requires that the MST Coordinator be a professional who is knowledgeable about trauma and mental health and who possesses expertise in issues specific to MST. The MST Coordinator role is almost always fulfilled by a mental health provider who is very familiar with local services important for MST Survivors and readily able to describe these services. To facilitate provision of information about VA's services more broadly, the national MST Support Team has developed outreach and educational materials for MST Coordinators to distribute. In addition to this standardized information, as mental health providers, MST Coordinators are skilled at assessing difficulties related to MST and thus readily able to provide information tailored to each Veteran's specific treatment needs.

Gender

Question 6: Dr. McCutcheon and Dr. Bell, the VA has sponsored significant research on the links between sexual assault and harassment, posttraumatic stress disorder (PTSD), and suicide. Based on your research, what can you tell me about the differences in male and female survivors in terms of these links?

VA Response: As noted in Dr. Bell's testimony, research has identified a relationship between sexual trauma and PTSD, between PTSD and suicide, and between sexual trauma and suicide. Studies have shown that the association between sexual trauma and suicide holds even after controlling for mental health conditions like depression and PTSD.

With regard to how gender impacts these relationships, research to date has relatively and consistently shown that both men and women have an increased risk for suicide after experiencing sexual trauma. This appears to be true for both civilian and Veteran samples. Although some studies have identified some potential differences in the strength or nature of this relationship, it would be premature to make definitive statements about gender differences in this area. However, this is a very active area of research and as the field's knowledge continues to grow, more definitive conclusions about gender differences may be possible in the future.

Question 7: Dr. McCutcheon and Dr. Bell, do female and male survivors of military sexual assault or harassment present with symptoms differently? If so, how do treatment protocols accommodate and respond to these differences?

VA Response: It is crucial for VA and others to continue expanding the research base on how gender shapes reactions to and recovery from MST. The literature on gender differences in response to civilian sexual trauma is similarly small but growing.

Generally, studies have shown that men and women experience similar types of mental health difficulties after experiencing MST, with the most common mental health conditions for both being PTSD, depression, anxiety disorders, and substance use disorders. There is also often considerable overlap in the specific difficulties with which men and women present after experiences of sexual trauma, including struggles with self-blame, difficulties trusting others, and lack of social support.

Some recent work has suggested, however, that the strength of association between MST and negative mental health outcomes may be larger for men than for women. Clinically, it is common for men to present with struggles related to gender role socialization, including questions about their masculinity and/or sexual orientation, particularly if the perpetrator of the MST was male. Men may also be particularly reluctant to disclose experiences of MST for fear of encountering negative reactions from others, given widespread misinformation and stigma related to sexual trauma among men.

Women may also face unique issues in their recovery, such as the possibility that MST may intensify pre-existing concerns about safety, given significant rates of violence against women in United States society more generally. There may be factors related to their experience as a woman in the military that affect recovery from MST as well. For example, women are often numerically a minority in their unit, and it is possible that stressors associated with minority status may amplify the impact of MST or create additional challenges for recovery.

Treatment always needs to be tailored to the specific difficulties of each individual Veteran. Best practices would include discussing with the Veteran how his or her gender and sense of self might be affected by the experiences of MST. Treatment often includes providing psychoeducation to counter rape myths, having discussions about the impact of gender socialization and societal inequalities related to gender, and addressing any gender-specific issues with which the Veteran might present. Research examining whether different evidence-based treatment approaches are differentially effective based on patient characteristics is in the early stages but will provide crucial information to allow VA and others to be more targeted in treatment planning. Early data show no substantial gender differences in the efficacy of some of the most commonly used evidence-based psychotherapies, but gender is a key variable for consideration as this literature continues to expand.

Question 8: Dr. McCutcheon and Dr. Bell, do you believe there should be different treatment programs for male and female survivors?

VA Response: Limited research exists on the relative effectiveness of single-gender and mixed-gender programming for male and female sexual trauma Survivors. This is true both for civilian and military/Veteran populations. Both single-gender and mixed-gender treatment environments have advantages and may be clinically indicated at different points in a Veteran's recovery. For example, single-gender environments may facilitate addressing safety and gender-specific concerns, while mixed-gender environments may help Veterans challenge assumptions and confront fears about those of a different gender. Veterans themselves also vary with respect to their preferences about single-gender versus mixed-gender programming. For example, a man who experienced MST perpetrated by another man may prefer participation in a mixed-gender treatment program. Others may feel that a single-gender environment will best facilitate their recovery. Given these considerations, VHA does not promote one model as universally appropriate for all Veterans. The needs and preferences of a specific Veteran dictate which model is clinically most appropriate. As such, VHA makes a range of treatment options available to enable Veterans to decide, in collaboration with treatment providers, which option will best address their specific difficulties.

Question 9: Dr. McCutcheon and Dr. Bell, are there differences between findings in the civilian world and the military?

VA Response: Information about differences in civilian and military/Veteran research findings related to gender and treatment is integrated into responses to Questions 6, 7, and 8.

Transition Difficulties

Question 18: Dr. Guice and Dr. McCutcheon, how do DOD and VA currently transition servicemembers who have been sexually assaulted?

VA Response: VA has an extensive range of initiatives to facilitate all Servicemembers' seamless transition from DoD to VA, in general. To ensure the unique needs of MST Survivors are addressed, MST Coordinators work closely with their facility Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) Program Manager and Care Management Teams, the facility-level staff most closely involved with facilitating transitions between DoD and VA. In addition, MST Coordinators provide assistance and consultation on specific cases as needed. MST Coordinators are also encouraged to establish working relationships with DoD Sexual Assault Response Coordinators (SARC) associated with local military installations, to help facilitate seamless access to VA services.

A number of outreach and training initiatives complement these efforts. For example, information about VA's MST-related services is included in the mandatory outprocessing (i.e., Transition Assistance Program) completed by all Servicemembers.

In addition, VA's national MST Support Team has an established relationship with DoD's overarching Sexual Assault Prevention and Response Office (SAPRO). SAPRO and the MST Support Team have provided trainings to staff in each Department to

ensure that each are aware of each other's' services and are able to pass this information along to the Servicemembers with whom they work. Information about VA's MST-related health care services is included in DoD's SafeHelpline, and VA's MST outreach brochure is posted on SAPRO's myduty.mil Web site. SAPRO and the MST Support Team also communicate as needed to help connect individual Veterans and Servicemembers to services that match their treatment needs.

The MST Support Team has also engaged in conversations with each Department's Sexual Assault Prevention and Response (SAPR) programs about how to ensure that transitioning Servicemembers and newly-discharged Veterans, specifically, are aware of VA's MST-related services. This has resulted in several presentations to SAPR program staff and other DoD program offices, in order to encourage inclusion of information about VA services in outreach and training efforts. One particular area of discussion has been the inclusion of information about VA's MST-related services in SAPR orientation and other training materials for DoD SARCs. To support this effort, VA has provided informational materials about VA's MST-related services to SAPRO and individual SAPR programs for distribution to SARCs, other DoD staff, and Servicemembers.

Question 19: Dr. Guice and Dr. McCutcheon, are there gaps in the hand-off between DOD and VA?

VA Response: VHA believes that the comprehensive efforts coordinated by its national Care Management and Social Work program office and facility OEF/OIF/OND Program Managers and Care Management Teams provide a solid foundation to ensure seamless transitions for Veterans who experienced MST. As noted above, the MST Support Team and the Care Management and Social Work program office have collaborated to ensure that the MST-specific needs of Veterans are addressed as part of these existing efforts.

Question 20: Dr. Guice and Dr. McCutcheon, are there gaps in the hand-off between DOD and VA for those who are diagnosed with personality disorders and discharged from service?

VA Response: A diagnosis of a personality disorder would not affect a Servicemember's transition to VA or eligibility for VA services, provided he or she is eligible under title 38, United States Code, for VA benefits.

Question 23: Dr. McCutcheon and Dr. Bell, VA granted disability benefit claims for PTSD related to MST at a significantly lower rate than claims for PTSD unrelated to MST every year from 2008 to 2012. Because female veterans' PTSD claims are more often based on MST-related PTSD than male veterans' PTSD claims, female veterans overall are disparately impacted by the lower claims rates for MST-related PTSD. For every year between 2008 and 2011, a gap of nearly 10 percentage points separated the overall claims rate for PTSD claims brought by women and those brought by men. Among those who file MST-related PTSD claims, male veterans face particularly low claims rates, when compared to

female veterans who file MST-related PTSD claims. What have you done to reform VA regulations on disability claims based on PTSD related to in-service assault?

VA Response: Following the direction of Under Secretary for Benefits Hickey, the Veterans Benefits Administration began an aggressive program to address the sensitive issues related to MST and PTSD. This involved a nationwide focus beginning in 2011. Less than 6 months after an enhanced nationwide training agenda and deployment of specially trained claims processors and health professionals throughout the country, the percentage of disability claims granted for MST/ PTSD increased from 34 percent to about 55 percent. At that time, the grant rate for all PTSD claims was approximately 60 percent. Since then, the grant rates for MST/PTSD claims, as well as all PTSD claims, has fluctuated. For fiscal year (FY) 2013, the average grant rate for MST/PTSD claims was 49 percent, compared to 55 percent for all PTSD claims. The higher grant rates for all PTSD claims is likely due to the numerous combat-related claims that are the result of U.S. military operations in Southwest Asia. Regarding gender variations, the grant rate for male Veterans claiming MST/PTSD rose to within 7 points of the grant rate for female Veterans making the same claim. These rising MST/PTSD numbers show the benefits of the training initiative and special handling.

Additionally, VBA recognized that some Veterans' MST/PTSD claims were decided prior to the increased nationwide training and special emphasis on handling these claims. To provide those Veterans with the same evidentiary considerations as Veterans who file claims today, VBA notified those Veterans we could identify through our tracking system of the opportunity to request a review of their previously denied MST/PTSD claims.

VBA efforts have emphasized the liberal evidentiary approach available under current PTSD regulations, which provides for a VHA mental health examination if any circumstantial evidence of a behavior change or MST event is found in the record. The examiner's opinion regarding the occurrence of the MST stressor can then lead to PTSD service connection. These efforts, within the scope of current PTSD regulations, have produced a significant rise in the MST/PTSD grant rate. As a result, VBA does not see the need to alter current regulations.

Question 24: Dr. McCutcheon and Dr. Bell, treatment of MST-related PTSD claims varies widely from one VA regional office (VARO) to another. The VAROs that discriminated most egregiously in 2012 include those in St. Paul, MN; Detroit, MI; and St. Louis, MO. What have you done to improve training and oversight of VA offices with poor records in granting MST claims?

VA Response: VBA's Office of Quality Review, within Compensation Service, has obtained data regarding the adjudication of MST/PTSD claims from all VA regional offices. Variations in grant rates have been noted. In order to promote nationwide accuracy and consistency in adjudication of MST/PTSD claims, VBA's Quality Review staff will call in a percentage of cases from each regional office with a low grant rate and thoroughly review the decisions. If needed, additional training will be provided to these regional offices. This review is scheduled for April 2014.

Demographics

Question 30: Dr. Bell, during your testimony, you specified that MST can be affected by demographics. The VA reported some 600,090 veterans are seeking care for MST. What is the demographic breakdown by era of service, gender, and age?

VA Response: Below is a demographic breakdown by gender, age, and era of service for the 93,439 Veterans who received outpatient care from VA for either a mental or physical health condition related to MST in FY 2013.

Gender:
Among the 93,439 Veterans who received MST-related care in FY 2013, 58,061 (62.1 percent) were female, and 35,378 (37.9 percent) were male.

Age:
Among the 58,061 female Veterans who received MST-related care in FY 2013, 24,095 (41.5 percent) were between 18 and 44 years, 31,179 (53.7 percent) were between 45 and 64 years, and 2,787 (4.8 percent) were 65 years or older.

Among the 35,378 male Veterans who received MST-related care in FY 2013, 5,837 (16.5 percent) were between18 and 44 years, 20,802 (58.8 percent) were between 45 and 64 years, and 8,738 (24.7 percent) were 65 years or older.

Era of Service
Although VA cannot generally provide MST data aggregated by period of service, data is available specific to the cohort of Veterans who have been deployed in service of OEF/OIF/OND.

Among the 58,061 female Veterans who received MST-related care in FY 2013, 10,451 (18 percent) served in OEF/OIF/OND.

Among the 35,378 male Veterans who received MST-related care in FY 2013, 2,830 (8 percent) served in OEF/OIF/OND.

Veterans Receiving VA Outpatient Care Related to MST FY 2013		
	Women (N=58,061)	Men (N=35,378)
Gender	62.1%	37.9%
Age range		
18-44	41.5%	16.5%
45-64	53.7%	58.8%
65 or older	4.8%	24.7%
OEF/OIF/OND	18.0%	8.0%

Questions for the Record from Senator Tim Kaine

Overmedication

Question 33: Dr. McCutcheon and Dr. Bell, similar to Active Duty members, overmedication of veterans has been a recent concern. At a hearing for the House Committee of Veterans' Affairs in October 2013, a physician who formerly worked at the VA hospital in Hampton, Virginia, commented, "There are multiple instances when I have been coerced or even ordered to write [prescriptions] for Schedule II narcotics when it was against my medical judgment." How is the VA looking into situations where doctors may feel pressure to prescribe narcotics against their medical judgment?

VA Response: We cannot comment on individual cases. However, individual care plans are developed by clinicians. Currently VA medical centers are working to provide education for providers to help them develop opioid treatment plans and address their concerns.

Question 34: Dr. McCutcheon and Dr. Bell, what is the VA doing to monitor the multiple and various prescription drugs that are given to veterans to minimize the possibility of suicidal behavior?

VA Response: VA's duty is to minimize the risk of suicidal behavior no matter what method a patient may be considering. In fact, overdoses represent the most common method for suicide attempts, but not deaths, among VA patients. VA monitors prescribed medications in many contexts.

The first opportunity to monitor medication use to minimize the possibility of suicidal behavior is at the time a VA provider initiates or modifies a patient's medication regimen. During this encounter, the provider reviews all medication prescribed by VA providers, medications the patient reports receiving from non-VA providers, and non-prescription, over-the counter medications the patient reports using. The information on medications is used in conjunction with other clinical information to maximize the effectiveness of treatment and to minimize the potential for drug-drug and drug-disease interactions as well as the risk of suicide.

There are a number of additional safeguards that occur after this step. First, there are routine reviews of prescriptions by pharmacists during the process of filling and dispensing a prescription to identify prescribing errors. Second, during care transitions there are comprehensive reviews of medications, known as medication reconciliation, where medications prescribed by VA and outside providers are compared with those actually taken by the patient. Third, providers ask about whether patients have accumulated stores of medications or other potential means for completing suicide as part of the safety planning process whenever they identify patients at high risk for suicide.

In recent years, VA identified a number of medications, including anticonvulsants and antidepressants, which had the potential of contributing to the causes of suicide-related

behaviors and outcomes. Whenever these effects were observed, VA systematically sent information to providers notifying them about the findings and provided guidance about the need for providing increased monitoring, while ensuring patients with conditions such as seizure disorders and depression received effective treatment.

At present, VA is augmenting these ongoing strategies with two programs. One is the Opioid Safety Initiative, designed to enhance monitoring for all patients receiving opioids for pain management. The other is the Psychopharmacology Effectiveness and Safety Initiative, designed to improve the quality of psychopharmacological treatment as a key component of overall mental health treatment. This program has provided feedback to VISNs and facilities about prescribing patterns and is working to ensure that facilities have the knowledge and evidence-based, pharmacology tools to support clinical judgment.

Question 35: Dr. McCutcheon and Dr. Bell, one of my concerns that I've expressed to the VA Secretary is reducing the wait time for a veteran to schedule an appointment, particularly those veterans with symptoms of PTSD. For servicemembers with PTSD, what is the VA doing to reduce wait times between initial appointments and follow-up at military treatment facilities?

VA Response: The Department is addressing the current and growing demand for mental health services through a summarized strategy covering four major themes: 1) Development of policies that explicitly establish access standards and centralized oversight to track compliance with those standards; 2) Leveraging telehealth and other technologies that extend the reach of brick and mortar facilities into rural communities and digital phone technologies that provide "on demand" Veteran access to behavioral health support; 3) Staffing recruitment; and 4) Leveraging community partnerships.

Policies and Standards
First, VHA has redefined access to mental health as a Veteran's ability to schedule an appointment within 14 days of his or her desired date for new or established mental health appointments. FY 2014 data demonstrate that 95.5 percent of established patients are seen within that standard.

Telehealth
In order to reach Veterans in rural communities, telemental health efforts have resulted in telehealth psychotherapy mental health encounters tripling between FY 2011 and 2013. In addition, digital phone applications that support the treatment of PTSD (i.e., PTSD Coach) have been developed and downloaded 126,000 times for iPhones and Android smartphones in 75 countries.

Staffing
To meet this growing demand, VA has hired an additional 1,600 mental health clinicians and expanded its mental health workforce to include more than 800 Peer Specialists who are also Veterans.

Community partnerships
VA also recognizes that coordinated, collaborative care is effective care, and in FY 2013, VA hosted local mental health summits at each of our medical centers to broaden the community dialogue. Preliminarily data from these summits suggest that they fostered an improved understanding and relationship between VA facilities and the communities in which they are located.

Question for the Record from Senator Lindsey Graham

Sexual Trauma and PTSD

Question 39: Dr. Bell, what is the prevalence of PTSD in veterans who are victims of sexual trauma?

VA Response: Among the subset of Veterans who use VHA care and who received MST-related mental health care in FY 2012, 57 percent of women and 54 percent of men had a diagnosis of PTSD. It is important to note that these data are for only those Veterans currently receiving MST-related mental health care and not all Veterans who have experienced MST. As such, these data likely represent an overestimate of prevalence of PTSD among all Veterans who experienced MST.

Question 40: Dr. Bell, is history of sexual trauma a major risk factor for PTSD?

VA Response: Research has consistently found that both men and women are at increased risk for developing PTSD after experiencing sexual trauma, whether in civilian or military contexts. Sexual trauma is, in fact, more likely to result in symptoms of PTSD than are most other forms of trauma, including combat. Data suggest this finding holds for sexual assault in the military context as well, with MST being more strongly associated with PTSD and other health consequences than most other types of trauma.

Appropriate Therapies for Sexual Assault Victims

Question 43: Dr. Guice and Dr. McCutcheon, are DOD and VA providing the most appropriate medical and behavioral health therapies for sexual assault victims? Please explain.

VA Response: MST is associated with a range of mental health conditions and appropriate treatment will depend on a given Veteran's specific difficulties. Over the past decade, VA has made a significant commitment to ensuring that all Veterans have access to cutting-edge, evidence-based psychotherapies. For example, VA national policy requires every VA health care facility to provide evidence-based psychotherapies. VA Mental Health Services (MHS) has also conducted national rollouts of evidence-based psychotherapies such as Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), Acceptance and Commitment Therapy (ACT), and Cognitive Behavioral Therapy (CBT) to train VA mental health providers in these evidence-based approaches. Practice guidelines developed outside VA and DoD, such as the guidelines issued by the International Society for Traumatic Stress Studies and the American Psychiatric Association, concur with the VA/DoD guideline in recommending these treatments and similar cognitive-behavioral approaches for treating sexual assault Survivors. These rollouts of evidence-based psychotherapies have particular significance for Veterans who experienced MST, as they target mental health conditions that are strongly associated with MST. Also, several were originally tested and developed with sexual trauma Survivors. The rollouts are an important means of

providing Veterans with access to state-of-the-art treatment to assist them in their recovery from MST.

Civilian Approaches to PTSD Therapy

Question 44: Dr. Guice and Dr. McCutcheon, DOD and VA both use evidence-based therapies – like prolonged exposure therapy and cognitive processing therapy – to treat PTSD. What do civilian experts recommend as the most effective treatment approaches for PTSD?

VA Response: Treatment approaches always need to be tailored to the specific needs of individual Veterans and take into account not only comorbid health conditions but also the Veteran's treatment and broader psychosocial history, his or her current life context, and his or her individual preferences. Psychoeducation about PTSD and the impact of sexual assault can also be an important component of treatment. Regarding treatment for Veterans with PTSD specifically, a significant research base has accumulated identifying trauma-focused CBT, such as CPT and PE, as effective treatments for PTSD. CPT and PE in particular were originally developed to treat sexual assault Survivors and have a particularly strong evidence base in this area. Practice guidelines developed outside VA and DoD, such as the guidelines issued by the International Society for Traumatic Stress Studies and the American Psychiatric Association, concur with the VA/DoD guideline in recommending these treatments and similar cognitive-behavioral approaches for treating sexual assault Survivors.

Continuity of Care

Question 45: Dr. Guice and Dr. McCutcheon, how do DOD and VA ensure continuity of medical care, including mental health care, as victims of military sexual trauma transition from Active service to veteran status?

VA Response: Please see the response to Question 18.

Polypharmacy and Substance Abuse

Question 47: Dr. Guice and Dr. McCutcheon, as you know, sexual trauma victims can sometimes experience devastating physical injuries and mental health disorders. Often, medical providers will prescribe multiple medications, including drugs with abuse potential. Some servicemembers will also self-medicate with alcohol or other drugs. What are DOD and VA doing to identify and implement best practices to prevent substance abuse among sexual assault victims?

VA Response: Substance use is a key concern in the treatment of Veterans who experienced MST, as Substance Use Disorders (SUD) are one of the top five conditions associated with MST among Veterans seen in VA for MST-related mental health care. Facility MST Coordinators are encouraged to develop collaborative relationships with other clinical program coordinators, including VA's SUD-PTSD Specialists at each

facility, to integrate MST-specific materials into their training for staff and outreach to Veterans. MST Coordinators are also available to provide consultation to staff on cases involving MST, when needed.

It is VHA policy that Veterans treated in VA receive an annual screening for unhealthy alcohol use in Primary Care, Mental Health, or other Specialty Care Clinics. Those Veterans who indicate at-risk alcohol consumption receive brief counseling and either a recommendation to reduce their consumption to within recommended limits or to abstain from alcohol, as clinically indicated. Providers of patients with screening results that show the highest risk for alcohol use disorders are prompted to discuss referral to specialty addiction treatment providers for comprehensive evaluation or additional treatment.

VA/DoD Clinical Practice Guidelines for Management of PTSD and Acute Stress Reaction (published in 2010) and the accompanying Pocket Guide (published in 2013) specifically recommend against prescribing benzodiazepines for either acute stress reaction or PTSD, citing evidence of harm from use of benzodiazepines in patients with PTSD. VHA provides training in evidence-based treatment of acute stress reaction and PTSD emphasizing psychotherapy and medications without addictive potential.

Since FY 2013, VHA has implemented a national Opioid Safety Initiative that identifies patients on high doses of opioid medications for pain or patients who are receiving benzodiazepines and opioids concurrently. Consistent with the VA/DoD Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain, multiple efforts are underway to support more effective pain management strategies, including the availability of alternatives to opioid medications and urine drug testing to monitor those for whom long-term, opioid therapy is clinically indicated.

Question 48: Dr. Guice and Dr. McCutcheon, as sexual assault victims transition from DOD to VA health care, how do the two Departments transfer pharmacy data so healthcare providers have real-time data available to prevent harmful drug interactions and to avert over-prescribing psychoactive and/or narcotic drugs?

VA Response: Providers and pharmacists can view a patient's prescription records by viewing information in a variety of locations, such as Janus Legacy Viewer (JLV), VistAWeb, and Remote Data View. Each of these simply provides a 'view only' option (allowing users to see information entered at other sites), but they do not provide medication alerts.

Limited DoD pharmacy data elements are available through the Clinical Data Repository/Health Data Repository (CHDR) application. CHDR is a combined effort between DoD and VA. CHDR is used to exchange clinical data between VA's Health Data Repository (HDR) and DoD's Clinical Data Repository (CDR) for Active Dual Consumer (ADC) patients.

A Dual Consumer is a patient who is eligible for health care under both DoD and VA health plans or a patient who has been assigned to a joint venture site and meets the

requirements under a DoD/VA sharing agreement for coverage of specified clinical services. An ADC patient is a dual consumer who has actually been treated by both DoD and VA facilities. ADC patients can have their ADC status set to active or inactive. When an ADC patient's status is set as active, the sharing of DoD and VA records is initiated. In order to comply with laws and policies that are designed to protect the privacy of patient medical records, ADC patients have their status set to inactive status by default.

Detailed prescription data is not transferred to VA via CHDR. Even though detailed prescription data is not transferred, if a Veteran is marked as an active Dual Consumer, then HDR will display data showing all of the drugs the Veteran has been prescribed at DoD facilities. The record will not specify whether the Veteran is still prescribed these medications, or if the Veteran is still taking these medications.

Medication Order Check Healthcare Application (MOCHA) compares VA prescriptions against the list of DoD drugs in HDR. With this information, MOCHA provides an alert for known adverse drug interactions and possible duplicate therapy. This alert prompts the pharmacist or provider to check the viewable DoD records in JLV, VistAWeb, or Remote Data View to determine the point in time that the Veteran was prescribed the medication and at what dosages.

In addition to providing mediation alerts, MOCHA's duplicate therapy order checks detect over-prescribing by comparing the drug ordered by the provider against a patient's current and past prescription profile using DoD data in HDR. Finally, dosing checks (which are now being deployed as part of MOCHA 2.0) analyze the dosage of the current order being prescribed in order to ensure that the medication is not being overprescribed. Dosing order checks only occur at the time a medication is ordered. In other words, dosing checks do not occur upon transfer of prescription data from DoD to VA, but rather when a new drug order is made.

At any time, irrespective of whether MOCHA has issued an alert for duplicative therapy or for questionable dosage, the pharmacist or provider can view DoD prescription data using JLV, VistAWeb, or Remote Data View. The pharmacist or provider can then use this information to check for duplicate therapy, drug-drug interactions, or allergy concerns.

Question 49: Dr. Guice, Dr. McCutcheon, and Dr. Galbreath, how do benefits, support, and medical care for victims of sexual assault in the military compare to those offered to civilian victims?

VA Response: It would be difficult to provide a concise comparison of VA and civilian services for sexual assault Survivors, as there is no comparable equivalent to VA's single-source system of care in the civilian setting; the benefits, support, and medical care accessible to civilian Survivors depends greatly on their particular circumstances. VA can, however, summarize aspects of VA health care that are unlikely to be duplicated, at least to the same degree, in civilian systems.

First, it is VHA policy that all Veterans seen for health care are screened for MST. This recognizes, importantly, that many Survivors of sexual trauma do not disclose their experiences unless asked directly, may not be aware of available MST-related services, and may also not be aware of the extent to which their health conditions are related to sexual trauma. VA uses screening as an opportunity to make all patients aware of care that is available to them and to streamline access for those interested in this care.

Second, individuals who have experienced sexual trauma, both Veterans and civilians, may have a range of mental and physical health needs and seek treatment from a variety of clinics and medical settings. As a single umbrella provider, VA is well positioned to provide coordinated, tailored care that ensures the Veteran's history of MST is considered in all treatment provided. VA providers are familiar with internal resources available to address new or emergent treatment needs and can provide timely referrals as needed. This includes the ability to refer for non-VA care from a private provider if necessary. VA has a single system to document all MST-related care, regardless of type or setting, in the electronic medical record, which helps ensure that patients are not billed for the MST-related care they receive.

Third, VA has taken extensive steps to ensure that MST-related treatment is available in every VA health care facility. Every facility has providers knowledgeable about mental health treatment of MST, and every facility provides MST-related mental health outpatient services including formal psychological assessment and evaluation, psychiatry, and individual and group psychotherapy. Specialty services are also available to target problems such as PTSD, substance abuse, depression, and homelessness. Outpatient counseling is also available at community-based Vet Centers. For Veterans who need more intensive treatment, VA has inpatient programs available for acute care needs, and many VA facilities have Mental Health Residential Rehabilitation and Treatment Programs. Some of these programs focus specifically on MST or have specialized MST tracks. As noted, every VA health care facility has a designated MST Coordinator who serves as a point of contact on MST-related issues and can assist Veterans with accessing needed services.

Finally, VA provides all medical, mental health, and pharmaceutical care for MST-related conditions free of charge. There are no external payers or insurance plan involvement for this care; no co-pays are required, and there are no time limits on the extent of this care, nor any exclusions for any health conditions.

Question 50: Dr. Guice and Dr. McCutcheon, we heard testimony about medication being the initial therapy option while sexual assault victims wait a long time to see a counselor for treatment. Is it a common practice in both the civilian and military health systems to offer medications soon after a sexual trauma event?

VA Response: The VA/DoD Clinical Practice Guideline for PTSD and other mental health disorders describe evidence-based prescribing of psychotropic medication. The Guideline may be accessed on the Internet at www.healthquality.va.gov. Good clinical practice would typically involve consideration of whether medication might be useful in

the management and treatment of any mental health symptoms resulting from sexual trauma, either in the immediate aftermath of the experience or in the long term. Research has shown that the best mental health treatment outcomes often occur when a combination of psychotherapy and medications are used. Treatment planning in the case of an individual Veteran is always a Veteran-centric endeavor, with the Veteran and health care provider collaboratively determining what will be the best approach to address his or her specific needs. In VA, Survivors of MST typically are not coming for care soon after the event (because the event occurred in the military, prior to separation), so VA cannot comment on the use of medications soon after a sexual trauma event.

Questions for the Record
House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Oversight Hearing
"Vendors in the OR – VA's Failed Oversight of Surgical Implants"

January 15, 2014

Questions for the Record from Subcommittee Chairman Mike Coffman

Question 1: Please provide a detailed statement with citations to all guidance, including but not limited to directives, handbooks and/or regulations, regarding VA and/or VHA policies on access by surgical implant vendor representatives to clinical settings where implantation occurs? Please also describe any changes that are planned in this regard.

VA Response: VHA Handbook 1004.01, *Informed Consent for Clinical Treatment and Procedures* (available at http://www.ethics.va.gov/ETHICS/docs/policy/VHA_Handbook_1004-01_Informed_Consent_Policy_20090814.pdf), requires the use of the informed consent process and the use of the iMedConsent™ software program (or VA Form 10-431a, Consent for Clinical Treatment or Procedures when iMedConsent™ cannot be used) for procedures performed in and out of the operating room (OR) by any provider. Notably, VA's informed consent form specifically informs the patient that vendor representatives may provide technical advice but will not physically participate in the procedures. However, the informed consent process does not address vendors who are present in non-procedure areas. National level policy regarding vendors is in development.

VA has issued informal guidance to VA health care facilities in the form of two Privacy Fact Sheets titled, "Vendor Representatives in Surgical Setting" (dated December 2003) and "Disclosing the Minimum Amount of Protected Health Information (PHI) to Vendors Assisting with Implantable Devices or Observing Surgery" (dated September 2007). Both Fact Sheets address access to PHI by surgical implant vendor representatives in clinical settings. These Privacy Fact Sheets are meant to provide VA health care facility Privacy Officers with information on the legal requirements under the Privacy Act and Health Insurance Portability and Accountability Act (HIPAA) for disclosing or sharing PHI with surgical implant vendor representatives.

Question 2: Please provide a detailed statement with citations to all guidance, including but not limited to directives, handbooks, and/or regulations, regarding VA and/or VHA policies related to credentials and other qualifications necessary for surgical implant vendor representative participation in implant procedures. Please also describe any changes that are planned.

VA Response: There are no national level VA or VHA policies related to credentials and other qualifications necessary for surgical implant vendor representative

participation in implant procedures. Consistent with professional ethics standards and guidelines promulgated by professional medical societies, the policy currently in development will clarify that vendor representatives in VA are not allowed to engage in the practice of surgery or medical decision making or to be involved in direct patient contact during procedures; and that the role of vendor representatives is only to provide technical advice and/or to be involved in the remote calibration or adjustment of medical devices to the surgeons and manufacturers' specifications. The policy will further clarify requirements that vendors must meet before they are allowed to be present in clinical settings.

It is anticipated that the policy should be completed in early 2015. In the interim, VA's iMedConsent™ form states that vendor representatives may provide technical advice, but they will not physically participate in the procedures.

Question 3: Please describe in detail the oversight and enforcement processes that are in place or are planned regarding the agreed conditions of informed consent notices signed by patient/veterans, including those with respect to vendor presence.

VA Response: VHA Handbook 1004.01 constitutes VHA national policy on informed consent. It mandates the use of the iMedConsent™ software program or VA Form 10-431a to document the informed consent process. This policy applies to procedures performed both inside and outside of the OR by a provider. The oversight responsibility is assigned to the facility.

Question 4: In Mr. Matkovsky's written testimony, he refers to 38 CFR § 1.220, as guidance for vendors in clinical settings but on its face, this regulation applies to pharmaceuticals. Does VA and/or VHA interpret the regulation to include surgical implants? If so, please explain. If not, then please indicate whether VA and/or VHA plan to promulgate a similar regulation for surgical implants.

VA Response: 38 Code of Federal Regulations (CFR) § 1.220 provides guidance regarding pharmaceutical representatives. VA has not interpreted the regulation to apply to vendor representatives for surgical implants. As for changes that are planned with regard to policy concerning surgical implant vendor access, please refer to VA's response to question #1 and #2 above.

Question 5: Please describe in detail the steps VA and/or VHA plan to take to include biological implants on Federal Supply Schedule contracts and/or national committed use contracts.

VA Response: In the fall of 2012, the Office of Acquisition, Logistics, and Construction's National Acquisition Center (NAC) attempted to increase the number of biologic sources under Federal Supply Schedule (FSS) Group 65 Part II Section A (FSS 65IIA) Medical Equipment and Supplies. During this process, a review of the FSS Agency Specific clause AS1904, Regulatory Requirement Provisions (August 2000),

which includes CFR Part 800-1200 revealed that human cells, tissues and cellular, and tissue-based products (i.e., allografts) which as classified under 21 CFR 1271 were believed to be a controlled-substance in lieu of a medical device. As such, it was then determined allografts should be removed from all FSS contracts awarded under 65IIA. During the week of May 31, 2013, VA Contracting Officers notified all affected FSS 65IIA contractors, via a bilaterally-generated modification, that all allograft line items would be effectively removed from their respective contracts by June 15, 2013. All FSS contractors were given until June 6, 2013, to sign, date, and return the bilateral modification. FSS contractors who did not comply by June 6, 2013, received a unilaterally-executed modification removing allograft products with an effective date of June 15, 2013.

After additional fact finding and consultation with VHA and the Office of General Counsel, VA determined that the NAC misinterpreted the language of AS1904 as it pertained to allografts. As a result, effective June 21, 2013, the Deputy Assistant Secretary for Acquisition and Logistics directed the NAC to rescind its decision to remove allografts from VA's FSS and restore all products previously offered by the schedule holders.

Question 6: Please describe in detail the steps VA and/or VHA plan to take to include biological implants on Federal Supply Schedule contracts and then did an immediate about face to put them back on schedule.

VA Response: VHA performed the following steps to include biological implants on national committed use contracts:

1) Convened a VHA-led panel of experts on February 27, 2014, to support establishing appropriate national committed use contracts for biological implants by; and
2) Developed and submitted complete requirements documentation to the VA Strategic Acquisition Center (SAC) by the end of fiscal year (FY) 2014 to support their follow through for award of national committed use biological implant contracts.

Question 7: In a memorandum dated May 23, 2012, Mr. Matkovsky indicated that biological implants should be purchased on the Federal Supply Schedule. Please indicate whether this directive has been followed and provide the specific number of purchases.

VA Response: The memorandum communicated requirements to both procurement and non-procurement staff to adhere to sourcing and waiver processes. The memorandum was not, however, a directive. Following the release of the memorandum, VHA undertook the full transition of procurements above the micro-purchase threshold (of $3,000) as indicated below:
Waivers:

The data below identify the number of waivers from FSS orders processed through local contracts:

FY 2012: 10 Waivers approved
FY 2013: 21 Waivers approved

Through the first quarter of FY 2014, there are eight waivers approved or under review. Waiver requests are typically for multiple items on a local contract. VHA is identifying improvements to further improve the level of adherence to waiver processes. As VHA has transitioned procurements above the micro-purchase threshold from prosthetics staff to procurement staff, it will be more feasible to improve adherence with internal VA policies.

Purchases from FSS Biologics Vendors:
It is difficult to track specific biologics vendors due to limitations in VA FSS tracking systems. The data below identify general trends for purchases from FSS vendors.

FY 2013: Total: $23.2 Million

Top 5 Federal Supply Schedule Vendors:	
Avkare	$14.7 Million
Shire Regenerative	$4.5 Million
Academy Medical	$2.4 Million
Advanced Biohealing	$1.3 Million
Cotton Medical Group	$309,000

Transition of Warrants:
Beginning in FY 2012 and concluding at the end of FY 2014, VHA removed procurement authority above the micro-purchase from over 1,000 for facility prosthetics staff. These duties were transitioned to approximately 200 warranted Contracting Officers.

Question 8: The GAO report states that VHA has a number of policy documents and trainings under development that are designed to improve compliance with the new purchasing process for surgical implants over $3,000. Please give us an overview of what these documents and trainings will entail and when you expect them to be in place. Also, please describe what steps VHA is taking to monitor the timeliness of orders and to make the process more efficient.

VA Response: The VHA Procurement Policy Office has drafted VHA Directive 1081, *Procurement Process for Individual Prosthetic Appliances*, which establishes procedures for procuring prosthetic appliances and sensory aids including surgical implants over the $3,000 micro-purchase threshold. This directive is undergoing VA's coordination, concurrence, and approval process and has obtained almost all required concurrences. The directive defines and standardizes the processes and policies that

VHA Acquisition workforce will follow when procuring the specified items. The directive also defines the circumstances under which Veteran Affairs Acquisition Regulation (VAAR) and Federal Acquisition Regulation (FAR) may be cited and other than full and open competition procedures utilized. Once approved and published, the directive will define the roles and responsibilities of the acquisition team members and streamline the procurement process to make it more efficient.

1. Issuing Consignment Agreements. A standard operating procedure (SOP) is being developed that provides guidance to the acquisition workforce for procuring implantable devices on a consignment basis so that the medical centers will have instant availability to the different type or model.

2. Monitoring Timeliness of Orders. VHA has developed a dashboard that tracks the timeliness of prosthetic orders by the Network Contracting Office. The tool tracks four events in the procurement process so when delays happen, the cause can be readily identified. These events include the following:

    - Consult to electronic Contract Management System (eCMS) Planning Module – This captures the date of the patient consult and the date a Network Contracting Office receives a procurement request.

    - eCMS Planning Module to Graphical User Interface Purchase Order (GUI PO) – This captures the date of receipt of a procurement request by the Network Contracting Office and the date funds are committed to support the contract award.

    - GUI PO to eCMS Award – This tracks the date that funds are committed and the date the purchase order is awarded by the Contracting Officer.

    - Consult to eCMS Award – This tracks the overall time frame from the patient consult to the date the purchase orders are awarded by the Contracting Officer.

The Network Contracting Office dashboard shows the average amount of days for each of the above events. The dashboard is robust and allows us to drill down by the types of products purchased to identify what may be causing overall timeframes to be less than optimal. Network Contracting Offices and Network Prosthetics Departments each own part of the process, and there are conference calls each week to discuss performance and timeliness. Good performers will share best practices, and performance outliers are required to describe the actions they are taking to reduce timelines. VHA is successfully using this dashboard to not only monitor timeliness but also work with Network Prosthetics Representatives and Network Contracting Officers to improve performance.

Question 9: Given that VA and/or VHA is making open market purchases and not properly documenting them, how does VA ensure that it is not violating the Competition in Contracting Act? How will VA ensure compliance and hold employees accountable for adherence to federal acquisition regulations related to future open market purchases?

VA Response: VA takes several steps to ensure it is not violating the Competition in Contracting Act. VHA clinicians determine which surgical implants will best meet the clinical needs of individual patients. This is not a decision made by Contracting Officers. Many times, the manufacturer and size of a particular implant is not known until the surgery is being performed, and the surgeon observes the internal physical characteristics of the patient. 38 United States Code § 8123, Procurement of Prosthetic Appliances, states, "The Secretary may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper, without regard to any other provision of law." VHA has provided justification templates to our acquisition workforce and has an audit program to ensure contract files have proper documentation. When a specific product is not identified in the physician's consult, competition is used by Procurement/Contracting Officers. Effective October 1, 2013, VHA transitioned purchasing authority for items greater than $3,000 to Contracting Officers. This threshold is significant because it denotes the micro-purchase limit. For these transactions, VHA performs quality assurance reviews to assess compliance of our procurement staff.

Question 10: GAO found that VA and/or VHA have oversight mechanisms in place regarding procurement of surgical implant purchases but that corrective action to prevent recurrence of poorly documented open market purchases is not pursued. What plans do VA and/or VHA have for improvement in this regard?

VA Response: VHA has provided justification and approval templates to our acquisition workforce and has an audit program to ensure contract files have proper documentation. The transition of the procurement workload for open-market surgical implant purchases from VA medical center prosthetics departments to Network Contracting Offices was completed on October 1, 2013. Although it is still early in the transition, expectations are the existing guidance and oversight program will produce improvements in the documentation of open-market surgical implant purchases. The oversight program includes a corrective action plan/improvement plan requirement.

Question 11: Please describe the status of the Veterans Implant Tracking and Alert System (VITAS) and VA and/or VHA plans and timetables to implement the system. Also, please describe how VA and/or VHA expect to overcome the data reliability problems that in 2012 prevented VITAS from succeeding.

VA Response: VITAS is designed to track implants (e.g., coronary stents, dental, aortic valves, etc.) to include both non-biologic and biologic implants. Biologics that are not "implanted" such as wound care products will not be tracked by this software solution. VITAS, as designed, will draw on a number of registries for source implant device data including, but not limited to, the VistA Dental Package, Cardiovascular Assessment, Reporting and Tracking (CART) System, and VistA Surgery Package. VITAS software, as developed, was undergoing Initial Operating Capability (IOC) testing when the developer contract concluded prior to VITAS release and implementation. If

funded for completion, two challenges identified in IOC will require resolution. The first challenge identifies the National Prosthetics Patient Database (NPPD) as an unreliable resource for implant tracking purpose. The proposed solution is to replace the NPPD with the VistA Surgery Package as source data for surgical implants placed in the operating room. The second challenge relates to locating the patient for notification in the event of a product recall. VITAS, as designed, queried the VA Primary Care Management Module (PCMM) to provide a primary care physician as the sole point of contact for recall notification. This was identified in IOC testing as a potential risk to timeliness of notification since PCMM is currently not a comprehensive data source for Veterans receiving care and treatment in VA. The solution is for VITAS to provide notification to additional providers (e.g., surgeon, cardiologist, and dentist) and VHA administrators (e.g., facility Chief of Staff) for patient notification in the event of a product recall consistent with current VHA policy.

Question 12: Please describe the controls that VA and/or VHA have in place or plan to implement to prevent implantation of expired or contaminated surgical implants and enable the identification of patients with such implants for recall purposes.

VA Response: VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedures*, mandates that "time-outs" must be facilitated by a checklist and occur immediately prior to the start of a procedure including verification that the correct implant is available, if applicable. An additional step is required immediately prior to implantation of the medical device. The privileged provider performing the procedure must confirm the correct implant with a team member, including a "read-back" of the relevant information. Documentation of the correct medical implant must be placed in the patient's electronic health record.

If a potentially contaminated surgical implant is recalled by the manufacturer or the Food and Drug Administration, VA's National Center for Patient Safety (NCPS) Product Recall Office posts a recall notice with a timeline for removal actions to affected VA facilities through the VHA Alerts and Recalls intranet database.

Facility Recall Coordinator (FRC) in each facility receive the recall notices from the Product Recall Office and work daily to remove defective medical products and food through assignments made to the Facility Designated Area Specialists within each medical center. Through this process, established by VHA Directive 2008.080, *Recall of Defective Medical Devices and Medical Products, Including Food and Food Products,* VA facilities remove potentially harmful products from inventory in a timely and effective manner.

NCPS' Product Recall Office receives feedback confirmation from each FRC that the facility did or did not have the affected product in stock at the time of the recall and removed any recalled product from inventory. This prevents potentially contaminated surgical implants from being used. The Product Recall Office monitors compliance to the recall process for each facility.

House Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs

"Beyond Transformation: Reviewing Current Status and Secondary Effects of VBA Technology"

February 5, 2014

Question 1: Can you please explain, in detail, how station targets for VA Regional Offices are created? Consistently committee staff has found that station targets are not being met. Are the station targets unrealistic? If not, what is being done to hold offices accountable for not reaching their targets?

VA Response: The performance of regional offices (RO) is evaluated against national and RO-specific targets that are based on the Veterans Benefits Administration's (VBA) strategic goals. These targets are established at the beginning of each fiscal year (FY), across all the business lines and for a variety of measures, including quality, timeliness, production, and inventory. Challenging performance expectations are established that build on the previous year's performance, giving consideration to current staffing levels and anticipating that each RO is working to ensure the most efficient utilization of those resources. RO directors are held accountable for their performance, which is reflected in their end-of-year evaluations. As appropriate, performance improvement plans are put in place for employees and closely monitored by the area director.

Question 2: The most recent performance data available in ASPIRE is more than two months old. Can VA commit to providing Congress and the public with timely information regarding the performance of VA Regional Offices?

VA Response: VBA has increasingly been asked for production statistics that reflect the status of claims actually being worked at each RO, referred as claims at the Station of current Jurisdiction (SOJ), instead of the production credited to the station where the claim was originally received, referred to as Station of Origination (SOO). We acknowledged this requirement in recent changes to the Monday Morning Workload Report, which now shows production statistics for each RO both before and after any brokering of claims to or from other ROs. As brokering will continue to increase in FY 2014 and FY 2015, VBA adjusted the data for ASPIRE to reflect SOJ versus SOO in our monthly statistics towards achieving our FY 2015 goals. We have recalculated the previous months of ASPIRE data in FY 2014 accordingly and reposted October 2013 through January 2014. These new files were available online on March 7, 2014. February end-of-month data for Compensation and Pension was posted to ASPIRE on March 11, and we expect to continue publishing prior-month data to ASPIRE no later than the 10th business day of the following month. We apologize for any confusion that may have resulted during this changeover period.

Question 3: How does VBA define an underperforming office?

VA Response: The performance of any one RO can be impacted by a number of internal and external factors including experience level of the employees and management team, types and complexity of received claims, fluctuations of incoming claims volume, and the impact of nationally directed initiatives (such as the brokering associated with the Oldest Claims Initiative). In general terms, an underperforming RO would be one consistently not meeting its performance targets, which are established at the beginning of each fiscal year and intended to build on the previous year's performance.

Question 4: What are the performance standards for individuals working in the various segmented lanes? How many claims is a VSR/RVSR expected to complete if the work in the "express lane", the "core lane", the "special operations lane", and on non-rating work?

VA Response: The performance standards are consistent for all claim processors, regardless of the assigned segmented lane. VBA sets the standards for work to be completed based on the position and experience level of the employee.

a. **Do these standards vary by office or are they the same across the country?**

   VA Response: VBA performance standards are consistent for all claims processors across the Nation.

b. **If the standard is the same but actions are weighted, please provide us an index explaining how different actions are weighted.**

   VA Response: Performance standard credit is weighted for both Veterans Service Representatives (VSR) and Rating Veterans Service Representatives (RVSR). Performance standard credit for VSRs is weighted based on the complexity of the action completed. For example, completing an initial letter in response to a Veteran's claim for benefit is weighted higher than a contact with a Veteran via telephone. RVSR's credit is weighted based on the complexity of the case and number of issues rated. For example, an RVSR on the special operations team that rates a highly complex claim with nine medical contentions will receive a higher weighted credit than a RVSR that rates a claim with two medical contentions on the express team. Attached are the current national performance standards that provide an index of the weighted actions.


VSR Standard Final.doc


RVSR Standard Final.doc


DRO Standard Final.doc

Question 5: Can we please receive a briefing and documentation on the NLA pilot?

VA Response: VBA can provide a briefing at the Committee's convenience.

The Veterans Benefits Management System (VBMS) notification letter automation (NLA) automates the award notification letter with very little manual handling by the end user. The expectation is that the implementation of this new process will reduce the time that claims await award generation and authorization. This allows VBA employees to focus their critical expertise on award processing. The new process will facilitate standardization of the letters nationwide in a way not previously possible. The new system supports much more rapid language changes than legacy products, facilitating timely updates to our standardized system language.

This functionality uses rules-based logic to drive generation of notification letters based on various inputs as part of a rating decision or award action. Prior to this automated process, users were required to manually select paragraphs to populate the notification letter.

The Portland RO began the VBMS NLA pilot in August 2013, and it is being used by two of the RO's teams (Express and Non-Rating). The Lincoln RO began piloting VBMS NLA in November 2013.

Program successes include:

- 365 automated letters were generated as part of the pilot.
- 84percent of automated letters generated after VBMS 6.0 release.
- The VBMS NLA pilot supported and led to incorporation of NLA functionality in the VBMS-Awards application.
- Time-study results showed a 40 percent reduction in letter generation time and resources using the VBMS NLA process, compared to the traditional legacy system processing.

The Lincoln and Portland ROs are currently piloting VBMS NLA. National deployment of the VBMS-Awards application with the embedded NLA functionality is currently in the planning stages.

Question 6: Can VA please provide the formula for determining "claims produced per Direct FTE" on the executive dashboard as well as the figures used in that calculation?

VA Response: Claims produced per direct full-time equivalent (FTE) employees represents total claims completed during a given month divided by the cumulative FTE employees for that month. Since rating claims are processed by both compensation and pension employees, cumulative end of month FTEs for both business lines is used. Direct FTE includes VSRs, RVSRs, Decision Review Officers (DRO), Pension and Veterans Service Center field employees such as Claims Assistants, Fiduciary

employees, National Call Center employees, Military Service Coordinators, Homeless Veterans Coordinators, and Women Veterans Coordinators. The end of month February calculation was based on 14,101 direct FTEs.

Question 7: VARO Directors indicated that they are challenged to provide incentives to employees. Can you please provide the code/regulation that governs RO leadership's abilities to provide such incentives?

VA Response: RO directors are allowed to provide performance incentives under the following statute, regulations, and publications:

- 5 United States Code, Chapter 45 - Incentive Awards;
- 5 Code of Federal Regulations (CFR), Part 451 – Awards;
- 5 CFR, Part 531, Subpart E – Quality Step Increases;
- VA Handbook 5017 – Employee Recognition and Awards; and
- Office of Personnel Management publication "Human Resources Flexibilities and Authorities in the Federal Government."

VBA utilizes a three-tier incentive program to recognize individuals and ROs for excellent performance during the fiscal year.

Individual recognition (level one) awards are given to those employees whose performance significantly exceeds their performance requirements. All performance requirements for claims processors contain critical elements for both quality and timeliness/production. At the heart of the performance award program is a foundational focus on quality. Group awards (level two) are made to offices or elements of offices that achieve and exceed performance targets, including all claims accuracy goals. Special contribution awards (level three) are reserved for recognition by the Under Secretary for Benefits.

Question 8: How many provisional rating decisions have been made since the inception of tactic?

a. How many of those claims have been appealed?

VA Response: Between April 19, 2013, and November 2013, approximately 14,500 provisional ratings were completed (7,300 for 2-year claims and 7,200 for 1-year claims). This represents approximately two percent of the rating-related decisions made under the Oldest Claims Initiative through November 8, 2013.

In April 2013, the Department of Veterans Affairs (VA) implemented a temporary initiative to expedite compensation claims decisions for Veterans who had waited one year or longer. Between April 19, 2013, and November 8, 2013, VA claims raters made provisional decisions on some of the oldest claims in inventory, which allowed Veterans to begin collecting compensation benefits more quickly, if they were eligible.

Provisional decisions were based on all evidence VA had received to date and during the time the claim had been pending. Provisional rating notices noted the evidence on

which the decision was based and listed any documentation that had not been provided or the VA had been unable to obtain. Exams were provided by VHA in an expedited manner if they were required for a rating. When benefits were awarded in the provisional decision, the Veteran began receiving compensation immediately.

This initiative provided a one-year safety net for Veterans to submit further evidence should it become available and protects the Veteran's right to appeal the decision. Any awarded benefits will be retroactive to the original date the claim was submitted. If no additional evidence is obtained, the provisional decision will become final after one year (or earlier if the Veteran requests), at which time a final decision and appeal rights will go into effect. These Veterans then will have the standard year to appeal the decision, effectively extending the current appeal window, while also providing them with near-term decisions and benefits, if eligible, based on the evidence in the claims file.

Because provisional decisions are not final decisions they are not appealable. All Veterans who received a provisional rating will receive a final decision that will include their standard 1-year appeal rights.

Question 9: How many VA Regional Office Director positions are currently vacant? How long have they been vacant for?

VA Response: As of March 24, 2014, six RO director positions are vacant.

Position	Length Open
Regional Office Director, Los Angeles	9 months
Regional Office Director, San Diego	6 months
Regional Office Director, Montgomery	2 months
Regional Office Director, Denver	2 months
Regional Office Director, Oakland	2 months
Regional Office Director, Baltimore	Less than 1 month

Securing skilled and experienced leaders to fill director vacancies remains a top priority for VA. Upon notification of an upcoming vacancy, VA initiates immediate action to recruit the highest qualified candidate. During the search for highly qualified applicants, experienced management officials are detailed to ensure appropriate leadership of RO operations is maintained.

National Work Queue

Question 1: One of the concerns raised in the VFW's testimony is the fact that service officers are not provided lists informing them of what claims have been brokered? How does VA currently inform the VSO's of the location of brokered claims, and how does VA expect this to change moving forward?

VA Response: Veterans Service Organizations (VSO) have full access to claims

information for the Veterans they represent through the Stakeholder Enterprise Portal, including the location that the claim is being worked. In addition, Veterans can access real-time claim status updates through eBenefits or by calling the National Call Centers.

VBA does not expect the relationship between the VSOs and the ROs to change moving forward. VSOs can still ask questions related to specific claims to the Veterans Service Center leadership at the RO where they are located, regardless of where the claim is being processed.

Question 2: Why was the national work queue not communicated to Congress prior to its implementation?

VA Response: The national work queue (NWQ) supported by VBMS has not yet been implemented. Currently, the framework is being developed and is expected to be completed in the first quarter of FY 2015. In the current transition phase, while availability of NWQ functionality in VBMS is pending, VBA is employing the national workload brokering strategy under its Oldest Claims Initiative.

Question 3: In a National Work Queue, how will poor performing offices and employees be held accountable?

VA Response: In the initial release of the NWQ, VBA will match its inventory with claims processing capacity at the RO level, moving claims electronically from a centralized queue to an office identified as having capacity to complete the work. With this national workload approach, VA will continue to focus on the improvement of its traditional performance metrics, with an emphasis on improving quality and consistency of claims processing nationwide to ensure Veterans and their families receive timely benefits, regardless of where they reside. Individual RO employees and managers will continue to be held accountable for both production and quality. Future iterations of the NWQ will include more robust workload management capabilities to automate portions of the claims process and metrics in order to direct work based on national priorities. VA has established a work group that includes VA field and headquarters staff to develop and refine logic that will drive the electronic routing of work through the NWQ and establish appropriate metrics.

Question 4: How will the resource allocation model be modified in consideration of the National Work Queue?

VA Response: The resource allocation model will be modified as more sophisticated VBMS workload management capabilities and metrics become available. VBA has also established a work group that includes VA field and headquarters staff to develop and refine business rules that will collect data for use in the development of future resource allocation models.

Question 5: According to the fact sheet provided to the committee on

February 3, 2014, with regards to the National Work Queue, VBA has suggested that they will support medical-issue and skill-based workload distribution. Can you please expand upon this; will this be for all medical conditions, what are VBA's intended goals?

VA Response: In the initial release of the NWQ, inventory routing will be based on productive capacity at eachRO. Future iterations of the NWQ will include more robust workload management capabilities to automate portions of the claims process and metrics in order to direct work based on national priorities. VBA will analyze the transactional data from VBMS and other corporate systems to assess the complexity of tasks and decisions made by claims processors to determine future skill-based functionality for the NWQ.

Question 6: What is the Area Director's role in the new model and who specifically will manage workload at the National level?

VA Response: The role of an area director remains unchanged. Area directors are responsible for the effective delivery of all Veterans benefits and programs in the field organization. They will continue to provide leadership in all operational areas including performance measurement and improvement, workload management, and resource management. Under the NWQ, VBA will integrate a team of workload managers and analysts to identify patterns, analyze impacts, and recommend policy and procedures for routing claims to ROs.

Question 7: VSOs are concerned about losing the ability to have face-to-face interaction with the VA employee processing the claim. How is VA going to ensure VSO service officers can contact the case workers?

VA Response: VSOs have full access to claims information for the Veterans they represent through the Stakeholder Enterprise Portal. The current relationship between VSOs and RO leadership will not change as a result of the NWQ. VSOs will continue to have the ability to bring their questions and concerns on individual cases to the attention of Veterans Service Center leadership at their local ROs.

Question 8: What is VA doing to ensure the "sense of ownership" is not undermined as the claims are sent to other regions?

VA Response: In April 2013, VBA launched its Oldest Claims Initiative to expedite decisions for Veterans who were waiting the longest for a decision on their claims. VBA managed this initiative from its headquarters and the four area offices, redistributing the oldest claims across the Nation to utilize the resources of all ROs to better meet the needs of our Nation's Veterans. VBA's success with this initiative demonstrated the potential of a national workload management strategy for improved benefits delivery by optimizing every member of the VBA workforce through a sense of holistic ownership.

Question 9: Please provide statistics on the quality of brokered and non-brokered claims.

VA Response: VBA's quality assurance program does not currently segregate brokered claims and non-brokered claims. As of March 2014, the quality of rating workload (to include brokered work) was 96.3 percent at the issue level and 90 percent at the claim level.

Question 10: In the future phase of NWQ, how is VA ensuring that the holistic view of complex claims is retained as the individual issues are sent off to other regions and employees?

VA Response: Starting in FY 2015, as workload management functionality is deployed in VBMS, VBA will centrally manage and distribute the claims inventory from the national level. In this phase, the claims workload will be distributed from VBA Central Office down to the RO level, taking advantage of RO capacity from a national perspective and ensuring production consistency. Based on additional VBMS automation in 2015, claims will be routed nationally down to the individual employee level, based on the nature of the claim and the skill set of the claims processor.

After the initial release of the NWQ slated for September 2014, VBA will analyze the transactional data from VBMS and other corporate data to assess the complexity of tasks and decisions made by claims processors. This data will assist VBA in determining skill-based, issue-level functionality for the NWQ.

Question 11: How is the VA going to allocate resources (FTE, budget, etc.) to high and low performing ROs?

VA Response: VBA's area directors and the Office of Field Operations will continue to monitor claims inventory levels, distribution of workload, performance, and accountability and allocate resources accordingly. VBA will also continue to refine its workload management procedures for application in the NWQ electronic environment as well as identify the best distribution of FTE, budget, etc. across the ROs.

Question 12: There is concern that previous attempts to centralize claims for death pensions and Dependency and Indemnity Claims (DIC) were problematic with high error rates and delays. Is VA incorporating any lessons learned from that experience?

VA Response: The initial release of the NWQ will mirror the current claim processing strategy; it is not attempting to centralize additional claim types. As future iterations of NWQ evolve, VBA will explore lessons learned and other takeaways from a holistic perspective.

eBenefits

Question 1: What percent of claims are being submitted through eBenefits? What are VA's goals for online claim submission?

VA Response: As of February 2014, 4.3 percent of disability compensation claims have been submitted through eBenefits in FY 2014. The FY 2014 goal is to receive 12 percent of its disability compensation claims through eBenefits by the end of the year. That target increases to 20 percent by the end of FY 2015.

Question 2: Can you please provide the findings of the breach core data team's investigation to the committee?

VA Response: VA's Data Breach Core Team (DBCT) reviewed the circumstances regarding the January 15 eBenefits software defect and determined that individuals should be offered credit monitoring.

The results of VA's investigation of the incident are included below:

On January 15, 2014, VA's Office of Information and Technology attempted to update a system that supports the eBenefits portal. During implementation of this scheduled enhancement, VA discovered that an error had occurred related to the way the upgrade was deployed, and that error was causing some Veterans and Servicemembers logged into eBenefits to see other individuals' personally identifiable information (PII). VA quickly validated the concerns and reversed the deployment on January 16, 2014. VA moved quickly to limit the scope of the issue and prevent any further exposure and then conducted a top-to-bottom review.

During the 4 hour and 57 minute period of time between system update and subsequent rollback, 1,362 Veterans and Servicemembers who logged into eBenefits may have had their information and information about their dependents seen by up to 5,399 of their fellow Veterans and Servicemembers who were also logged into eBenefits.

VA brought the eBenefits portal back online on Sunday, January 19, 2014, at 10:00 a.m. EST. Before bringing eBenefits back online, the Department ensured that the

software defect had been resolved, that Veteran information was protected, and that potential vulnerabilities were addressed. VA waited until Veterans Benefits Administration call centers were staffed before placing the system back online.

For the majority of the Veterans, Servicemembers, and dependents whose information may have been viewed by other users, the following data elements were at risk for exposure: name, mailing address, partially-concealed financial information, partially-concealed or fully visible Social Security Number, partially-concealed claim number, disability rating, benefit payment amount and effective date, and period of service.

As required by Department policy, VA immediately referred the incident to the DBCT to review. After adjudicating the facts provided, the DBCT determined that notification and credit monitoring should be offered to affected individuals.

As provided by the law, the notifications and credit monitoring are based on the level of risk, impact, and harm to each individual affected. VA completed mailing notification letters on February 14, 2014. Immediately after resolving the issue and determining eBenefits was functioning correctly, VA conducted a thorough after-action review of the situation and established key lessons learned that will help prevent similar incidents from occurring in the future. VA's analysis identified an error exposed by an upgrade to VA's authentication management system. The error caused eBenefits users with accounts matching certain conditions to see the cached data of Veterans or Servicemembers who had logged in just prior to them. VA has now implemented fixes to the eBenefits software so that if a similar error condition occurs again, the attempted action will fail rather than sending unintended information.

Additionally, in an effort to maximize accessibility to systems in high demand, such as eBenefits, VA attempts to perform minor software upgrades and patches without taking the system offline. In this situation, VA performed the upgrade while Veterans and Servicemembers continued to use eBenefits. Because VA did not take dependent systems (such as eBenefits) offline during the upgrade, the return of incorrect information was initiated with the certificate mismatch. This would not have occurred had VA disabled eBenefits while the system enhancement was rolled out. Going forward, VA will not deploy system enhancements while the system is still online.

VA is confident that this incident was not the result of a system security vulnerability or a violation of VA's privacy and information security Rules of Behavior. VA monitors its network for breaches and has studied access to eBenefits during the time of the incident. VA found no indicators of malicious behaviors or processes, nor any indications of a breach through any system security vulnerability. Moreover, there has been no indication that any unauthorized users gained access to other internal network VA web applications using eBenefits as a proxy. Additionally, none of VA's external partners who monitor the Department's network boundaries have reported any unusual activity at the time the software defect was in effect. Finally, when VA rolled back the system update, the problem ceased to exist.

In order to identify the number of users who access the eBenefits system, VA maintains an audit log of who signs in and when. During the period when the defective update was in production, there were 10,154 users logged into the system. Of those users, 5,399 were using features of the system that would have potentially allowed them to see data from other Veterans in addition to their own data, and 1,362 may have had their data and/or their dependents' data erroneously exposed to other Veterans and Servicemembers. The Veterans and Servicemembers who saw information other than their own had read-only access to that data and could not alter any data other than their own.

In order to further address the impacts of the eBenefits portal software defect, VA has consulted and coordinated with appropriate agencies in an effort to ensure this type of incident does not happen again. VA has worked with the Department of Defense Manpower Data Center to uniquely identify all Servicemembers who were impacted. Additionally, the US-Computer Emergency Readiness Team notified VA's National Security Operations Center of possible misconfiguration of an application.

VA is confident in the security and functionality of the eBenefits portal and encourages Veterans to use this important tool to manage and track their claims and other important information. VA immediately responded to maintain Veteran trust in eBenefits after this incident occurred. VA responded quickly to Congressional and media inquiries and communicated with VSOs. VA has also posted on its blog a message to Veterans explaining what happened in this incident and what actions VA plans to take to directly contact affected Veterans. VA will work to continue and enhance this important dialog with Veterans.

Since the time of the incident, VA has received no reports of additional compromise of PII due to this incident.

The eBenefits tool, which is critical for Veterans, VSOs, and VA to help Veterans take control of the benefits they have earned, is now fully functional and available for Veterans and Servicemembers to use.

HAIMS

Question 1: Is the VBMS- HAIMS interface fully operational? How many service and treatment records has VA retrieved using the HAIMS interface? The November update to the Transformation Plan indicates DOD committed to providing 100% complete searchable electronic records, has DOD now met its commitment and is this capability fully rolled out at all 56 VAROs?

VA Response: The interface between the VBMS and the Healthcare Artifacts and Image Management Solution (HAIMS) became fully operational on January 1, 2014. The capability was also fully rolled out to all 56 ROs on January 1, 2014.

Question 2: Where is HAIMS scanning conducted?

VA Response: When the Servicemember separates/retires from military service, the paper STR folder is sent to the respective central cell for digitization and certification. The Army and the Air Force central cells are located in San Antonio, Texas. The Navy continues to operate at its contingency site located at a contract facility in Chantilly, Virginia.

VBMS

Question 1: What is the total for VA spending on VBMS from inception?

VA Response: VBMS (IT – Non Pay only) – Actual IT obligations/spend from FY'09 (inception) to FY'13 for development/investment is $357.3M and for sustainment is $121.1M for a total of $478.4M. Planned IT obligations/spend for FY'14 is $83.8M for development/investment and $100.4M for sustainment for a total of $184.2M.

VBMS (VBA GOE – Non Pay only) – Actual obligations/spend from FY'10 (inception) to FY'13 is $168.1M (Note: Nothing in FY'09). Planned obligations/spend for FY'14 is $159.9M which includes $132.4M for the VCIP (Scanning contract).

Work Credit

Question 1: Can VA provide an update on the current work credit system and any labor agreements and discussions?

VA Response: VBA regularly revisits and revises performance standards in response to organizational and process changes. Revised standards were most recently implemented in February 2013, and revisions to the VSR and RVSR production and quality standards were recently presented to our national labor partners. VBA is currently working with the American Federation of Government Employees (AFGE) on the new performance standards set to be implemented in April 2014.

Question 2: Can VA provide the committee with a copy of the AFGE labor agreement?

VA Response: A copy of the VA/AFGE Master Agreement and Article 67 can be found below. This agreement was amended on January 9, 2012, to include Article 67, which governs skills certification for VBA employees who process claims for compensation and pension benefits.


DVA_AFGE_Art_67_ Skills_Certification_Ja


Master_Agreement_ between_DVA_and_A

IDES

Question 1: In the hearing VA suggested that it would eliminate the backlog of IDES claims by March (Final Rating) and August (Initial Rating). Can VA please provide additional clarity on its plan to achieve this goal?

VA Response: To achieve the goal, the Seattle Disability Rating Activity Site (DRAS), has implemented several initiatives and added a new leadership position. In October 2013, the Seattle DRAS began using Disability Benefits Questionnaires (DBQ) for all Integrated Disability Evaluation System (IDES) cases and assigned a permanent division chief over the DRAS mission. In January 2014; the DRAS resumed mandatory overtime. In March 2014, the Seattle DRAS began utilizing the scanning vendor to enable them to process all final ratings in a paperless environment.

Additionally, the Army continues to support the DRAS by lending personnel to assist with making cases ready to rate. As a result of these initiatives, the Seattle DRAS eliminated excess inventory for final ratings in March 2014 and is on track to eliminate excess inventory for proposed ratings by the end of August 2014.

Question 2: Can more claims be brokered to the Providence DRAS to reduce the wait times of Servicemembers waiting on rating decision from the Seattle DRAS?

VA Response: Providence brokered-in 250 proposed ratings per month from the Seattle DRAS from August 2013 to December 2013. Providence's inventory rose beyond the projected 250 claims per month due to the furlough, loss of mandatory overtime, increased receipts from the Air Force (approximately 50 percent increase), and personnel changes. Therefore, brokering was suspended in January 2014 to allow Providence's inventory and timeliness to stabilize. .

Question 3: Can more IDES ratings decisions be brokered to additional VA Regional Offices?

VA Response: IDES ratings generally have more conditions to rate than general ratings and the conditions tend to be more complex (e.g., traumatic brain injury). In addition, the IDES rating process is slightly different from the traditional rating process (e.g., proposed ratings, interacting with the Physical Evaluation Board, etc.). For these reasons, IDES claims are best processed at DRAS sites.

Question 4: Numerous references have been made to negative experiences from the SM's in IDES with regards to QTC physicians and facilities. How is VA checking the quality and consistency of the QTC examinations, facilities, and personal?

VA Response: A VBA medical officer randomly reviews a total of 148 QTC medical examinations each quarter to ensure they are sufficient for rating purposes. When VBA

finds insufficient examinations, it provides feedback to the field, training to the vendor, and/or contacts the Servicemember or Veteran, as appropriate. QTC is meeting its contractual target of 92 percent accuracy.

VBA also surveys Servicemembers and Veterans regarding the quality and timeliness of care they received during their examinations. VBA analyzes the feedback monthly and uses it to support of the overall examination process. VBA and its vendors immediately investigate negative comments, communicating directly with the Veteran or Servicemember when feasible. Below are metrics for the first quarter of FY 2014:

Vendor	Performance	Appointment Time & Place	Cleanliness	Provider concern and attention	Overall satisfaction
QTC	96%	94%	97%	95%	95%

Questions for the Record
Committee on Veterans' Affairs
Subcommittee on Health
U.S. House of Representatives

"VA Accountability: Assessing Actions Taken in Response to Subcommittee Oversight"

February 26, 2014

Questions for the Record from Chairman Dan Benishek, M.D.

Question 1: During the hearing, you stated that, "...last year, VA removed 3,000 employees-approximately one percent of its workforce." Please provide the location, position, salary grade, and reason for dismissal of each of the 3,000 employees that the Department removed last year. Please also provide the number of employees that were resigned on threat of discipline last year.

VA Response: Due to the large amount of data required to fulfill this request, VA continues to work to respond to this question and will follow up with the Committee as soon as possible.

Question 2: During questioning by Representative Wenstrup, you stated that the Department has conducted "several" studies comparing the cost of providing a given medical service through VA to the cost of providing the same service through either Medicare or the private sector. Please provide an electronic copy of the studies.

VA Response:

Studies:

Nugent, G.N., Hendricks, A., Nugent, L.B., Render, M.L. Value for taxpayers' dollars: what VA care would cost at Medicare prices. Medical Care Research and Review 2004; 61, 495-508.

Value for taxpayers dollars.pdf

Winkler, SL., Vogel, B., Hoenig, H., Ripley, DC., Wu, S., Fitzgerald, SG., Mann, WC., Reker, DM. Cost, utilization, and policy of provision of assistive technology devices to veterans poststroke by Medicare and VA. Med Care. 2010 Jun;48(6): 558-62.

Cost Utilization and policy of provisions of

Nugent, G., Hendricks, A. Estimating private sector values for VA health care: an overview. Medical Care 2003; 41, II2-10.

Estimating private sector values.pdf

Note: some recent studies focusing on specific conditions have found that VA costs are greater than private sector health care costs while, noting that VA subjects had higher rates of comorbidities (e.g., 2012 study on End Stage Renal Disease). An abstract is available at: http://www.ncbi.nlm.nih.gov/pubmed/21945972), and attached below.

Ends Stage Renal Disease.pdf

Question 3: Please provide a copy of the Information Bulletin that was distributed to Veterans Integrated Service Network (VISN) leadership in September 2013 regarding Military Sexual Trauma (MST) Coordinators and describe how the Department intends to measure and track the implementation, utilization, and effect of the Information Bulletin.

VA Response: A copy of the Information Bulletin is attached. As noted in VA testimony at the February hearing, the intent of this Bulletin was to remind VISN and health care facility leadership of the importance of ensuring that all facilities are in compliance with standing Veterans Health Administration (VHA) policies pertaining to MST. The Bulletin called attention to six policy-related issues. This response will describe the mechanisms in place in VHA to monitor these six areas:

1. *Sufficient protected time for the MST Coordinator role.* The Bulletin reminded leadership of the importance of ensuring that MST Coordinators are given adequate unscheduled time to fulfill the responsibilities of that role. Compliance with this policy will be monitored by periodic site visits to health care facilities conducted by the VHA Office of Mental Health Operations (OMHO). Site visitors conduct extensive interviews with key staff in the facility mental health service, including the MST Coordinator and local mental health leadership, to evaluate the quality of available services, assess compliance with policy, and make recommendations. The interview question template used by site visitors has recently been updated to include a question about whether the MST Coordinator has sufficient protected time.

2. *Sufficient capacity to provide care.* The Bulletin reiterated the requirement that health care facilities provide MST-related treatment services adequate to meet the local demand, and offer options to accommodate Veterans' treatment needs when timely care is not available. This is an area of focus during the OMHO site visits referred to above. Additionally, the MST Support Team in the VHA Mental Health Services office completes an annual report to determine the facility staffing capacity

required to meet the mental health needs of Veterans who experienced MST. As noted in testimony, VA has set a benchmark of 0.2 full time equivalent employees (FTEE) per 100 Veterans as the minimum staffing level for MST-related mental health care. In the most recent analysis, 99 percent of VA health care systems were at or above this benchmark. As follow-up, the MST Support Team, in collaboration with OMHO, partnered with mental health stakeholders at the local and VISN levels to develop an action plan to increase the staffing level in the one health care system that fell under the benchmark. The health care system is demonstrating consistent progress on all four action items in quarterly progress reports. OMHO and the MST Support Team currently provide regular support and guidance on an as-needed and at least quarterly basis.

3. *Sensitivity to the needs of all Veterans who have experienced MST.* The Bulletin instructed facilities to ensure that appropriate specialized services are available to meet the treatment needs of both men and women Veterans who experienced MST, and that these services are organized (administratively and physically) in a way that is sensitive to gender-specific concerns. To help ensure compliance, questions specific to this issue have been added to the interview question template used by OMHO during their site visits. The MST Support Team also continues to consult with facility MST Coordinators about treatment service organization on an as-needed basis, which provides a secondary method to ensure MST Coordinators are aware of the need to address this issue.

4. *Shared responsibility and coordination of care.* The Bulletin emphasized the importance of coordinating care across the medical and mental health clinics where MST survivors receive treatment services. Facility MST Coordinators are well-aware of MST survivors' unique range of health care needs, and engage in monitoring, consultation, and staff education as needed to ensure that facility clinics communicate effectively and are providing coordinated services. This is also an area assessed by OMHO during site visits.

5. *Training.* The Bulletin reminded leadership of the need to ensure that all staff receives education and training about MST-related issues appropriate to their role with Veterans. Coordinating local education and training efforts is one of the MST Coordinators' primary duties; they help ensure that facility mental health and primary care providers are completing mandatory MST training and that frontline staff have the knowledge to work sensitively with MST survivors. Additionally, the MST Support Team completes an annual report submitted to Congress that assesses compliance rates with MST mandatory training requirements and helps coordinate follow-up with facilities where compliance falls under the VHA national benchmark of 96 percent. Finally, as noted in testimony, the MST Support Team conducts periodic test calls ("secret shopper calls") to facilities as a check on the training received by frontline staff. Every system is rated based on the ability of frontline staff to connect callers with the MST Coordinator seamlessly and staff members' attention to privacy and sensitivity concerns.

6. *Services provided by trainees.* The Bulletin reiterated national policies with respect to health profession trainees who provide treatment services to MST survivors. The VHA Office of Academic Affiliations (OAA) has program responsibility for national oversight of health profession trainee programs in VHA health care facilities. OAA ensures that facilities follow best practices and are in compliance with national policies with respect to the conduct of treatment services provided by trainees.

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Care & Services for V

Question 4: Please describe how the Department intends to measure and track the implementation, utilization, and effect of the revised MST clinical reminder screening process. Is the Department on track to roll out the revised screening process by the end of fiscal year 2014?

VA Response: The revised MST Clinical Reminder is on track to be implemented by the end of FY 2014. The revised screening language has been finalized and all support materials are complete. An Information Bulletin detailing facility actions required to prepare for the revision has been sent to all Veterans Integrated Service Network (VISN) Directors, and MST Coordinators and VISN Mental Health Leadership have been briefed on the upcoming revisions.

National release of the revised MST Clinical Reminder will occur after a standard testing process is completed through Office of Information & Technology (OIT). The revised MST Clinical Reminder will be rolled out via a national patch in the electronic medical record system. This is the standard technical process for all updates to the electronic medical record system and ensures uniform implementation in all facilities.

With regard to utilization and effect of the Clinical Reminder data, since FY 2005, VA Mental Health Services' (MHS) national MST Support Team has produced annual reports on the number and percent of Veterans in VHA care screened for MST and those who received MST-related treatment, with results aggregated by gender and by facility. These reports allow for annual monitoring of compliance with national policy regarding universal screening for MST as well as provide VHA with information about the number of Veterans who screen positive for MST.

The addition of the referral question to the Clinical Reminder will now additionally allow VHA to track whether Veterans who request MST-related mental health services are able to access those services. It will also provide data to inform VHA's efforts to establish benchmarks for Veterans' access to MST-related care after screening positive. Veterans who screen positive for MST will vary in their need and interest in MST-related treatment through VHA; without some indication of what percent of Veterans are interested in treatment, it is currently difficult to know the extent to which VA is reaching the subset of Veterans who actually need care.

As such, following implementation of the revised Clinical Reminder, the MST Support Team's annual reports will be expanded to include the number of Veterans who are screened for MST, the number who disclose experiences of MST, and the number who request and access MST-related mental health care. This information will facilitate both local and national monitoring of policy compliance, improve VHA's ability to determine whether expected rates of Veterans are accessing MST-related care, and refine its evaluation of its capacity to provide MST-related care.

Question 5: Please provide information regarding the number and location of any and all inpatients facilities or programs that exist specifically for the treatment of MST and whether such facilities or programs treat male Veterans, female Veterans, or both.

VA Response: VA offers over 240 Mental Health Residential Rehabilitation and Treatment Programs (MH RRTP) with more than 8,000 beds that provide 24-hour supervision, daily professional and peer services, and comprehensive care addressing medical and mental health concerns and psychosocial needs. These programs provide specialized treatment for substance use disorders, posttraumatic stress disorder, serious mental illness, and other mental health concerns that can be associated with experiences of MST. It is important to note that no MH RRTPs are officially designated as MST treatment programs; rather, programs are defined based on the diagnoses and symptoms for which treatment is provided (for example PTSD Residential Rehabilitation Treatment Programs) with some programs specifically focusing on provision of care related to a Veteran having experienced military sexual trauma.

The overall percent of men with a completed episode of mental health residential treatment in FY 2013 who reported a history of MST is approximately four times higher than the overall percent of men utilizing outpatient care who reported a history of MST (5.3 percent of unique men in MH RRTPs versus 1.3 percent of unique outpatient men). Among women the rate is approximately double (55.5 percent of unique women in MH RRTPs versus 24.3 percent of unique outpatient women) suggesting that both men and women who have experienced MST are accessing residential treatment services. These data along with information from the FY 2013 Annual Review of MH RRTPs indicate that VA's MH RRTPs provided extensive MST-related services in FY 2013, with 95 percent of programs (228 programs) reporting that they provided MST-related care to Veterans admitted to their residential program either through staff working directly in the program or through engagement with outpatient providers during the residential stay.

MH RRTP programs vary in how they provide care and some Veterans may prefer to receive treatment for MST-related concerns directly within the residential program itself, as opposed to through engagement with outpatient providers during a residential stay. Over half of VHA's MH RRTPs (106 programs) are able to meet this need, as they have staff working in the program that provided treatment for mental health conditions associated with MST during FY 2013. The majority of these programs provided care to both men and women. A list of those programs that provided MST-related care by staff

working directly in the program during FY 2013 is attached and includes information on whether care is provided to men only, women only, or both men and women.

Table 1: MH RRTPs that provided MST-related care by staff working directly in the program during FY 2013.

VISN	FACILITY	PROGRAM TYPE	BEDS	GENDER
1	Bedford	DCHV	50	Both
1	Boston	SA RRTP	20	Men Only
1	Brockton	SA RRTP	24	Both
1	Brockton[1]	PTSD RRTP	8	Women Only
1	Brockton	DCHV	46	Both
1	Newington	PTSD RRTP	6	Both
1	White River Junction	SA RRTP	14	Both
2	Batavia	PTSD RRTP (M)	30	Men Only
2	Batavia[1]	PTSD RRTP (W)	6	Women Only
2	Bath	General DOM	187	Both
2	Buffalo	SA RRTP	24	Both
VISN	**FACILITY**	**PROGRAM TYPE**	**BEDS**	**GENDER**
3	Brooklyn	DOM SA	22	Both
3	Brooklyn	DCHV	50	Both
3	East Orange	SA RRTP	30	Both
3	Lyons[1]	PTSD RRTP (W)	10	Women Only
3	Montrose	DCHV	60	Both
3	Northport	SA RRTP	30	Both
3	Northport	PTSD RRTP	8	Men Only
4	Butler	DOM SA	31	Both
4	Butler	DCHV	25	Both
4	Coatesville*	DOM SA	79	Both
4	Coatesville	DOM PTSD	35	Both
4	Coatesville	DCHV	115	Men Only
4	Wilkes-Barre	SA RRTP	10	Both
5	Baltimore	General PRRTP	10	Both
5	Martinsburg	DOM PTSD	50	Both
5	Martinsburg	General DOM	79	Both
6	Asheville	SA RRTP	18	Both
7	Dublin	DOM SA	30	Both
7	Dublin	DOM PTSD	30	Both
7	Dublin	DCHV	65	Both
7	Tuscaloosa	SA RRTP	21	Both
7	Tuscaloosa	PTSD RRTP	15	Both
7	Tuscaloosa	DCHV	48	Both
8	Bay Pines	PTSD RRTP	14	Both
8	Bay Pines[1]	DOM PTSD	16	Both
8	Bay Pines	DCHV	25	Both
8	Gainesville	SA RRTP	16	Both
8	Miami	SA RRTP	24	Both
8	Miami	PTSD RRTP	16	Both

8	Miami	General PRRTP	18	Both
9	Lexington	SA RRTP	15	Both
9	Lexington	PTSD RRTP	15	Both
9	Louisville	SA RRTP	14	Both
9	Mountain Home	General DOM	135	Both
9	Mountain Home	DCHV	35	Both
10	Cincinnati	PTSD RRTP (M+TBI)	22	Men Only
10	Cincinnati[1]	PTSD RRTP (W)	10	Women Only
10	Cleveland	General PRRTP	20	Both
10	Cleveland	DOM SA	43	Both
10	Cleveland	DOM PTSD	10	Men Only
11	Battle Creek[1]	PTSD RRTP	32	Both
11	Battle Creek	General PRRTP	40	Both
11	Danville	General PRRTP	35	Both
11	Marion IN	SA RRTP	30	Both
12	Madison	SA RRTP	12	Both
12	Milwaukee	DOM SA	45	Both
12	Milwaukee	General DOM	108	Both
VISN	**FACILITY**	**PROGRAM TYPE**	**BEDS**	**GENDER**
12	North Chicago	PTSD RRTP	26	Both
12	North Chicago	General DOM	39	Both
15	Leavenworth	General DOM	25	Both
15	Leavenworth	DCHV	177	Both
15	Marion IL	General PRRTP	14	Both
15	St. Louis	DCHV	50	Both
16	Biloxi	PTSD RRTP	20	Both
16	Biloxi	General PRRTP	32	Both
16	Jackson	SA RRTP	15	Both
16	Jackson	PTSD RRTP	12	Both
16	Little Rock	DOM PTSD	25	Both
16	Little Rock	General DOM	37	Both
16	Little Rock	DCHV	57	Both
17	Bonham	DOM SA	104	Both
17	Bonham	General DOM	120	Both
17	Dallas	SA RRTP	40	Both
17	Temple[1]	DOM PTSD	8	Women Only
17	Temple	General DOM	262	Both
18	Albuquerque	SA RRTP	24	Both
18	Albuquerque	General PRRTP	16	Both
18	Albuquerque	DCHV	40	Both
18	Phoenix	SA RRTP	20	Men Only
19	Denver	PTSD RRTP	19	Men Only
19	Ft. Harrison	General PRRTP	16	Both
19	Salt Lake City	SA RRTP	15	Both
19	Sheridan	DOM SA	23	Both
19	Sheridan[1]	DOM PTSD	17	Gender Cohort
19	Sheridan	DCHV	45	Both
20	American Lake	DOM SA	24	Both

20	American Lake	DOM PTSD	20	Both
20	Boise	SA RRTP	11	Both
20	Portland	DCHV	26	Both
20	Walla Walla	SA RRTP	28	Both
20	Walla Walla	General DOM	8	Both
20	White City	General DOM	387	Both
20	White City	DCHV	54	Both
21	Honolulu	PTSD RRTP	12	Men Only
21	Palo Alto[1]	PTSD RRTP (M)	40	Men Only
21	Palo Alto[1]	PTSD RRTP (W)	10	Women Only
22	San Diego	SA RRTP	29	Both
22	West LA	DOM SA	62	Both
22	West LA	General DOM	109	Both
22	West LA	DCHV	125	Both
23	Grand Island	SA RRTP	18	Both
23	Hot Springs	DOM PTSD	10	Both
23	Hot Springs	General DOM	40	Both
23	Hot Springs	DCHV	50	Both
VISN	**FACILITY**	**PROGRAM TYPE**	**BEDS**	**GENDER**
23	St. Cloud	General DOM	148	Both

[1]There is a smaller subset of programs that have been identified (through the MH RRTP Annual Program Review and additional data resources) as providing care primarily for MST-related concerns.

Abbreviations: DCHV: Domiciliary Care for Homeless Veterans; General DOM: General Domiciliary; General PRRTP: General Psychosocial Residential Rehabilitation Treatment Program; DOM PTSD: PTSD Domiciliary; DOM SA: Substance Abuse Domiciliary; SA RRTP: Substance Abuse Residential Rehabilitation Treatment Program; PTSD RRTP: PTSD Residential Rehabilitation Treatment Program; (M): Men Only (W): Women Only; TBI: Traumatic Brain Injury.

Similarly, none of VHA's inpatient mental health programs are officially designated as MST treatment programs. These programs provide treatment to address acute care needs (e.g., psychiatric emergencies and stabilization, medication adjustment) and most would be able to provide MST-related care for any acute needs with which a Veteran might present.

Question 6: Please describe the actions the Department is taking to expand access to care for male Veterans who have experienced MST.

VA Response: VHA is committed to ensuring that appropriate services are available to meet the treatment needs of both men and women Veterans who have experienced MST. With regard to MST-related care to men specifically, VHA monitoring data indicate that efforts to promote male Veterans' engagement in MST-related services have been successful. MST-related outpatient treatment rates among men have increased every year since VA Mental Health Services' national MST Support Team began monitoring them in FY 2007. The number of men receiving MST-related care from VHA has more than doubled in the past seven years (from 16,441 in FY 2007 to 35,378 in FY 2013). During this period, the number of MST-related outpatient visits received by men has increased 235 percent (from 109,679 MST-related health care visits in FY 2007 to 367,412 MST-related health care visits in FY 2013).

As noted in the response to Question #3, the most recent VHA data show that 99 percent of VA health care systems have adequate capacity to provide MST-related care. Complementing these existing resources, VHA's efforts to expand mental health services broadly also may benefit male Veterans who experienced MST. To this end, the VHA Office of Mental Health Operations (OMHO) is developing and implementing a national strategy to expand mental health services via several means. One, by redefining access measures for new and established Veterans receiving mental health care, VHA is approaching its goal of ensuring that all Veterans are able to schedule a mental health visit within 14 days of their desired date. Two, by leveraging telehealth and other technologies, VHA is extending access into rural communities. Three, by investing in provider recruitment, VHA is ensuring that mental health provider staffing levels have increased in recent years to keep pace with Veterans' needs. Finally, by leveraging community partnerships, VHA has successfully initiated a number of pilot programs with community agencies across the country to provide additional mental health resources in areas of need.

The response to Question #3 delineated some of VHA's efforts to ensure that treatment programing and environments are sensitive to the unique needs of male Veterans who experienced MST. In addition, VHA policy strongly encourages facilities to offer Veterans being treated for mental health conditions related to MST the option of being assigned a same-sex mental health provider or an opposite-sex provider if the MST involved a same-sex perpetrator. Additionally, some female and male Veterans may benefit from single-gender treatment environments, to foster their sense of safety, ability to address gender-specific concerns, and strong peer and social support. To accommodate Veterans who do not feel comfortable in mixed-gender treatment settings, many facilities throughout VA have separate programs for men and women. Residential and inpatient programs must have separate sleeping areas for men and women.

Outreach to Veterans to facilitate engagement with care is another critical element to expanding access for male Veterans. VHA outreach materials and efforts reference both men and women and use gender-inclusive language. For example, Internet Web sites such as About Face (available at: www.ptsd.va.gov/apps/AboutFace) and Make the Connection (available at: maketheconnection.net) include video galleries of personal testimonials from male and female Veterans who have experienced MST. Information about men is consistently included in VHA's major MST-related educational offerings, including VHA's mandatory trainings on MST for mental health and primary care providers and the national MST Support Team's monthly training calls.

Question 7: Please provide a copy of the "national educational resources" referenced in the Department's written statement that have been "shifted to clarify the importance of creasing multiple opportunities for disclosure [of MST]." What impact are these resources expected to have and how will such impact be tracked and measured?

VA Response: The MST Support Team's major training resources regarding screening have traditionally included statements such as: "The MST screen only needs to be completed once and is often done by primary care or other medical providers.

However, it is good practice to include questions about MST in all mental health intakes as Veterans may be more open to disclosure when meeting with a mental health provider."

The revision of the MST Clinical Reminder has provided opportunities to amplify and reinforce this message. Three new national education resources specific to the Clinical Reminder revision (attached) highlight that with the revised Clinical Reminder, Veterans will be re-assessed for experiences of MST if a Veteran declines the initial screening or if a Veteran has additional military experience following a prior 'no' to the MST Clinical Reminder. These and other existing resources on screening highlight the importance of assessing for MST, even after the Clinical Reminder has been completed. For example, slide 24 of the attached "staff training presentation" reminds providers that:

- Veterans may not feel comfortable disclosing their MST experience during the initial screening.
- Providing additional opportunities for disclosure is important and include:
    - Trauma assessment in mental health clinics as part of a clinician's standard assessment of social and military history.
    - Providers should be knowledgeable about MST and know how to contact the MST Coordinator.
    - Extensive outreach efforts help to ensure Veterans are aware of MST-related care and ways to access that care.
- A provider can alter the reminder response at a later date. For example, the reminder can be changed to 'MST Yes' if a Veteran responds 'no' initially then discloses an MST experience later in treatment.

These materials are intended for use by MST Coordinators in educating providers about the upcoming changes to the Clinical Reminder, as well for use in ongoing staff education, as a complement to existing materials that focus more on the clinical aspects of screening. To support MST Coordinators' training efforts, the MST Support Team's monthly Teleconference Training Series call in February focused on the revised Clinical Reminder; on that call, MST Coordinators were introduced to the Clinical Reminder revision training materials that the MST Support Team would make available and a demonstration was given of how the "staff training presentation" might be presented.

These resources, in conjunction with materials focusing on the clinical aspects of screening, are designed to increase provider knowledge, sensitivity, and skill in

screening for experiences of MST and increase the frequency of additional assessment of MST experiences. The final impact of these educational resources is expected to be Veteran disclosure of an MST experience when and with whom they would like to disclose – either during initial completion of the MST Clinical Reminder, or through additional assessment at a later time. As noted in the response to Question #4, the completion of the MST Clinical Reminder and the MST disclosure rate are monitored in the MST Support Team's annual reports.

Question 8: Please provide information regarding the pilot program that Mr. Matkovsky, VA's Assistant Deputy Under Secretary for Health for Administrative Operations, stated the Department was undergoing in VISN 15 and VISN 23 to test an alternate procurement structure for certain high-cost medical equipment. Please include information regarding how the Department intends to measure the outcome of the pilot program.

VA Response: VA is transitioning to a new acquisition process for certain medical imaging modalities. Modalities including Portable X-Ray Units, Portable C-Arms, Ultrasound Systems, Bone Densitometers, and Computed Radiography equipment will be procured through a coordinated process that involves both the VHA Service Area Office (SAO) and VA National Acquisition Center (NAC) contracting offices. The VA NAC will delegate authority to VHA SAO to process delivery orders against base NAC contracts.

We are piloting this new process. The first pilot acquisitions were for VISN 15 in FY2013. Information about these acquisitions is below. This process is being used to acquire Bone Densitometers for VISN 23 in FY2014. This acquisition is in process, with contract award projected in July 2014.

Modality: Portable C-Arms
Quantity: 21
National Contract Price: 4,541,482
Awarded Price: $3,518,129
Negotiated value added Items (additional warranty, training, trade-in allowance) provided at no charge: $674, 614
Date Acquisition Process Initiated (start market research): June 17, 2013
Date Requirements Package submitted to VHA Contracting Office: July 5, 2013
Date Solicitation Issued: July 22, 2013
Date of Contract Award: September 24, 2013
PALT: 81 days (includes local CRT and legal review)

Modality: Portable X-Ray Units (Digital)
Quantity: 26
National Contract Price: $4,441,364
Awarded Price: $3,125,375
Negotiated value added Items (additional warranty, training, trade-in allowance) provided at no charge: $872,875

Date Acquisition Process Initiated (start market research): June 3, 2013
Date Requirements Package submitted to VHA Contracting Office: July 5, 2013
Date Solicitation Issued: July 23, 2013
Date of Contract Award: September 23, 2013
PALT: 80 days (includes local CRT and legal review)

We monitor these pilots closely to learn from the processes and outcomes. Considerations that we assess include, but are not limited to: award price versus standard NAC contract price; procurement cycle time; cycle time from identification of need to availability of equipment for patient care; feedback from both internal and external stakeholders.

Question 9: Is the Department still on track to complete the approximately 909 outstanding delivery orders from 2012 by the end of April 2014? If now, why not and when will the outstanding delivery order be filled?

VA Response: The Department is on track to complete approximately 900 delivery orders from the September 2012 consolidation by the end of April 2014. Evaluation of vendor bids has been completed. Contracting Officers are processing delivery orders.

Question 10: Please describe how the Department intends to "...look at the consolidation process and change that as well." What changes are planned for VA's current consolidate process and what is the Department's timeline for full implementation of the planned changes?

VA Response: The consolidation process that VA has used to acquire high tech medical imaging equipment is being modified. Some key changes include:

- Utilizing VHA SAO contracting offices to acquire selected (lower cost) imaging equipment;
- Utilizing generic specifications that define required characteristics, rather than using vendor quotes as benchmark requirements;
- Consolidating strategically aligned requirements by VISN, or small groups of VISNs;
- Enhancing communications by leveraging VISN points of contact and including executive leadership;
- Enhancing technical evaluation processes by incorporating Biomedical Engineers and medical staff, and providing them more robust training; and
- Initiating requisitions earlier in each fiscal year.

Many of these process changes have been implemented or partially implemented. Our goal is to continue transition toward these new processes through the balance of FY 2014 and through FY 2015.

Processes are further described below.

<u>Procurement of Lower Cost Imaging Modalities</u>

This grouping of equipment includes the following imaging equipment: portable x-ray machines, mobile C-arms, bone densitometers, Computed Radiography (CR) equipment, and ultrasound machines. Generally, this equipment costs less than $250,000 per unit.

If a VISN plans to procure equipment in one of the low cost modality equipment categories, then the equipment will be purchased by VHA SAO contracting (utilizing the VA NAC's national IDIQ (Indefinite Delivery, Indefinite Quantity) contracts) instead of the VA NAC contracting staff. This was piloted in FY 2013 by VISN 15 with positive outcomes, including a much quicker acquisition cycle and comparable pricing. VISNs that wish to participate in this type of procurement will identify requirements via specifications that describe salient characteristics, rather than citing a specific vendor product or equal. VISNs need to commit funding earlier in the fiscal year (typically by end of March) and the procurement will be completed by the September or the respective fiscal year.

In the event that needs arise in the later part of the year, requirements will be sent to the VA NAC for procurement via the traditional consolidation process.

Procurement of High Cost Modalities of Medical Equipment

This grouping of equipment includes (but not limited to) the following imaging modalities: magnetic resonance imaging (MRI) scanners, computed tomography (CT) scanners, PET/CT scanners, nuclear medicine cameras, radiography/fluoroscopy (R/F) rooms, general and digital radiographic equipment, interventional rooms (IR), and cardiac catheterization labs.

If a VISN requires a sufficiently large quantity of one or more of the high cost modalities, then the equipment may be procured by the VA NAC as its own consolidated procurement, separate from the needs of other VISNs/facilities. VISNs that wish to participate in this type of procurement will identify requirements via specifications that describe salient characteristics, rather than citing a specific vendor product or equal. Construction site preparation necessary to accommodate installation of these modalities will be aligned with equipment acquisition and delivery timelines.

Benefits to utilizing this procurement strategy include a shortened acquisition cycle time, comparable pricing, streamlined technical evaluation due to aggregating the same modalities for multiple locations into one procurement, efficiencies of scale, and reduced total cycle time from identification of the need to availability for patient care.

This process has been conducted for the New Orleans facility and the Denver facility. It is being conducted in FY 2014 for VISN 22 requirements and VISN 23 requirements.

Enhanced Communications and Process Coordination

Communications regarding medical imaging equipment acquisitions have been streamlined and enhanced. VHA is funneling most communications through points of contacts in its VISN Offices, rather than having the VA NAC communicate directly with

151 individual medical facilities. VHA has more actively engaged Biomedical Engineering personnel to facilitate technical evaluations of the medical equipment with medical staff. Instructions and training have been, and will continue to be, enhanced to help all stakeholders better understand their roles in the acquisition process. Milestones and due dates are regularly communicated through executive leadership.

Internal processes have been evaluated and automated where feasible. For example, Non-Disclosure Agreements are now available on line and submitted electronically, thus expediting the procurement process. We will continue to identify opportunities to automate and streamline processes.

Question 11: Please describe the actions that have been taken in the last year to respond to veteran and stakeholder concerns regarding the negative impact of changes to VA's prosthetic procurement process.

VA Response: There has not been a negative impact to Veterans receiving prosthetic appliances and sensory aids, but there have been some delays in vendors receiving payments. To address this, VHA developed a dashboard that tracks the various phases of the procurement process. Weekly reviews are held with Prosthetics and Contracting Offices that have dashboard timelines that are outside the norm. On March 6, 2014, the VHA met with the Paralyzed Veterans of America to demonstrate the dashboard and provide assurance that Veterans would continue to receive timely delivery prosthetic devices. In addition, VHA has issued VHA Directive 1081, *Procurement Process For Individual Prosthetic Appliances And Sensory Aids Devices Above the Micro-Purchase Threshold.* This VHA Directive defines the procedures for procuring prosthetic appliances and sensory aids and defines the roles and responsibilities of acquisition team members.

Question 12: Please list the "incentive structures" in the Patient Centered Community Care (PC3) program that Mr. Matkovsky mentioned in response to questions regarding PC3 reimbursement rates.

VA Response: The language provided below was extracted from the PC3 contract and applies to monetary incentives/disincentives for the contracted networks.

Incentive Fee: Upon meeting the minimum performance threshold for all performance objectives, the contractor shall be eligible to receive a monetary incentive for the following Quality Assurance Surveillance Plan (QASP) objectives:

- 1a - Time from receipt of authorization to appointment completion – 30 days or less;
- 2 - Timeliness from completion of the authorized episode of care to return of clinical documentation;
- 3 - Timeliness of critical and urgent findings reporting; and,
- 4 - Network adequacy to enable access.

If the contract fails to meet these objectives, a monetary disincentive applies. Please note no incentive or disincentive will be applicable for the start-up/implementation period.

The contractors' administrative fee shall be increased (incentive) or decreased (disincentive) by a maximum of three percent of Administrative Services Fee based on the previous 3-month performance and a weighted average of QASP performance objectives 1a, 2, 3, and 4. The performance objectives shall be weighted as follows:

- Performance Objective 1a at 25 percent
- Performance Objective 2 at 25 percent
- Performance Objective 3 at 35 percent
- Performance Objective 4 at 15 percent

Payments or deductions shall apply to the total amount of completed authorizations and shall be applied according to the methodology below.

QASP Performance Objectives 1a, 2, and 3 for all years and objective 4 beginning in option year 1:

- 3 percent increase for performance greater than or equal to 97.5 percent
- 2 percent increase for performance greater than or equal to 95 percent and less than 97.5 percent
- 1 percent increase for performance greater than or equal to 92.5 percent and less than 95 percent
- No incentive or disincentive for performance greater than 87.5 percent and less than 92.5 percent
- 1 percent decrease for performance greater than 85 percent and less than or equal to 87.5 percent
- 2 percent decrease for performance greater than 82.5 percent and less than or equal to 85 percent
- 3 percent decrease for performance less than or equal to 82.5 percent

QASP Performance Objective 1b (Time from receipt of authorization to appointment completion – 21 days or less) is an enhanced performance objective to encourage contractors to exceed the appointment scheduling standard of 30 calendar days for performance objective 1a (time from receipt of authorization to appointment completion).

In addition to the structure above, and related to Performance Objective 1a, the Contractors' administrative fee shall be increased by one percent (for a maximum possible incentive of four percent in combination with the incentive above) of Administrative Services Fee based on the previous three month performance when meeting the enhanced performance standard for appointment completion as defined.

Question 13: What impact does the Department estimate full implementation of PC3 will have on VA's third-party collections?

VA Response: The full impact of Patient-Centered Community Care (PC3) implementation on third party collections is yet to be seen as the networks are becoming fully operational. Realization of revenue opportunities will depend upon the number of Veterans seeking care for non-service connected conditions who have billable third party insurance and the treatment is covered under those third party policies.

Based on the current information available, VA estimates a $14.5 million potential annual impact to revenue based on the following expected impacts of PC3:

- *Increased efficiency of billing timeframes* – As the networks bill VA on a more-timely basis, and the claims are in turn paid more timely, days to bill for Non-VA Care (NVC) should be reduced. This increase in efficiency should lead to realizing collections quicker than in the previous model.
- *Improved revenue* – PC3 is expected to result in increased third party revenue opportunities due to improvements in the scheduling process and reduction in denials related to timely filing. Specifically, patients will be scheduled within 5 days of the referral, and appointment information will be provided to VA medical centers (VAMC) and entered into the scheduling package. This will facilitate Consolidated Patient Account Center (CPAC) precertification efforts, documentation and timely claims submission.

    - The revenue estimate assumes NVC collections per billing ratio (FYTD14 is 40 percent) to improve and align with VA collections to billing ratio which is currently 41 percent.

A	B	C=A*B
Expected Billings ($) from Reduced Days to Bill	FYTD 2014 VA Third Party Collection to Billing Ratio	Estimated Potential Revenue Impact
$35,374,005	41 percent	$14,503,342

VA continues to monitor the NVC process through the full implementation of PC3 to ensure all the efficiencies are realized.

Question 14: Please provide an update on the request for information (RFI) that the Department released to "...identify commercial best practices for automation of health care billing systems..." What response has the Department received to the RFI and how and when does the Department intend to incorporate those best practices into VA's third-party collections processes?

VA Response: VHA Chief Business Office released a Sources Sought notification (solicitation number VA118-14-I-0166) to the public on March 11, 2014. The purpose of the Sources Sought notification was to request information from qualified contractors regarding the development, configuration and implementation of an Automated Billing System (ABS). Along with general company information, the contractors were asked to provide two important pieces of information: 1) a technical capability statement containing a summarized technical approach for implementing a system within VHA; and 2) a Rough Order of Magnitude (ROM) estimate regarding expected implementation costs.

Responses to the Source Sought notification were due on March 27, 2014. VHA received 11 vendor responses to the solicitation and these responses are still under review by the VHA's Chief Business Office. We expect to use information gathered from the vendor responses for several purposes. First, we will review details of the technical approaches focusing on innovation and commercial best practices conveyed in the responses. All relevant and useful information gleaned from this review will be integrated into CBO's requirements documentation to ensure our planned procurement is based on industry best practices and state-of-the-art functionality. Second, we will analyze the proposed vendor technical approaches in the context of their respective ROM estimates to improve our understating of the planned work breakdown structure and to develop a more accurate Independent Government Cost Estimate (IGCE). Finally, we will work with responding vendors to arrange product demonstrations. This will allow the CBO technical team to observe the vendor solutions first-hand and will allow us to further refine the quality and accuracy of our technical requirements for the planned ABS procurement.

Question 15: Please list and briefly describe each of the "many tools" that Dr. Agarwal, VA's Deputy Under Secretary for Health for Policy and Services, testified had been developed to, "...assist the local facilities in managing specialty [care] resources appropriately." Please also describe how the Department intends to track the implementation and utilization of these tools and measure the impact they have on veteran access to specialty care services.

VA Response: Policy guidance has been provided by the Deputy Undersecretary for Operations and Management (DUSHOM) to the VAMC leadership via Memoranda dated June 26, 2013, and December 16, 2013. These include pathways for review of labor mapping (physicians and support staff), algorithms for interpreting and acting on workload and productivity data, and standards to review productivity in individual specialty group practices with guidelines on acceptable range for productivity by particular specialty based on facility complexity. The Office of Productivity, Efficiency, and Staffing (OPES) is the repository of much of the data for facility use, and has additional guides on analysis. Based on the DUSHOM guidance, those group specialty practices that require action plans be generated by the service/facility are then forwarded to the facility's Veterans Integrated Service Network (VISN) for review. The OPES database allows for longitudinal tracking of the success of services/facility's

action plans and this database examines both productivity and access to the group specialty practices at all facilities.

The following reports/databases serve as the key reports available to facilities to assist in managing their Specialty Practices:

Physician Productivity Cube:
The Specialty Physician Productivity Cube (database) contains all VA physicians. The physician workforce accounts for nearly 10 percent of the VHA budget, representing a significant healthcare resource and resource driver. The Physician Productivity cube contains coded (Current Procedure Terminology (CPT)) detailed information on the professional services delivered by our physician workforce to our Veteran patients at all VA sites. The physician productivity cube assesses the deployment of the physician staff to the missions of clinical care, research, and education as well as administrative responsibilities. It provides an assessment of the distribution of the physician workforce by geography and specialty as well as productivity measurement (Centers for Medicare and Medicaid Services (CMS) work Relative Value Unit (wRVU)/Direct Clinical Full Time Equivalent (FTE)).

Specialty Productivity-Access Report and Quadrant tool (SPARQ):
The Specialty Practice Management Quadrant Tool provides an algorithm for the effective management of VHA's specialty physician staffing and productivity practices. The tool is designed to drive performance improvement in Veteran access to specialty care and effective use of available resources. The SPARQ tool includes measures of: Specialty Specific Non-VA Care expenditures and VA Reliance, Measures of value that include compensation per RVU for total physician salary as well as clinical components, availability of support staff etc. The tool expands into measures of the care team bringing in Advanced Practice Provider (APP=Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists) workload (RVUs). The tool has additional views for local leadership (Chief of Staff, Director, Service Chiefs) included that permit a view of all specialties so that local managers can effectively manage their specialty practice resources.

Specialty Physician Productivity Report:
The report provides detailed productivity by specialty and practice setting (facility complexity level) to be used as benchmarks and may also be used for identification of best practices. This report trends the changes in productivity levels over the previous 5 years and is updated monthly.

Specialty Workforce Report:
The annual Specialty Workforce Report is available to all VHA that provides key information on the specialty physician workforce and is analogous to external benchmarking reports such as Medical Group Management Association (MGMA) and University Health Consortium (UHC) data. Specialty Physician Workforce Reports provide: productivity, per population staffing levels, Associate Provider Staffing, and support staff ratios for sites to effectively manage physician practices.

Productivity Standards and Outlier Report: This report contains observed Specialty Practice productivity levels and identifies sites that are outside of productivity expectations established and communicated to all VHA sites by the DUSHOM. Sites that have been identified as being out of range are required to implement remediation plans.

Question 16: Please provide information regarding the "comprehensive education and communication plan" that is currently underway regarding specialty physician productivity and staffing standards.

VA Response: As part of the Specialty Physician Productivity and Staffing work VHA developed and implemented a comprehensive communication plan. VHA's Office of Productivity, Efficiency and Staffing maintains a VA Intranet site that serves as the main portal of communication and reporting of activities related to Physician Productivity and Staffing. This portal and the reports located at this site are monitored for web hits. For the time period FY 2013 – February 2014 there were 27,268 hits on Physician Productivity Products and Reports. VHA's Office of Productivity, Efficiency and Staffing conducts routine training for managers each Thursday afternoon, and all VISNs and facilities have been provided training on the Physician Productivity Cube.

The DUSHOM has hosted a number of conferences (with VISN Chief Medical Officers and a number of Quality Manager Officers) to review and educate them on the various responsibilities of facilities and VISNs. The Office of the Deputy Under Secretary for Policy and Services held two conferences in August, 2013 which facility Chiefs of Staff attended and which included education as to the implementation of the DUSHOM Memorandum. The Office of the Deputy Under Secretary for Policy and Services, Patient Care Services, has also had a meeting of all Specialty Services National Program Directors, September 2013, which included education and discussion of productivity. Patient Care Services has also had telephone meetings with the Chief of Medicine Field Advisory Committee. The VISN Taskforce which piloted much of this work on productivity has hosted calls with medical and surgical subspecialty service leaders throughout VHA on a regular basis, to educate and gain feedback from the field on the implementation of the DUSHOM Memorandum.

Additionally, the following list provides details of tailored educational sessions that have been provided to these focused groups:

Session:	**Target Audience**
Friday National Hotline X2	Medical Center Executive Leadership
National Open Forum Calls X5	Medical Center Leadership and Providers
CMO/QMO Calls and F-2-F Meetings	VISN Clinical Leadership

Nephrology Field Advisory Committee	Specialty Leadership
Gastroenterology Field Advisory Committee	Specialty Leadership
Orthopedics Field Advisory Committee	Specialty Leadership
Ophthalmology Field Advisory Committee	Specialty Leadership
Urology Field Advisory Committee	Specialty Leadership
Gynecology Field Advisory Committee	Specialty Leadership
Hospitalists Field Advisory Committee	Specialty Leadership
Laboratory and Pathology Workgroup	Specialty Leadership
Anesthesia Field Advisory Committee	Specialty Leadership
Chiefs of Medicine Field Advisory Committee	Specialty Leadership
VISN 1 Chief of Surgery Group	Specialty Leadership
VISN 3 Chief of Surgery Group	Specialty Leadership
VISN 7 Chief of Surgery Group	Specialty Leadership
Systems Redesign Specialty Care Collaborative	Medical Center Leadership and Providers
Local Training on Physician Productivity Cube & SPARQ Tool	Every Thursday by VISN/Medical Center Appointment
Optometry Field Advisory Workgroup	Specialty Leadership
Chiropractic Field Advisory Workgroup	Specialty Leadership
Podiatry Field Advisory Workgroup	Specialty Leadership

Question 17: VHA Directive 2009-053, which provides pain management policy and implementation procedures, is scheduled to expire on October 31, 2014. Please describe the Department's efforts to-date to prepare to update and reissue this directive and list any and all proposed policy or implementation changes that have been proposed.

VA Response: The Department intends to update and reissue Directive 2009-053, *Pain Management*. The National Director for Pain and the Deputy National Director for Pain (Specialty Care Services, Patient Care Services), in collaboration with other

experts and offices, are responsible for updating the directive. Specifically, the updated directive will address the following:

1) Implementation of the Opioid Safety Initiative including strategies for training and monitoring of outcomes. (see below)

2) Development of and implementation/dissemination of VHA projects to provide pain management training to its teams of clinicians so that facilities and VISN achieve competency in Stepped Pain Care, as outlined in Directive 2009-053, including all ambulatory settings: in primary care, pain specialty care and pain rehabilitation, including:
    a. The DoD-VA Health Executive Council (HEC) Pain Management Work Group's Joint Investment Fund projects:
        i. The Joint Pain Education and Training Project (JPEP), a "train the trainers" project which is developing a standardized curriculum and training program for pain champions and team who will serve as JPEP Faculty in their roles as teachers of interdisciplinary students, residents, and fellows and clinical staff in all VHA facilities.
        ii. The Tiered Acupuncture Training Across Clinical Settings (ATACS), which is presently identifying and training medical acupuncturists across the VA and DoD who are being trained to teach Battlefield acupuncture to primary care team members throughout the health system.
    b. VHAs Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO) pain management training program that provides pain management training of primary care providers in rural or relatively inaccessible settings through an "Academic Detailing" model employing a curriculum and longitudinal supervision of clinical cases such as now occurs in residency training programs.
    c. Further development of the Pain Management Mini-Residency program which has been designed, approved and will provide its first training this spring. This program provides:
        i. A course of on-line pain management instruction in the conceptual and knowledge foundation of pain management, followed by;
        ii. An intensive, clinical skill-building in person instructional experience that trains physicians to competencies such as regional pain examinations and office procedures, followed by;
        iii. Longitudinal instruction though virtual networks such as SCAN-ECHO and primary care pain champion conferences.

3) Further clinical studies to establish evidence-based therapies in Integrative Medicine (CAM) and behavioral treatment.

4) Development and testing of an efficient, patient-centered, point-of-care, interactive pain assessment system, such as the Pain Assessment Screening

Tool and Outcomes Registry, Patient Reported Outcomes Measurement Information System (PASTOR-PROMIS) with the following capabilities:

a. Provides real-time clinical data pain for decision-support in pain management
b. Serves to populate a data registry to facilitate the standardization of goal-oriented measurement-based biopsychosocial stepped pain management throughout VHA.

5) Development of the Chronic Care Model project with the Office of Primary Care that includes the following six elements:

Chronic Care Model	
Six Pillars	**Critical Aspects**
Health System	Visible support from all levels of the organization, promote effective improvement strategies aimed at comprehensive systems of change, encourage open and systematic improvement of care, develop care coordination agreements.
Redesign of the Delivery System	Define roles and distribute tasks among team members, use planned interactions to support evidence-based care, provide clinical management services for complex patients, guarantee regular follow-up by the care team.
Use of Decision Support	Embed evidence based guidelines into daily clinical practice to integrate specialist expertise with primary care. These guidelines are shared with patients to encourage participation.
Use of Clinical Information Systems	Provide timely reminders for providers and patients, identify relevant subpopulations for proactive care, faciliate individual patient care planning and share information with patients and providers to coordinate care.
Education and Self Management Skills	Emphasize the patient's central role in managing their care and use effective self management support strategies that include assessment, goal setting, action planning, problem solving and followup.
Access to Community Resources	Encourage patients to participate in effective community programs. For example, a patient may benefit from joining a community based support group to promote self-help strategies.

Question 18: Please describe the role of the Opioid Safety Initiative within VA's existing pain management programs and provide information regarding how the Department intends to measure and track the Initiative's implementation, utilization, and impact.

VA Response: VA recently developed and implemented an Opioid Safety Initiative (OSI) program to ensure opioid pain medications are used safely, effectively and judiciously. The basis for this is to make visible the totality of opioid use at all levels, patient, provider and facility, in order to identify high-risk situations. The OSI includes

key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average dosage per day of opioids such as hydromorphone, methadone, morphine, oxycodone, and oxymorphone. Patients at risk for adverse events from use of opioids are identified through the use of administrative and clinical databases using pre-determined parameters based on published evidence and expert opinion. Several aspects to measure the implementation of the Opioid Safety Initiative upon opioid use were underway at the time of the October 10, 2013, hearing and suggested positive impacts:

- Despite an increase in the number of Veterans who were dispensed any medication from a VA pharmacy, (i.e., all pharmacy users) in October 2012 compared to November 2013, 39,088 fewer Veterans received an opioid prescription from VA during that time period.
- Performing urine drug screens is a useful tool to assist in the clinical management of patients receiving long-term opioid therapy. As of November 2013, urine drug screens were performed on 80,294 more patients than in October 2012.
- Whenever clinically feasible, the concomitant use of opioid and benzodiazepine medications should be avoided. In November 2013, 9,609 fewer patients were receiving these drugs at the same time than in October 2012.
- Lastly, the average dose of selected opioids has begun to decline slightly in VA, demonstrating that prescribing and consumption behaviors are changing.

While these changes may appear to be modest given the size of the VA patient population, they signal an important trend in VA's use of opioids. VA expects this trend to continue as it renews its efforts to promote safe and effective pharmacologic and non-pharmacologic pain management therapies. Very effective programs at several VA facilities yielding significant results have been identified (e.g., Minneapolis, Tampa, and Columbus), and are being studied as best practice leaders.

Question 19: Please describe that actions, if any, that the Department has taken to ensure that pain management points of contact (POCs) within VA medical facilities regularly communicate with pain management specialists, as appropriate, about Veteran patients experiencing acute or chronic pain. Please include any and all guidance that has been sent to the field regarding the referral process from pain management POCs to pain management specialists.

VA Response: Points of contact for Pain Management have been identified at all VA Medical Centers to receive information from VACO offices pertinent to pain. The role of the Pain POCs, at the VISN and at the facility level, is primarily to coordinate efforts in regard to pain management from an administrative side. The Pain POCs are expected to work closely with the Pain Specialists at each facility within the facility Pain

Management Committee. However, Pain POCs are not the point of contact for clinical issues regarding individual patients. For Veterans, the POC for their individual pain needs clinically, in regard to evaluation and treatment, is their primary care provider within the Patient Aligned Care Teams (PACT), as necessary, in collaboration with the pain medicine specialty team at the facility. Thus the POCs are not expected to regularly communicate with the clinical providers including pain specialists about specific Veteran patients experiencing acute or chronic pain, in regard to their clinical management. They may assist, as appropriate, within their administrative capacities. A referral process from pain management POCs (administrative function) to Pain Specialists (clinical function) is not appropriate. A general approach, titled Implementation of the Opioid Safety Initiative (OSI), was forwarded to all POCs. (See attachment).

Implementation of
Opiod Safety Initiativ

Question 20: During the Subcommittee's October 10, 2013, oversight hearing entitled, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans," a VA witness testified about a VA-wide best practice in pain management called the "Chronic Pain Rehabilitation Program." Please describe what efforts, if any, VA has taken to implement related or similar programs in other VA medical centers and clinics.

VA Response: The Under Secretary for Health chartered an Interdisciplinary Pain Management Center Work Group to provide guidance and oversight for VHA's efforts to develop VISN level tertiary care Pain Management Centers. These Centers have the capacity for providing advanced pain medicine diagnostics, surgical and interventional procedures, and in addition provide intensive, integrated chronic pain rehabilitation for Veterans with complex, co-morbid, or treatment refractory conditions.

There are currently ten Commissions for the Accreditation of Healthcare Facilities (CARF)-accredited pain rehabilitation centers in VHA. This includes one Center at the James Haley Veterans Hospital in Tampa, Florida, that is one of only two multidisciplinary pain management centers that has been twice recognized by the American Pain Society as a Clinical Center of Excellence (the other being a program at Stanford University). VHA is in process of greatly expanding access to such Chronic Pain Rehabilitation Centers. Each VISN is expected to have at least one CARF-accredited tertiary, interdisciplinary pain care program no later than September 30, 2014. Some VISNs may have two or more such programs. In addition, there is system-wide education effort ongoing to educate physicians in Primary Care (PACT) and other providers taking care of Veterans with chronic pain conditions about Chronic Pain Rehabilitation approaches and to include components of Chronic Pain Rehabilitation approaches into Primary Care.

Questions 21: Please describe the six ongoing pilot programs that are in place to test the Departments initiative regarding state prescription drug monitoring programs, to include information regarding how VA intends to measure the outcome of the pilot programs. Please also elaborate on the Information Technology "limitations" that were referenced in regard to the pilot programs.

VA Response: VA currently has five test sites that send Veterans' prescription data to state prescription drug monitoring programs on a daily basis. The test sites are located at the following VAMCs: Fayetteville, Arkansas; Muskogee and Oklahoma City, Oklahoma; Durham, North Carolina; Louisville, Kentucky; and Nashville/Murfreesboro, Tennessee.
VA intends to measure the success of the pilot programs by determining the extent to which state prescription drug monitoring programs are able to receive Veterans' prescription drug information. As of March 31, 2014, VA has experienced a successful prescription transfer rate of 100 percent (i.e., 100 percent of the prescription data that is being sent from VA is being received by the state drug monitoring programs at the test sites). If this rate of success continues through the duration of the testing period, VA could release the software nationwide as early as August 2014.

VA's solution is limited to the use of secure FTP (sFTP) and the American Society for Automation in Pharmacy (ASAP) message structure. This solution is supported by 45 states.

Question 22: Please describe the actions, if any, that have been taken to make the VA formulary more consistent with the DoD formulary.

VA Response: VA has a long-standing practice of providing active duty service members access to pharmaceuticals prescribed by their DoD physicians when they receive care in a VA medical facility. Similarly, when a newly discharged service member chooses VA to be their health care provider, every effort is made to assure a smooth transition to VA, including a careful assessment of their existing medication therapy.

VA does not believe it is in the best interest of its beneficiaries nor the American taxpayers to make its formulary more consistent with the DoD formulary. However, VA does believe it has a responsibility to ensure all VA beneficiaries have appropriate access to medically necessary pharmaceuticals, and we believe we are meeting that challenge in a clinically and fiscally responsible manner.

VA's ability to ensure appropriate access to pharmaceuticals has been validated repeatedly by various groups including the Government Accountability Office, the Institute of Medicine, the Office of Inspector General, and has also been substantiated in countless articles in the peer-reviewed medical literature (see attached examples). In some cases, VA offers a more generous prescription benefit than DoD by including drugs on its formulary which DoD does not.

For example, VA recognizes the health benefits of weight loss and uses medications as part of a robust weight loss program (MOVE). DoD is prohibited from providing weight loss drugs (e.g., Qsymia and Belviq). DoD is also prohibited from providing over-the-counter drugs and must instead use more expensive prescription pharmaceuticals in their place. Removing drugs like these from VA's formulary so it is more like DoD's may contribute to a decrease in the quality of care for Veterans and unnecessarily increase drugs costs without a corresponding increase in care.


VA_Quality.pdf


Annals_Editorial_VA_Care.pdf


Cancer care in VA versus Medicare surv


Cancer Care VA editorial.pdf

VA and DoD treat different populations, so some DoD drugs are not needed in VA. As a general matter, VA provides direct care to a large proportion of older males, a smaller proportion of females and no pediatric patients. DoD's beneficiaries include males of all ages, a larger proportion of females, and generally no pediatric patients. If VA were to add medications not needed by its beneficiary population, it would result in an unnecessary increase in cost, again with no corresponding benefit.

The legislation and regulations which govern the DoD Uniform Formulary require DoD to add every commercially available drug to its formulary as soon as the drug is approved by the FDA. VA only adds drugs to its formulary after a careful clinical review is done to ensure that the drug is proven to be safe and effective and necessary for the care of VA beneficiaries. It is important to note that some of the drugs DoD was mandated to add to the Uniform Formulary have been removed from the U.S. market due to safety problems. This has occurred in VA to a much lesser extent, so making VA add drugs to its formulary as DoD does would expose Veterans to an increased risk of adverse drug events. VA cannot emphasize enough the importance of critically evaluating the safety of newly approved drugs. From 1997 through 2011, 31 drugs have been withdrawn from the U.S. market and all except 1 of them were withdrawn for safety reasons. VA only had 2 of the 31 drugs withdrawn from the market on VA Formulary (see attachment below).


Withdrawal from Market.xlsx

In summary, VA and DoD have different health care delivery systems. DoD is primarily a payer of care and uses some of the drugs it is required to have on its formulary, not because they are clinically needed but because they are what non-DoD physicians prescribe, and they must be added to the formulary to reduce costs. VA's formulary is designed to meet the needs of its beneficiaries by strictly relying on robust medical evidence and it is likely the highest quality, lowest cost formulary system in the country. If VA were to expand its formulary to be more like DoD's, costs would increase, there would not be a corresponding increase in the quality of care, and VA would expose

Veterans to unnecessary risks for adverse events by listing drugs on its formulary that have not demonstrated evidence of safety and efficacy outside of clinical trials.

Questions for the Record from Congressman Keith Rothfus

Question 1: On September 9, 2013, you testified at a field hearing in Pittsburgh that VA would delay taking any administrative disciplinary action relating to the systemic failures and mismanagement at the VA Pittsburgh Healthcare System (VAPHS) that resulted in the deaths of at least six veterans due to an outbreak of legionella until the U.S. Justice Department concluded its criminal investigation. Then, on November 21, 2013, the Justice Department announced that it had concluded that investigation and that no criminal charges would be brought. It has now been over three months since that announcement, and the VA has yet to hold anyone at VAPHS accountable. Accordingly, please provide a detailed explanation of what VA has done internally to investigate those responsible for these preventable deaths, what VA has left to be done to conclude that investigation, and a date certain by which the families of the victims and Members of Congress can expect that the VA will take such administrative disciplinary action.

VA Response: VHA Labor Relations/Employee Relations (LR/ER) provides advice and guidance concerning conduct and performance issues that involve VHA senior managers:

- Senior managers include all VHA Senior Executive Service (SES) appointments, Title 38 equivalents and all 38 U.S.C. § 7306 appointees, Associate/Assistant Medical Center Directors, facility Chiefs of Staff and Associate Directors for Patient Care Services/Nurse Executives.
- The LR/ER group also provides this assistance for any GS-15 position or above, or Title 38 equivalent in VA Central Office (VACO) or with direct reporting alignment to VACO.
- VA conducted an organizational assessment of the VA Pittsburgh Healthcare System (VAPHS). The assessment team was asked to review management and oversight controls employed by the VAPHS and VISN 4 surrounding Legionella issues from 2011 to present. The assessment was completed on November 20, 2013.
- Based on the findings of the assessment, administrative disciplinary actions are being finalized. Government wide regulations and VA policy require that due process be completed prior to finalizing any disciplinary action.
- Proposed disciplinary actions ranging from reprimands to suspensions have been issued. Each disciplinary action has appeal rights that may delay the date of final disciplinary action. Congressman Rothfus' office will be updated upon final resolution of these matters.

Question 2: On November 26, 2013, following the conclusion of the Justice Department's investigation into the legionella outbreak at VAPHS, Senator Pat Toomey and I sent a letter to Secretary Eric Shinseki requesting information about what administrative disciplinary action the VA planned to take, if any. To date, though, over three months later, neither Senator Toomey nor I have received any response. Can you please explain why the Secretary's office found it acceptable to not send any response to our inquiry? Is this indicative of how VA and the Secretary's office views Congressional inquiries and oversight generally?

VA Response: VA Pittsburgh Healthcare System has extended its condolences to the families of the Veterans with Legionella who died. VA is dedicated to doing whatever it takes to minimize the risk of Legionella and create the safest environment possible for our Nation's Veterans to heal. With the investigation by the U.S. Attorney and VA Office of Inspector General completed, the Veterans Health Administration (VHA) has initiated administrative actions related to the outbreak. As is customary, the administrative review was initially paused to avoid interfering with the ongoing investigations. VHA leadership has now initiated actions with careful consideration of the statutory protections and rights of employees, including due process. While we are focused on completing this process in a timely manner, VHA's priority is to carry out these actions objectively and consistent with applicable administrative guidelines. When this process is fully complete, VA will provide an update to the Committee. Again, VA is committed to providing the best quality, safe, and effective health care our Veterans have earned and deserve and extend our condolences to the families of the Veterans with Legionella who died.

Question 3: During the hearing on February 26, 2014, you stated that only one death resulted from the legionella outbreak at VAPHS. Yet, the Centers for Disease Control and Prevention (CDC) found in its investigation that at least 21 veterans were sickened as a result of the outbreak, five of whom died. Moreover, since the CDC released its report, a sixth veteran death has been connected to the outbreak as well. Accordingly, please provide a detailed explanation why VA has concluded, despite the findings of the CDC that only one death resulted from the outbreak of legionella at VAPHS.

VA Response: I would like to clarify that I made an error when I stated the date of death of one of the patients occurred on July 12, 2012, at the VA Pittsburgh Healthcare System. The date of death was July 4, 2012. Further, of the six deaths discussed at the hearing, VHA is in possession of five death certificates. In the case of the sixth death, the Veteran passed away at a community hospital, and VHA does not currently possess the death certificate. As previously reported, one death was attributed to Legionella pneumonia as the primary cause of death. I based my testimony on the immediate cause of death. However, there was a second patient who had a contributing cause of death listed as Legionella pneumonia on the death certificate, but it was not the primary cause of death. VA extends its condolences to the families of the Veterans affected by acquiring Legionella in our health care system. We are committed

to doing whatever it takes to minimize the risk of Legionella and create the safest environment possible for our Nation's Veterans to heal.

Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices

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Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices

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Critics charge that Veterans Health Administration (VA) medical centers are inefficient and the cost of veteran health care would be reduced if VA purchased care for its patients directly from private-sector providers. This analysis compares VA medical care expenditures with estimates of total payments under a hypothetical Medicare fee-for-service payment system reimbursing providers for the same counts of each service VA medical centers provided in fiscal 1999. At six study sites, hypothetical payments were more than 20

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percent greater than actual budgets. Nationally, this represented more than $3 billion in 1999 and more than $5 billion in 2003. Data limitations suggest the estimate is conservative. Less than half of the difference is due to VA's low pharmacy costs. The study demonstrates the potential savings to patients and taxpayers of the VA health care system.

Keywords: *health care; costs; veterans; health policy*

The Veterans Health Administration (VA) is the largest public health care system in the United States. The VA provides health care services to more than 4 million eligible veterans in facilities located in all 50 states. Periodically, critics suggest VA be eliminated and vouchers or other payment forms be provided to eligible veterans allowing them to use their benefits in the private health care sector (Iglehart 1996; Moskowitz 1995; Pittman 1995). Because government provision of goods and services is generally presumed to be economically inefficient (Stiglitz 1986), it has been suggested that this move would result in reduced national health care expenditures.

Past assessments found VA's costs to be the same as or lower than private sector hospital costs, but methodological issues (e.g., not pricing outpatient services) made these analyses less than definitive (Hendricks, Remler, and Prashker, 1999). Transformations of the health care industry (e.g., increased competition, managed care, prospective payment, shift from inpatient to outpatient care) also affect the validity of past comparisons. A new comparison of taxpayers' costs for VA-provided care can help to focus debates concerning efficient ways to meet the country's legal and social mandate to provide health services for veterans. It also has implications for other public sector hospitals funded directly by governments.

NEW CONTRIBUTION

This analysis updates and expands estimates of payments for VA services using Medicare rates. It is the first estimate for all services, not just acute inpatient care analogous to services covered under Medicare's prospective payments. It is also the first study to document and try to quantify billable VA services (e.g., physician inpatient visits) that are not usually captured in VA's

Chang, Michael Erdmann, Allan Erickson, Elizabeth Franchi, John Gardner, Gail Graham, Debra Jones, Theodore Lotchin, Gary Roselle, Amy Rosen, Yujing Shen, Robert White, Shuo Zhang. This work was supported by the Veterans Health Administration, Health Services Research and Development, grant no. SDR 97001-1. The opinions are the authors' and do not reflect those of the Department of Veterans Affairs, the Veterans Health Administration, or Health Services Research and Development. Errors remain the responsibility of the authors.

standardized databases. The comparisons provide information relevant to national discussions of Medicare benefits and policy debates about national health care infrastructure.

METHODS

This study compares expenditures for all VA health care provided nationwide over fiscal year (FY) 1999 (October 1, 1998, through September 30, 1999) to hypothetical payments under Medicare rates for the same services. Payment estimates were based on a microstudy of six medium-sized, university-affiliated, acute VA hospitals, chosen to give a diversity of VA services and locations (Albuquerque, New Mexico; Birmingham, Alabama; Cincinnati, Ohio; Kansas City, Missouri; Milwaukee, Wisconsin; and Providence, Rhode Island). The facilities included nursing homes (two), substance abuse and psychiatric domiciliary care (two) and spinal cord units (two), but not long-term psychiatric care.

A microstudy was necessary because (1) significant amounts of care for which VA would have to pay separately under fee-for-service (e.g., ambulatory surgeries and care that VA purchases under contracts with private sector providers) are not consistently captured (or easily identified) in its current computerized workload system and (2) significant amounts of care for which public and private payers would not pay separately under fee-for-service (e.g., chaplain visits) could be coded as if they were billable. Special procedures captured the former and identified and excluded as many of the latter as possible. A comprehensive review of the methodology provides details for pricing acute and special inpatient care, nursing home stays, outpatient clinics, and professional, pharmacy, and prosthetic care (Nugent and Hendricks 2003).

Study assumptions included sufficient private capacity for VA to buy care at Medicare reimbursement rates and that the VA benefit package would remain the same. Medicare payment schedules were used as the standard for pricing VA services wherever possible because Medicare is a federal medical insurance program with a uniform benefit package and an existing mechanism for reimbursing health care providers nationally. An agreement with the Department of Health and Human Services to make VA "in effect, a Medicare+Choice option for veterans holding Medicare Part B" coverage supports the program's relevance to VA (Freedberg 2003).

The hypothetical payment rates were Medicare's total allowed amount including both the patient and Medicare portion (i.e., including any deductibles or copayments for which Medicare beneficiaries would be responsible). Because of the complexity of Medicare reimbursement rules, payment

strategies, and methods, an oversight committee that included VA and non-VA experts on health care costs and payment regulations reviewed and approved study methods.

MICROSTUDY ESTIMATES

The study population was all veterans receiving care at the six study hospitals in FY 1999. Estimated payments for Medicare-covered services were based on Medicare rates and surrogate prices if Medicare had no rates for the care (see Table 1). For covered Medicare benefits (acute inpatient services, nursing home stays, professional and facility fees), the existing Medicare rates included geographic and other adjustments for each site (Render, Roselle, et al. 2003; Hendricks, Whitford, and Nugent, "What Would VA Nursing Home Care," 2003; Ingenix, Inc. 2000; Roselle et al. 2003). For VA services restricted under Medicare (e.g., pharmacy), we applied Medicare payment methodologies without the restrictions. For example, we assumed that Medicare's formula for discounting rates for pharmaceuticals applied to all prescriptions, not just the program's restricted list (Render, Nowak, et al. 2003). For services not covered by Medicare (e.g., dental), we used rates from the most representative available providers (Staffs of the Management Decision and Research Center and the Association for Health Services Research 1996).

CAPTURING SERVICES

We extracted computer utilization records for all care at the study hospitals in FY 1999 (Department of Veterans Affairs 1998; Ingenix, Inc. 2000). Table 2 summarizes data sources.

Study coding staff coded ambulatory surgeries (diagnoses, procedure codes) directly from medical records because these services were not routinely captured in FY 1999. From hospital outpatient administrative files, we extracted workload for providers entitled to professional fees under Medicare. Inpatient administrative files provided estimates of providers' workload for inpatient admissions, discharges, and other visits. We estimated surgeons' fees for *ICD-9-CM* (*International Classification of Diseases*, 9th rev., Clinical Modification) procedures listed in the VA's national procedure file but did not calculate anesthesiology fees because of a lack of detail about the duration and difficulty of the surgery. We converted prescription and dispensing data in the Pharmacy Benefits Management System into 30-day equivalent prescriptions. We counted prescribed prosthetics by Health Care Financing Administration Common Procedural Code System (HCPCS) from the National Prosthetic Patient Database.

TABLE 1 Summary of Payment Rates by Type of Health Care Service

Health Benefit	*Payment Source Data*	*Payment Element*	*Payment Calculation*
Acute inpatient	1998 Medicare Provider Analysis and Review	Diagnosis Related Group	Σ (VA Diagnosis Related Group frequency) × (average Diagnosis Related Group payment by area)
Rehabilitation	1998 Medicare Provider Analysis and Review	Per diem, Tax Equity Financial Reform Act 1975	Σ (Rehabilitation days) × (average rehabilitation per diem)
Facility fees	1997 Medicare Cost Report	Medicare Fee Schedule and Ratio of Cost to Charge	Σ (*Common Procedural Terminology*, fourth rev. frequency)(Medicare Fee Schedule) + (*Common Procedural Terminology*, fourth rev. frequency)(Ratio of Cost to Charge)
Pro fees	1999 Relative Value Units	Medicare Fee Schedule	Σ (*Common Procedural Terminology*, fourth rev. frequency)(Medicare Fee Schedule)
Nursing Home		Historical cost and Resource Utilization Groups	Σ (nursing home days) × (average per diem)
Domiciliary	1998 Medicare Provider Analysis and Review	Ambulatory Payment Category 0033	Σ (days of care) (Ambulatory Payment Category rate 0033)
Residential care	1998 Medicare Provider Analysis and Review	Ambulatory Payment Category 0033	Σ (days of care) (Ambulatory Payment Category rate 0033)
Pharmacy	1999 RedBook	Medicaid Maximal Allowable Charge and discounted Average Wholesale Price	Σ (National Drug Code frequency) (Medicaid Maximal Allowable Charge) + (National Drug Code)(Average Wholesale Price – 5%)
Prosthetics	1998 Durable Medical Equipment, Prosthetics, Orthotics and Supplies	Medicare Fee Schedule	Σ (*Common Procedural Terminology*, fourth rev. frequency)(Medicare Fee Schedule for each *Common Procedural Terminology*, fourth rev.)
Dental	1999 American Dental Association	Discounted fee schedule	Σ (*Common Procedural Terminology*, fourth rev. frequency)(American Dental Association fee schedule at 75th percentile)

Note: Redbook = price list of average wholesale prices by National Drug Code.

TABLE 2 Source of Data for VA Workload by Type of Health Care Services

Health Care Service	*Workload Source*	*Workload Identifier*
Acute inpatient	National Patient Care Database (Patient Treatment File)	*International Classification of Diseases*, 9th rev., Clinical Modification
Rehabilitation	National Patient Care Database (Patient Treatment File)	*International Classification of Diseases*, 9th rev., Clinical Modification
Facility fees	Veterans Integrated Health Systems Technology Architecture (Patient Care Encounter)	*Common Procedural Terminology*, fourth rev.
Professional fees	Veterans Integrated Health Systems Technology Architecture (Patient Care Encounter)	*Common Procedural Terminology*, fourth rev.
Nursing home	National Patient Care Database (Extended Care File)	*International Classification of Diseases*, 9th rev., Clinical Modification
Domiciliary	National Patient Care Database (Patient Treatment File)	*International Classification of Diseases*, 9th rev., Clinical Modification
Residential Care	National Patient Care Database (Patient Treatment File, Patient Care Encounter)	*International Classification of Diseases*, 9th rev., Clinical Modification
Pharmacy	Pharmacy Benefits Management	National Drug Codes
Prosthetics	National Prosthetic Patient Database	Health Care Financing Administration Common Procedural Code System
Dental	Veterans Integrated Health Systems Technology Architecture (Patient Care Encounter)	Health Care Financing Administration Common Procedural Code System

VA prosthetics workload was merged with Medicare payment rates by HCPCS codes and multiplied by Medicare payment rates (Render, Taylor, et al. 2003). For non-Medicare-covered items (e.g., hearing aids) we inflated VA costs by 30 percent (to reflect the lowest ratio of Medicare fee to VA cost). Pharmacy and prosthetics payment calculations and findings were similar to those of other VA-Medicare comparisons (Department of Health and Human

Services, Office of Inspector General 1998; Iha et al. 2001; U.S. General Accounting Office 2000).

VA COST

VA's Cost Distribution Report (CDR) is a budget allocation system for costs from accounting and payroll records (Nugent, Grippen, et al. 2003). Each fiscal year, the CDR is reconciled with accounting records and therefore accurately represents annual hospital expenditures. We adjusted CDR costs for six study sites by adding corporate overhead, interest on capital assets (at the September 1999 long-term Treasury rate of 6.05 percent) and malpractice costs from the Tort Claim Information System. These adjustments accounted for 3.3 percent of VA costs.

NATIONAL ESTIMATES

A major lesson from the microstudy was that VA files undercount health care services, particularly the use of durable medical equipment and inpatient care by professional providers who could bill directly for those services under Medicare. To estimate hypothetical payments for the entire VA, we inflated some counts of care in the national database, assuming that the validated microstudy counts were representative of the experience at other VA medical centers. National costs needed no proportional reallocations of overhead required by the microstudy (which included only the share of overhead for the six study sites). National overhead, malpractice, and interest on capital are included in the national VA costs below.

RESULTS

Estimated payments for VA services at the study sites in FY 1999 plus VA's research and education budget were $973 million, almost 21 percent greater than the taxpayer's actual cost of $806 million (see Table 3). Thus, VA's medical budget plus corporate overhead and the opportunity cost to the taxpayer of VA capital (which was not an actual cash outlay) would have had to be $167 million more to purchase as much in the private health care sector as the six sites provided.

We estimate that acute inpatient expenditures at study sites would be 15.6 percent higher at Medicare's private sector rates. Hypothetical payment for nursing home care would be 21 percent more at Medicare rates. The greatest increase in taxpayer costs would be for outpatient pharmaceuticals, rehabilitation, and partial hospitalization. For outpatient pharmacy services, the

TABLE 3 Estimated Hypothetical Payments and VA Costs for Six Study Sites

Category of Cost	*Hypothetical Payment Estimate ($000s)*	*VA Fiscal Year 1999 Costs ($000s)*
Inpatient facility (VA + purchased acute care)	221,558	191,577
Nursing home (VA + purchased care)	30,451	25,243
Rehabilitation + partial hospitalization	71,670	42,097
Total institutional inpatient	323,679	258,917
Professional fees (including malpractice)	109,543	93,165
Outpatient diagnostic	192,184	174,863
Outpatient care, purchased[a]	19,855	19,855
Home health care, purchased	5,284	5,284
Total outpatient	326,866	293,167
Prosthetics/durable medical equipment (durable medical equipment)	49,769	30,600
Pharmacy	200,757	118,811
Dental	12,832	8,299
Miscellaneous benefits	19,795	31,584
Total other patient care	283,153	189,294
Trainee salaries	22,973	22,973
Research support	17,063	17,063
VA overhead	0	24,937
Other activities	40,036	64,973
Total, all costs	973,734	806,351

a. Includes professional and facility fees for services currently purchased from private-sector providers.

budget would need to be 69 percent more if veterans filled their prescriptions at payment rates set according to Medicare's existing formula. Similarly, in the private sector, the budget would be 70 percent higher to provide rehabilitation and partial hospitalization services and 55 percent higher for the same dental care. Only "Miscellaneous Benefits" (including travel payments, readjustment counseling, and other centralized benefits) have VA costs exceeding the hypothetical estimate. The difference represents costs the study sites assigned to this account that could not be directly linked with health services that could be priced in the private sector.

TABLE 4 National Estimated Hypothetical Payments and VA Costs

Category of Cost	*Hypothetical Payment Estimate ($000s)*	*VA Fiscal Year 1999 Costs ($000s)*
Institutional inpatient (VA + purchased acute care)	4,752,897	5,278,716
Nursing home (VA + purchased care)	2,096,365	1,537,171
Rehabilitation + partial hospitalizations[a]	1,267,812	558,921
Total inpatient	8,117,074	7,374,808
Professional fees (including malpractice)	2,387,245	2,089,313
Outpatient diagnostic	5,666,978	3,988,826
Outpatient care, purchased	387,791	387,791
Home health care, purchased	159,583	159,583
Total outpatient	8,601,597	6,625,513
Prosthetics/durable medical equipment	847,669	449,013
Pharmacy	3,020,589	1,769,707
Dental	234,217	175,062
Miscellaneous benefits	459,548	548,996
Total other patient care	4,562,023	2,942,778
Trainee salaries	372,210	372,210
Research support	396,165	396,165
VA corporate overhead		405,637
Interest on VA assets		695,022
Other activities	768,375	1,869,034
Total, all costs	22,049,069	18,121,133

a. Includes domiciliary lodging in VA budget.

Nationally, the VA's medical care costs in FY 1999 were $18.8 billion (see Table 4). Our estimated hypothetical payments were $22 billion. That is, hypothetical Medicare-based payments were 17 percent higher than the VA budget, including overhead, interest on capital, and malpractice. Since interest on capital represents opportunity cost, actual cash outlays to purchase the same services would increase payments by an additional $695 million. If VA enrollees were converted to coverage under Medicare payment rules but with the same budget as VA currently has, services would necessarily be reduced. Areas where the budget differences might be greatest are for outpatient pharmaceuticals, prosthetics, rehabilitation, and partial hospitalization.

Note that the hypothetical payments for national institutional inpatient care are about $500,000 less than the VA costs for that category. We believe that this represents costs that VA facilities assigned to this account that could not be directly linked with health services (e.g., the cost of subacute care imbedded in acute inpatient hospitalizations) that could be priced in the private sector. In the microstudy, some services could be identified in additional records or files that were unavailable at the national level, which relied on the computer files at VA's automated data repository in Austin, Texas.

CONFIDENCE IN THE ESTIMATES

POSSIBLE OVERSTATEMENT OF HYPOTHETICAL ESTIMATES

The estimated cost of VA care under a hypothetical VA-Medicare program using private sector providers may be either overstated or understated, even given the study's restrictive assumptions. There are two major reasons for possible overstatement. First, we used Medicare rather than Medicaid payment rates for nursing home care. Second, the Medicare reimbursement for pharmaceuticals (average wholesale price minus 5 percent) was very high compared to private sector plans.

A sensitivity analysis using a very deep average discount of 40 percent on pharmaceutical prices would still be 15 percent higher than actual VA expenditures (Render, Nowak, et al. 2003) but would reduce the hypothetical payments by almost $1 billion. A separate sensitivity analysis using 1999 Medicaid Statistical Information System per diems for care provided to VA patients enrolled in Medicaid programs suggest this VA care might be purchased at 50 percent to 60 percent of our estimates (Hendricks, Whitford, and Nugent, "What Would VA Nursing Home Care," 2003). This change would cut the hypothetical payments by $1 billion. In 1999, only about 5 percent of all VA patients were enrolled in Medicaid across the country, but the proportion among patients using VA nursing homes or other long-term care services was 2 to 3 times greater (Hendricks 2003). It is not reasonable, however, to expect that all postacute nursing home care would qualify VA patients for Medicaid or that veterans with service-connected disabilities would give up their compensation to qualify for Medicaid benefits.

POSSIBLE UNDERSTATEMENT OF HYPOTHETICAL ESTIMATES

The cost burden to taxpayers resulting from the hypothetical change to the VA system may be understated here because of (1) more intensive practice

patterns in the private sector resulting in reimbursements for more procedures or multiple private sector admissions for nonurgent health problems; (2) the assumption that private-sector rates would be unchanged despite greater severity of illness for the VA patient population; (3) workload that is undocumented in the VA system but billed separately under Medicare; (4) the relaxation of VA's strict formulary for medications; and (5) increased utilization because of expanded access to eligible veterans who are currently not enrolled in VA.

The assumption that care provided for veterans in a fee-for-service model would be the same as that provided at VA facilities is problematic because market forces and medical practice patterns differ. The extrapolation of payment for VA health care services to private sector providers with different incentives, different cost structures, and different types of facilities makes it difficult to predict with certainty VA enrollees' use of services in the community. For example, despite similar rates of mortality, veterans receiving care paid for under Medicare were more likely to have invasive procedures including cardiac catheterization, coronary bypass surgery, and percutaneous transluminal angioplasty than VA patients (Wolinsky et al. 1985).

Differences in risk pools and utilization of services also have a direct bearing on health-related costs. There are some similarities between how VA patients and the Medicare population use health care services, but patients cared for by the VA tend to be at higher risk for greater cost given their lower educational status, lower socioeconomic bracket, generally poorer health (self-reported), greater likelihood of being out of the labor force, and reduced family support (Randall et al. 1987). Each of these characteristics could understate the potential cost of these patients because of higher rates of serious illness, mortality, lengths of stay, and psychiatric hospitalization.

Private sector hospitals have invested in staffing and automated tools to increase billing effectiveness; conversely, the VA's information system is clinically oriented, patient-centered, and lacks private-sector applications to maximize billing. Consequently, we could not price many services, especially at the national level, for which a private sector system would charge (Nugent et al. 2000). For example, the VA's databases do not capture multiple episodes for reimbursable procedures such as a radiation therapy, chemotherapy, and transfusions. This workload was lost for purposes of our estimation, as were prosthetic limbs manufactured onsite and subacute care provided during acute admissions. This difference and the previously reported practice of transferring selected patients from the private sector to the VA (Hurley, Linz, and Swint 1990) may contribute to an underestimate of the cost liability of privatizing VA care.

Some differences between VA costs and the estimated private sector payments reflect the VA's unique negotiating positions within local markets or as a national buyer of hearing aids, other assistive devices, or pharmaceuticals. For example, each participating hospital had local contracts negotiated below Medicare payment rates that could disappear (e.g., for nursing home care). Conversely, VA's medication costs have risen in the past when Congress tried to reap the same discounts for the Medicare program (Iglehart 1996; Department of Health and Human Services, Office of Inspector General 1998, 2001). Pharmacy costs would also likely increase without VA's formulary unless a privatized veteran benefit incorporated the strict limits it imposes on VA physicians.

DISCUSSION

Our multisite study to examine the amount of health care VA could buy in the private sector extrapolated detailed cost data gathered from six university-affiliated VA medical centers to national costs. If the current VA structure were replaced by a privatized care system, such as an expanded Medicare program, we assumed that all veterans currently eligible for care by the VA would automatically be eligible for coverage by federal funds under the hypothetical Medicare plus VA program.

The hypothetical payments for VA health care services were at least 17 percent to 20 percent higher than the cost of the VA system itself, 97 percent of which is borne directly by the taxpayer. There are reasons to think that the hypothetical payments could be over- or underestimated, but on balance we believe they underestimate what VA would face under the hypothesized system.

While the hypothetical payments of virtually all service categories are higher than VA's own costs, the greatest differences are in areas such as pharmacy and dental care, in which enrollees' options for private coverage are costly or not readily available. The pharmacy savings are from price reductions alone, ignoring the potential savings from the VA's strict formulary (Huskamp, Epstein, and Blumenthal 2003). The analysis compared VA's own payments for each pharmaceutical to published average wholesale prices discounted according to Medicare regulations.

These overall savings demonstrate that the VA is able to provide a richer benefit package at lower cost than U.S. veterans would be able to obtain through the private sector under Medicare fee-for-service programs. Expanding access to care through private sector providers would cost taxpayers at least $3 billion more for current enrollees' care. Other studies strongly suggest that these savings from a government hospital system do not come at the

expense of quality care (Molloy et al. 1999; Petersen et al. 2000; Wright et al. 1997).

A final national implication of privatizing VA health care is the reconfiguration that would be required for medical residencies. VA's current 8,700 graduate medical residencies account for almost 9 percent of the medical residency positions in the country (Brotherton, Simon, and Tomany 2000). If these residencies are absorbed by private sector hospitals, Medicare payments for non-VA beneficiaries would likely rise as a result of higher indirect medical education payments under current Medicare reimbursement formulas.

REFERENCES

Brotherton, S. E., F. A. Simon, and S. C. Tomany. 2000. U.S. graduate medical education, 1999-2000. *Journal of the American Medical Association* 284:1121-26.

Department of Health and Human Services, Office of Inspector General. 1998. Comparing drug reimbursement: Medicare and the Department of Veterans Affairs. Report no. OEI-03-97-00293.

———. 2001. Medicare reimbursement of prescription drugs. Report no. OEI-03-00-00310.

Department of Veterans Affairs. 1998. VistA veterans health information management and technology architecture. Monograph.

Freedberg, S. J., Jr. 2003. Veterans Affairs suspends enrollment in health program. *Congress Daily*. January 17. www.govexec.com/dailyfed/0103/011703cdam1.htm.

Hendricks, A. 2003. *VA extended care: VA's experience under the Millennium Act. Report to Congress.* Bedford, MA: CHQOER.

Hendricks, A. M., D. Remler, and M. Prashker. 1999. More or less? *Medical Care* 37 (4): AS54-62.

Hendricks, A., J. Whitford, and G. Nugent. 2003. What would VA nursing home care cost? Methods for estimating private sector payments. *Medical Care* 41 (6): II52-60.

Hendricks, A., J. Whitford, and L. Nugent. 2003. Estimating private sector payments for VA specialized inpatient care. *Medical Care* 41 (6): II43-51.

Hurley, J., D. Linz, and E. Swint. 1990. Assessing the effects of the Medicare prospective payment system on the demand for VA inpatient services. *HSR* 25 (1 Pt. 2): 239-55.

Huskamp, H. A., A. M. Epstein, and D. Blumenthal. 2003. The impact of national prescription drug formulary on prices, market share, and spending. *Health Affairs* 22 (3): 149-58.

Iglehart, J. K. 1996. Reform of the VA health care system. *New England Journal of Medicine* 335:1407-12.

Iha, A. K., M. G. Shlipak, W. Hosmer, C. D. Frances, and W. S. Browner. 2001. Racial differences in mortality among men hospitalized in the Veterans Affairs health care system. *Journal of the American Medical Association* 285 (3): 297-303.

Ingenix, Inc. 2000. *Evaluating VHA costs for professional services.* Salt Lake City, UT: Author.

Molloy, M., M. J. Sorrell, R. H. Bower, P. O. Hasselgren, and B. J. Dalton. 1999. Patterns of morbidity and resource consumption associated with laparoscopic cholecystectomy in a VA medical center. *Journal of Surgical Research* 81:15-20.

Moskowitz, D. W. 1995. Future of the Department of Veterans Affairs. *Journal of the American Medical Association* 274 (14): 130-31.

Nugent, G., and A. Hendricks. 2003. Estimating private sector values for VA health care: An overview. *Medical Care* 41 (6): II2-10.

Nugent, G., E. Franchi, L. Nugent, S. Schehr, A. Rodriguez, and C. Nadeja. 2000. Third party billing in the VHA: A look at cost and policy. *Federal Practitioner* 11:31-41.

Nugent, G. N., G. Grippen, Y. C. Parris, and M. Mitchell. 2003. Using the Cost Distribution Report in estimating private sector payments: What adjustments should researchers make? *Medical Care* 41 (6): II80-90.

Petersen, L. A., S. L. Normand, J. Daley, and B. J. McNeil. 2000. Outcome of myocardial infarction in Veterans Health Administration patients as compared with Medicare patients. *New England Journal of Medicine* 343 (26): 1934-35.

Pittman, J. A., Jr. 1995. The future of the VA: Centralization, costs, politics, and presentism. *Journal of the American Medical Association* 273 (8): 667-68.

Randall, M., K. E. Kilpatrick, J. F. Pendergast, K. R. Jones, and W. B. Vogel. 1987. Differences in patient characteristics between Veterans Administration and community hospitals: Implications for VA planning. *Medical Care* 25 (11): 1099-104.

Render, M. L., G. Roselle, E. Franchi, and L. B. Nugent. 2003. Methods for estimating private sector payments for VA acute inpatient stays. *Medical Care* 41 (6): II11-22.

Render, M. L., J. Nowak, E. K. Hammond, and G. Roselle. 2003. Methods for estimating and comparing the VA outpatient drug benefits with the private sector. *Medical Care* 41 (6): II61-69.

Render, M. L., P. Taylor, J. Plunkett, and G. N. Nugent. 2003. Methods to compare VA expenditures for assistive devices to Medicare payments. *Medical Care* 41 (6): II70-79.

Roselle, G., M. L. Render, L. B. Nugent, and G. N. Nugent. 2003. Estimating private sector professional fees for VA providers. *Medical Care* 41 (6): II23-32.

Staffs of the Management Decision and Research Center and the Association for Health Services Research. 1996. Resources for research and decision making: An annotated database inventory. *Medical Care* 34:MS111-46.

Stiglitz, J. E. 1986. *Economics of the public sector.* New York: Norton.

U.S. General Accounting Office. 2000. Prescription drugs: Expanding access to federal prices could cause other price changes. Report no. GAO/HEHS-00-118.

Wolinsky, F. D., R. M. Coe, R. R. Mosley, II, and S. M. Homan. 1985. Veterans' and nonveterans' use of health services: A comparative analysis. *Medical Care* 23 (12): 1358-71.

Wright, S. M., J. Daley, E. D. Peterson, and G. E. Thibault. 1997. On terms of acute myocardial infarction in the Department of Veterans Affairs: Does regionalization of health care work? *Medical Care* 35 (2): 128-41.

Cost, Utilization, and Policy of Provision of Assistive Technology Devices to Veterans Poststroke by Medicare and VA

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Background: The increase in provision of assistive technology devices (ATDs) has spurred controversy over Medicare policy aimed at reducing cost-policy that forces social isolation and conflicts with legislation, facilitating participation for individuals with disabilities. In contrast, Department of Veterans Affairs (VA) policy does not limit provision of AT to "in home" use only but rather, states "all enrolled and some non-enrolled veterans are eligible for all needed prosthetics."

Objectives: Examine ATD provision policy by comparing 2 systems, Medicare and VA. Empirically analyze differences in ATDs provided, cost, and duplication in provision.

Research Design: Retrospective study of VA databases, including VA Medicare data.

Subjects: A population based study of 12,0461 veterans post-stroke.

Measures: Frequency of provision of ATDs by Health Care Common Procedural Code, purchase price, and capped rental payments.

Results: Of the poststroke veteran cohort, 39% received no AT, 56% received AT from the VA only, 1% received AT from Medicare only, and 3% received AT from both the VA and Medicare. Most ATDs were for activities of daily living, followed by walkers/canes/crutches. In specific ATD comparisons, VA costs were substantially lower than Medicare for purchased items and slightly lower than Medicare for capped rental payments.

Conclusion: VA provides a broader variety of ATDs at a lesser cost than Medicare. Analyses of policy differences between VA and Medicare suggest VA policy is driven by veteran need whereas Medicare policy is driven at least in part, by containing costs that have skyrocketed as a result of fraudulent claims.

Key Words: wheelchair, assistive technology, durable medical equipment, activities of daily living

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Assistive technology devices (ATDs), also known as durable medical equipment (DME), allow individuals to avoid institutionalization, live more independently, and with better quality of life.[1] ATDs make care easier[2] and lessen functional decline.[3,4] The increase in use of ATDs has spurred controversy over policy aimed at reducing cost.[1,5–9] While cost containment is important, so are mobility needs of individuals with disabilities. We examine ATD provision policy by comparing 2 systems, Medicare and Department of Veterans Affairs (VA). In addition, we analyze empirical differences in ATDs provided, cost, and duplication.

MEDICARE POLICY

Use of ATDs by persons dependent in at least 1 activity of daily living (ADL) has increased from 76% in 1984 to more than 90% in 1999.[4,10,11] The number of Medicare beneficiaries seeking reimbursement for power wheelchairs increased 189% over 3 years, from 55,000 in 1999 to almost 159,000 in 2002, while the Medicare population rose only 1% per year during that same period.[12]

The cost of providing power wheelchairs increased 450% from 1999 to 2003.[12] The Centers for Medicare and Medicaid (CMS) attributed this growth to technical progress, payment error, and fraud.[8] To decrease Medicare's vulnerability to fraud.[12,13] Congress mandated a competitive bidding program and face-to-face examination of the beneficiary by a licensed/certified healthcare professional (Medicare Modernization Act, 2003). In response CMS established competitive bidding and mandatory accreditation of DME vendors (Social Security Act/Medicare DME Access Act of 2007).[14,15] In

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addition, CMS implemented a requirement that the technology be used only "in the home"–a requirement that forces social isolation[16,17] and conflicts with legislation facilitating community participation.[16]

Medicare Payment System

Manual wheelchairs are typically leased under a capped rental arrangement during which beneficiaries are liable for a 20% copayment (Omnibus Budget Reconciliation Act of 1987). After 13 months, beneficiaries own the wheelchair. Suppliers are responsible for monthly billings to CMS for each beneficiary-many that can be for less than $20–at unknown administrative costs.

Power wheelchairs can either be rented for 13 months or purchased during the first month. The following illustrates the complexity of the Medicare policy:

■ *. . . based on 10% of the base year purchase price increased by the covered item update. This is the fee schedule amount for months 1 through 3. Beginning with the fourth month, the fee schedule amount is equal to 75% of the fee schedule amount paid in the first 3 rental months. The purchase fee schedule amount for power wheelchairs is equal to the rental fee (for months 1 through 3) multiplied by 10.*[18]

VA POLICY

VA experienced similar increases: provision of power wheelchairs increased 103% over 3 years (4664 in fiscal year [FY]1999–9451 in FY2001).[19] VA provision of manual wheelchairs increased only 6% during the same period.[19] VA cost of provision of ATDs increased from $153 million in 2001 to nearly $360 million in 2008 (written communication, Veterans Affairs, November 11, 2008). VA policy does not limit provision of ATDs to "in home use"; rather, "all enrolled and some nonenrolled veterans are eligible for all needed prosthetics."[20]

Veteran Payment System

All ATDs are purchased via General Services Administration contract, blanket purchase agreements, issued from stock, or purchased from local vendors. Whenever possible, reclaimed wheelchairs are restored and reissued.

METHODS

This project was approved by the Kansas City VAMC, the VA Pittsburgh, and the University of Florida/North Florida/South Georgia Veterans Healthcare System Institutional Review Boards. This retrospective, population-based study used a 2-year cohort (FY 2001–2002) of 12,046 veterans poststroke identified using VAs Functional Status and Outcomes Database and VA Medical SAS datasets. Veteran demographic data were obtained from the VA Medical SAS datasets. VA ATD utilization and cost data were obtained from the VA National Prosthetic Patient Database. Medicare ATD utilization and cost data were obtained from the VA Medicare datasets.[21] All comparative analyses involving Medicare data were limited to the subset of the study cohort age 65 or older at the index stroke admission. Descriptive analyses (frequency, mean, median, percentage) were used to (1) Compare provision of ATDs to veterans poststroke by Medicare and by VA; (2) Compare costs of ATDs provided by Medicare and VA by Healthcare Common Procedure Code (HCPCS); and (3) Investigate duplication in provision of ATDs across payers (Medicare and VA).

RESULTS

During FY2001 to 2002, 12,046 veterans were treated for index stroke in a VA inpatient facility. During FY2001 to 2003, 1% of this cohort received ATD(s) from Medicare, 3% received ATD(s) from Medicare and VA, 56% received ATD(s) from VA only, and 39% did not receive an ATD. Refer Table 1 for demographic data.

Provision of ATDs

About half (52%) of the ATDs provided by VA were ADL devices whereas only 11% of the ATDs provided by Medicare were ADL devices. Medicare and VA provided similar percentages of walkers/crutches/canes, 23% to 24% (152 and 5097 respectively).

Costs, Purchased Devices

Because of the limited number of devices provided by Medicare and further fractioning of Medicare devices into purchased or rented, only 6 HCPCS-level comparisons could be made between the 2 payers. Medicare costs (mean and median) were higher than VA costs for all items (with the exception of custom ankle foot orthotics; the VA median cost was $1 higher, Table 2.

Costs, Medicare Rented Devices

Because VA does not rent devices from vendors, and not all devices from Medicare were rented for 14 months at which time they became the property of the beneficiary (eg, HCPCS E0165 bedside commode, 35 rental lines/8 beneficiaries = mean of 4 rental months per beneficiary), we compared the average cost per beneficiary (total amount spent per HCPCS/number of rental lines/beneficiary N = average cost per beneficiary) with VA purchase cost—which is a mean cost per veteran. Using the example above, the average rental cost of a bedside commode per beneficiary was $183 compared with a mean VA cost of $95. Medicare costs were higher for bedside commodes, some beds and manual wheelchairs, but these items also had the lowest number of average rental months (Table 3). In comparison, the Medicare cost of $83 for a 2-month rental of the E1031 institutional recliner was considerably less than the $559 VA cost (list price beginning at $754). Medicare and VA costs were similar for the K0011 power wheelchair with an average 12-month rental.

Duplication in Provision of ATDs

Less than 1% of devices provided were duplicate or very similar devices provided to 1 veteran by both Medicare and VA.

DISCUSSION

Little systematic data exists on access to ATDs and assessment of fair market pricing.[4,22,23] We compared provision, cost, and duplication of ATDs provided to veterans by Medicare and VA.

TABLE 1. Demographic and Clinical Characteristics According to Device Provided by Medicare, Medicare +VA, or VA. Column Percentages Relative to the Number of Unique Veterans in Each Cohort Are Presented

Variable	Entire Cohort	Device Provided by			
		Medicare Only	Medicare and VA	VA Only	No Device
No. unique veterans	12,046 (100%)	139 (1%)	406 (3%)	6798 (56%)	4703 (39%)
Gender					
Male	11,799 (98%)	138 (99%)	396 (98%)	6658 (98%)	4607 (98%)
Female	247 (2%)	1 (1%)	10 (3%)	140 (2%)	96 (2%)
Missing*			0		
Race					
Hispanic, white	919 (8%)	18 (13%)	79 (19%)	545 (8%)	277 (6%)
Hispanic, black	77 (1%)	2 (1%)	7 (2%)	42 (1%)	26 (<1%)
American Indian	48 (<1%)	0	3 (1%)	33 (<1%)	12 (<1%)
Black	2602 (22%)	24 (17%)	87 (21%)	1517 (22%)	974 (21%)
Asian	53 (<1%)	0	1 (<1%)	35 (<1%)	17 (<1%)
White	8243 (69%)	95 (68%)	229 (56%)	4597 (68%)	3322 (72%)
Missing*	104 (<1%)	0	0	29 (<1%)	75 (1.6%)
Age in yr					
Mean (SD)	68 (11)	74 (9)	73 (9)	69 (11)	68 (12)
Missing*			0		
Service connected					
Yes	3328 (28%)	27 (19%)	106 (26%)	2005 (29%)	1191 (25%)
No	8717 (72%)	112 (81%)	300 (74%)	4793 (71%)	3512 (75%)
Missing*			0		
Married					
Yes	5923 (49%)	78 (56%)	242 (60%)	3452 (51%)	2151 (46%)
No	6055 (51%)	60 (43%)	164 (40%)	3308 (49%)	2523 (54%)
Missing*	68 (<1%)	1	0	38 (<1%)	29 (<1%)

*Missing indicates number of (%) veterans missing this data.

TABLE 2. Comparison of Medicare and VA Purchase Costs Per HCPCS

AT Device	HCPCS	Medicare Purchase				VA Purchase		
		N	Mean	Median	Fee Schedule*	N	Mean	Median
Walker-folding	E0135	25	$116	$67	$73–$86	1,974	$31	$29
Walker-wheeled/folding	E0143	68	$107	$95	$104–$123	420	$54	$48
Commode chair	E0163	65	$128	$90	$96–$113	313	$44	$33
Wheelchairs-power	K0011	79	$4628	$4650	$460–$541	66	$3512	$3421
AFO-std off the shelf	L1930	11	$318	$188	$179–$239	253	$53	$35
AFO custom	L1970	14	$577	$598	$538–$718	76	$528	$599

Because device costs were contaminated with unrealistically low and high cost values, these values were derived from a database that truncated observations to the middle 90th percentile.

*CMS 2001 DME vendor reimbursement schedule available at: (http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/List.asp).

Provision

More than half of the ATDs provided to our veteran cohort by VA were ADL-related (eg, devices for eating, dressing, toileting, bathing). Only 11% of the devices provided to veterans by Medicare were ADL-related. Iwashyna and Christie[24] investigated the provision of mobility and ADL-related ATDs to all Medicare beneficiaries but reported results only for mobility-related ATDs. This finding may be because bathing and toileting equipment are typically denied by Medicare as "convenience item; not primarily medical in nature" (Medicare National Coverage Determinations Manual) in spite of evidence supporting the positive relationship between activity/mobility limitation, incontinence, and pressure ulcers.[25] In fact, a patient hygiene program incorporating comprehensive bathing and incontinence protocols have been shown to reduce the incidence of new pressure ulcers.[26]

Wolff et al[5] found 53% of mobility-related ATDs (ADL devices excluded) provided by Medicare were walkers/canes/crutches, 39% were manual, and 8% power wheelchairs. For comparison, if we analyze only the mobility-related ATDs Wolff et al included (walker/canes/crutches, manual and power wheelchair, excluding other ATD catego-

TABLE 3. Comparison of Medicare Rental and VA Costs Per HCPCS

		Medicare Rental							VA Purchase		
HCPCS	Description	Rental Lines	Mean	Median	Fee* Schedule	Patients N	Average Rental Months	Average $ Per Patient Median	N	Mean	Median
E0165	Commode chair		$32	$11	16–19	8	4	$138	272	$95	$94
E0255	Beds	63	$82	$76	102–120	14	5	$368	13	$690	$770
E0260		563	$143	$137	146–171	150	4	$535	24	$412	$575
E0261		13	$130	$153	119–140	2	7	$843	28	$591	$530
E1031	Institutional recliner		$37	$30	44–52	4	2	$83	48	$559	$385
K0001	W/c manual	392	$55	$40	47–56	102	4	$211	1686	$160	$148
K0002		31	$58	$59	71–84	7	4	$257	17	$439	$422
K0003		61	$68	$59	78–92	13	5	$321	275	$361	$302
K0004		187	$101	$81	116–137	31	6	$607	343	$362	$318
K0006		13	$110	$82	109–128	3	4	$477	63	$479	$378
K0011	W/c power	12	$278	$285	460–541	1	12	$3331	66	$3512	$3421

These values derived from a database that truncated observations to the middle 90th percentile.
*CMS 2001 DME vendor reimbursement schedule available at: (http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/List.asp).

ries), 41% of ATDs provided to our cohort by Medicare were walkers/canes/crutches compared with 68% of ATDs provided by VA; 39% of ATDs provided to our cohort by Medicare were manual wheelchairs compared with 30% of ATDs provided by VA; 20% of ATDs provided to our cohort by Medicare were power wheelchairs compared with 2% of ATDs provided by VA. These percentages are similar even though these are different cohorts: community dwelling Medicare beneficiaries and veterans poststroke.

Cost

Comparison of Medicare and VA ATD costs is difficult because of the capped rental program. As a hypothetically example for the standard manual wheelchair, for the first 3 months Medicare would pay $111.42 (80% × $46.43 = $37.14 × 3 months) and $278.60 (75% × $37.14 × 10 months) for the remaining 10 months for a total of $390.02. Vendors must bill Medicare monthly for each beneficiary. In comparison, VA 2001 contract cost for the standard manual wheelchair ranged from $126 to $241 fully accessorized. Wolff et al[5]reported the 2001 mean cost for manual wheelchairs provided to Medicare beneficiaries was $360 (excluding beneficiary responsibility).

The cost for walkers in our data ranged from $100 to $122 when provided by Medicare and $31 to $54 when provided by VA. Wolff et al[5] reported the 2001 mean cost for walkers provided to Medicare beneficiaries was $97 (excluding beneficiary responsibility). Across multiple ATDs, Medicare costs were estimated to be 38% to 40% higher than VA costs.[22,23]

Duplication

Dual use of Medicare and VA services has been the focus of much research.[27–30] We found relatively little duplication (<1%) in the provision of ATDs across Medicare and VA payers perhaps because the VA ATD benefits exceed Medicare ATD benefits.

Policy Implications

Advances in mobility device designs have increased community participation and accessibility for individuals with disabilities.[16] Current Medicare policy, however, provides coverage for mobility devices (wheelchairs, walkers, and scooters) for use "in the home" only. In contrast, VA does not restrict provision of ATDs to "in home use." The VA mission is to improve the independence and quality of veterans at home and in the community. Our results suggest that VA is providing a larger variety of devices at a lower cost. VA provides inexpensive devices to support independent toileting and bathing under a variety of conditions, for example, rails that assist with toileting and an extended tub bench that eliminates the need for the veteran to step over/into the tub. Medicare only reimburses a multipurpose device that can be used as a commode or shower chair. A limitation of one size fits all multipurpose devices is limited adaptability to various physical environments. For example, the base dimensions may not fit in a bathtub or the patient may not have the physical capacity to move the device from the tub to the toilet.

Disability rates and the percent of elderly living in nursing homes is declining.[4,31–32] Increased use of ATDs has been cited as one of the reasons for falling disability.[32] Investment in the provision of ATDs, especially low cost equipment such as bathing devices, can mean the difference between living alone or requiring paid assistance.

Limitations of the Study

In addition to the previously listed limitations, we acknowledge that ecological bias when using aggregate rather than individual data. Clinical differences may exist between Medicare beneficiaries and veterans: the VA population is older, sicker, and poorer.[33] As with any use of administrative data, validity is a concern. Coding errors were evident in the Medicare data: devices coded as paid had costs that suggested

they were actually rented. Due to potential threats to the validity of ATD cost data, cost comparisons should be considered preliminary. No coding errors were found in the NPPD data indicating VA coding errors have been substantially reduced.[19,34,35] Neither Medicare nor VA costs included clinician time to evaluate or train the client.

CONCLUSION

Advances in technology have increased participation and accessibility for individuals with disabilities[16]; however, Medicare policy limits use of mobility devices to "in home" only. Our policy comparison suggests that VA is providing a larger variety of devices at a lower cost without limiting use.

REFERENCES

1. Hoerger TJ, Finkelstein EA, Bernard SL. Medicare beneficiary satisfaction with durable medical equipment suppliers. *Health Care Financ Rev.* 2001;23:123–135.
2. Hunt GG, Ginzler E, Barrett L. Caregiving in the US 2004. Washington, DC: National Alliance for Caregiving (NAC), AARP; 2004.
3. Mann WC, Ottenbacher KJ, Fraas L, et al. Effectiveness of assistive technology and environmental interventions in maintaining independence and reducing home care costs for the frail elderly: a randomized controlled trial. *Arch Fam Med.* 1999;8:210–217.
4. Cutler DM. Declining disability among the elderly. *Health Aff (Millwood).* 2001;20:11–27.
5. Wolff JL, Agree EM, Kasper JD. Wheelchairs, walkers, and canes: what does Medicare pay for, and who benefits. *Health Aff (Millwood).* 2005;24:1140–1149.
6. Batavia A. Of wheelchairs and managed care. *Health Aff (Millwood).* 1999;18:117.
7. Rakatansky H. Doctor's fear of fraud. *Health Aff (Millwood).* 1999;19: 276–277.
8. Kuhn H. Testimony. 2004. Available at: http://www.hhs.gov/asl/testify/t040428.html. Accessed March 16, 2009.
9. ITEM Coalition. Letter to Thompson regarding Medicare coverage policy clarification on power mobility. 2004. Available at: http://itemcoalition.org/press/thompson_ltr.html. Accessed March 16, 2009.
10. Russell JN, Hendershot GE, LeClere F, et al. Trends and differential use of assistive technology devices: United States, 1994. *Adv Data.* 1997; 13:1–9.
11. Manton K, Corder L, Stallard E. Changes in the use of personal assistance and special equipment from 1982 to 1989: results from the 1982 and 1989 NLTCS. *Gerontologist.* 1993;33:168–175.
12. New efforts aimed at stopping abuse of the power wheelchair benefit in the Medicare program [CMS news release]. The Centers for Medicare and Medicaid Services; September 9, 2003. Medicare News, OIG News.
13. Leavitt M. Remarks as Delivered at the Durable Medical Equipment (DME) Fraud Press Conference [news release]. Washington, DC: US Department of Health and Human Services; May 9, 2007.
14. CMS HHS. Medicare program; competitive acquisition for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and other issues. Final rule. *Fed Regist.* 2007;72:17991–18090.
15. SSA. Competitive acquisition of certain items and services. Social Security Office. 2008.
16. Medicare Rights Center. Forcing isolation: Medicare's "in the home" coverage standard for wheelchairs. *Care Manag J.* 2005;6:29–37.
17. CMS. Clinical criteria for MAE coverage. http://www.cms.hhs.gov/CoverageGenInfo/06_wheelchair.asp#TopOfPage, accessed July 27, 2006.
18. CMS. Durable medical equipment (DME) background information for CMS-1304-P. Changes to Medicare Payment for Oxygen Equipment, Oxygen Contents, and Capped Rental Durable Medical Equipment: Proposed Rule (CMS-1304-P). July 27, 2006. Available at: http://www.cms.hhs.gov/DMEPOSFeeSched/. Accessed June 23, 2008.
19. Hubbard SL, Fitzgerald SG, Reker DM, et al. Demographic characteristics of veterans receiving wheelchairs and scooters from the Veterans Health Administration. *J Rehabil Res Dev.* 2006;43:831–844.
20. VA. *VHA Handbook.* 2005. Available at: http://www.va.gov/publ/direc/health/handbook/. Accessed December 14, 2002.
21. VIReC. VA Resource Information Center. Available at: http://www.virec.research.va.gov/index.htm. Accessed March 27, 2008.
22. Render ML, Taylor P, Plunkett J, et al. Methods to estimate and compare VA expenditures for assistive devices to Medicare payments. *Med Care.* 2003;41:II70–II79.
23. Nugent GN, Hendricks A, Nugent L. Value for taxpayers' dollars: what VA care would cost at Medicare prices. *Med Care Res Rev.* 2004;61: 495–508.
24. Iwashyna T, Christie JD. Low use of durable medical equipment by chronically disabled elderly. *J Pain Symptom Manage.* 2007;33:324–330.
25. Allman RM. Pressure ulcer prevalence, incidence, risk factors, and impact. *Clin Geriatr Med.* 1997;13:421–436.
26. Carr D, Benoit R. The role of interventional patient hygiene in improving clinical and economic outcomes. *Adv Skin Wound Care.* 2009;22: 74–78.
27. Rosen AK, Gardner J, Montez M, et al. Dual system use: are there implications for risk adjustment and quality assessment. *Am J Med Qual.* 2005;20:182.
28. Byrne MM, Kuebeler M, Pietz K, et al. Effect of using information from only one system for dually eligible health care users. *Med Care.* 2006;44:768–773.
29. Hynes DM, Koelling K, Stroupe K, et al. Veteran's access to and use of Medicare and Veterans Affairs Health Care. *Med Care.* 2007;45:214–223.
30. Wolinsky FD, An H, Liu L, et al. Dual use of Medicare and the Veterans Health Administration: are there adverse health outcomes. *BMC Health Serv Res.* 2006;6:131.
31. Sahyoun NR, Pratt LA, Lentzner H, et al. The changing profile of nursing home residents: 1985–1997. In: *Aging Trends.* Hyattsville, MD: National Center for Health Statistics; 2001.
32. Allaire SH, LaValley MP, Evans SR, et al. Evidence for decline in disability and improved health among persons aged 55 to 70 years: the Framingham Heart Study. *Am J Public Health.* 1999;89:1678–1683.
33. Kazis LE, Miller DR, Clark JD, et al. Health-related quality of life in patients served by the Department of Veteran Affairs. *Arch Intern Med.* 1998;158:626–632.
34. Fitzgerald SG, Reker DM, Cowper DC, et al. Assessment of the National Prosthetics Database: preliminary studies of validity. Pittsburgh, PA: VA Healthcare System; 2003.
35. Hubbard SL, Fitzgerald SG, Vogel WB, et al. Distribution and cost of wheel chairs and scooters provided by the Veteran Health Administration. *J Rehabil Res Dev.* 2007;44:581–592.

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Estimating Private Sector Values for VA Health Care: An Overview

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OBJECTIVES. To provide an overview of methods used to establish what taxpayer costs would be if all Veterans Health Administration (VA) patient care were paid for by the federal government but provided in the private sector.

METHODS. Study assumptions included (1) that there would be a hypothetical policy change to pay for VA care through a Medicare-based fee-for-service program, (2) that the VA coverage benefit would not change, (3) that practice styles would remain the same, and (4) that there would be no impact on market values. To achieve the objective, project staff adapted Medicare payment schedules and guidelines, where available, with oversight of an advisory committee with VA and non-VA expertise in costs and data. For six sites, detailed payments were estimated using VA utilization databases and software and Medicare rate schedules available in the private sector. Overhead, interest on capital, and malpractice costs were added to VA-reported operating costs. Patient severity was examined, and patient-level costs were explored.

FINDINGS. Detailed methods for pricing seven types of health services are presented. Three methods articles focus on process issues.

DISCUSSION. Because VA care is not directly comparable with private sector health care as a result in part of differences in benefits covered and the scope of services provided, estimating costs for this care based on a private sector model requires careful consideration of market valuation approaches. The articles in this supplement describe the methods used to estimate market values for VA care so that other researchers can use them in future studies.

Key words: Health care costs; veterans; benefits; health economics. (Med Care 2003;41: II-2–II-10)

Periodically under fire from critics for inefficiency, low-quality care, or high costs, the Veterans Health Administration (VA) has undergone a major reorganization in recent years to meet better the needs of eligible veterans who choose to use its services.[1–8] The VA annually pays for health care services for almost 4 million veterans. It directly provides most of that care in 173 hospitals and more than 600 outpatient clinics located in the community. It also contracts with private sector providers for some special services and for care for enrolled veterans living far from VA medical facilities. The VA's total operating budget for fiscal year (FY) 1999 was more than $18 billion, of which almost $17 billion was for medical care and approximately $1 billion was for training, research, and national administrative activities.

The relative cost to the taxpayer of VA-provided health care services compared with the expenditure for those same services provided in the private sector is important information for policy makers interested in obtaining the best value for veterans

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served by the VA. Legislators and managers (both clinical and administrative) need information on which to base not only budget decisions but also organization and performance measures for this, the nation's largest federal health care system. Recent studies have demonstrated the quality of VA care[9,10] and its national contribution to education and research,[11] but the lack of comparative cost data has made it impossible to counter public charges that maintaining a separate health care system for veterans is too expensive.

In 1998, the VA's Health Services Research and Development Service funded a study that asked, "If health care services provided by VA during a fiscal year were purchased in the private sector, would the cost to the taxpayer be greater than the cost of providing those services at VA medical facilities?" The Evaluating VA Costs project answered that question, finding taxpayer cost to be more than 20% greater under a hypothetical fee-for-service payment system. That conclusion is based on a comparison of the total cost of all health care services at six Veterans Affairs Medical Centers (VAMCs) during FY 1999 (October 1998 through September 1999) with the estimated cost of purchasing those services in the private sector using Medicare reimbursement regulations.

This study does not suggest what VA payments would be if the private sector were used by VA patients. It estimates only what payments would be if the private sector supplied the same number and types of services as those delivered in the VA. There are several reasons why it is problematic to predict what payments to private sector providers would be. First, VA constrains demand for care by limiting the number of VA providers. If the choice of providers were not geographically limited, one would expect more services to be used. Second, VA outpatient care tends to be hospital-based. In the private sector, most outpatient services are delivered in doctors' offices or other ambulatory centers, which are paid less than hospital-based sites. Finally, VA physicians are salaried or on contract, whereas Medicare providers are paid largely on a fee-for-service basis whether or not the physicians are salaried within their group practices.

The taxpayer bears 97% of the VA's current cost, with veterans or their health insurance paying the rest.[12] Although the hypothetical Medicare payments for virtually all service categories are higher than the VA's own budgeted expenditures, the greatest differences are in areas such as pharmacy and dental care, in which enrollees' options for private coverage are costly or not readily available. These savings demonstrate that the VA is able to provide a richer benefit package at a lower cost than US veterans would be able to obtain through the private sector. Expanding access to care through private sector providers would cost taxpayers at least $3 billion more for current enrollees' care in FY 1999 when the estimates are extrapolated to the VA as a whole.

This supplement describes the methods used to estimate expenditures for VA services if they were provided in the private sector. These methods are often as diverse as the types of care they capture. The overview discusses the reasons for the study and its assumptions, structure, and policy relevance. It outlines the nature of the articles that follow. These methods not only are important for comparisons of VA and non-VA providers but also can be used to study costs of care within the VA.

Background

Why Estimate the Market Value of Veterans Health Administration Services?

Most VA cost studies estimate costs of services for cost effectiveness analyses[13–15] or to inform make or buy decisions for specific programs.[16] In the last 25 years, two studies have compared VA costs with estimates of what the VA might pay if all of its inpatients were admitted to the private sector for care, finding savings of approximately 10% for institutional payments, but not including the costs of clinicians.[17,18] No study has compared the total market value of the many other services the VA system provides.

The most important methodologic problems with these two earlier studies of the market value of VA care is that estimates are limited to the inpatient population.[19] Historically, the VA has not created charge data of the type that researchers use to estimate private sector costs.[13] VA cost accounting systems either make arbitrary assumptions about the division of costs (eg, for physician services) across programs[20] or allocate large fixed costs (including services for which no units of care are captured in the administrative data) in a step-down method across all patients.[21] These methodologic approaches do not permit accurate comparison with patient or service-specific costs in the private sector.

By comparing the aggregate cost of the VA system with the sum of estimated payments to

private sector providers for the VA's patients, the Evaluating VA Costs study avoided the pitfalls of VA cost accounting allocations across services. A major concern, however, was that VA utilization databases do not capture all the services provided by VAMCs.[21,22] To address this concern, the microstudy described here included special efforts to capture service units often missing from VA data for outpatient procedures, contracts for non-VA services, and prosthetics. The articles in this supplement describe in greater detail than has been presented before the methods used to estimate hypothetical private sector payments for VA care.[23]

Study Assumptions

The objective of the Evaluating VA Costs project was to evaluate the VA's costs for care provided to veterans under two scenarios:

(1) At VA facilities
(2) At nonfederal health care facilities paid through a fee-for-service system

Such an evaluation of the status quo and a hypothetical system required a number of major assumptions.

Veterans Health Administration's Payments to Non-Veterans Health Administration Providers Would Be Based on Medicare Rates. This study used Medicare payments as the standard of comparison for most health care services, pricing VA services in compliance with Medicare payment schedules and guidelines, where possible, or in accordance with a surrogate protocol approved by an advisory committee. Medicare reimbursement is a standard for reasonable market fees for two major reasons:

(1) Medicare is the only federal medical insurance program, and the majority (53%) of VA patients are already enrolled in it[24].
(2) Medicare rates were based on the cost of non-VA services and therefore attempt to reflect those costs, including relevant adjustment factors.

Furthermore, using Medicaid or private insurance fee schedules has several limitations. Medicaid populations include large proportions of children and younger women whose acute care utilization is very different from that of VA patients. Elderly Medicaid patients are more likely to be in nursing homes and, again, are not as similar to VA patients overall. Medicaid and private insurers' fee rates vary across states, and deriving a national standard fee rate is impractical. Indemnity plans are also too dissimilar in benefits, and their rates are dependent on actuarial history that would be difficult to apply to VA patients. Finally, political disincentive stems from the fact that veterans' organizations have struggled for years to ensure that veteran benefits are considered entitlements and not welfare. Any implementation that used Medicaid rates not only would result in a lack of benefit uniformity but also could expect political opposition.

Veterans Health Administration's Benefit Package Would Remain the Same. There are significant differences between the VA health benefits package and Medicare's benefits for eligible beneficiaries. The VA provides a wide range of health care at no cost to the veteran or for a usually small copayment (eg, in FY 1999, $2 per prescription per month). The VA's benefit package covers both institutional and noninstitutional (eg, physician services) aspects of inpatient care (acute care, rehabilitation, psychiatric programs, domiciliary care, residential care, and nursing home care), outpatient services (ambulatory surgery, emergency care, routine office visits, testing and evaluation, day treatment, day hospitalization, and dental care), pharmacy benefits, and prosthetic care. Nursing home stays can be limited to 6 months for veterans without service-connected disabilities, and dental care has special restrictions.

In contrast, Medicare policies cover almost all the same services, but with more limited duration and financial protection. For example, Medicare's hospital insurance (Part A) covers medically necessary hospital services with a cost (in calendar year 1999) to the patient of $776 for the first 60 days of a stay.[25] For physician services, there is an annual $100 deductible, and the patient is liable for 20% of the Medicare-approved charge. Many beneficiaries buy supplemental (Medigap) insurance policies to cover these costs.

There are also differences in the populations using Medicare and the VA—differences related to eligibility, benefit limitations, benefits covered, and services unique to the VA. Public Law 104–262, October 9, 1996, established eligibility for veterans based on income and their service-connected status (ie, having a disability connected to the period of their active military service). In contrast, eligibility for Medicare is based on work history, age, disability, or use of end-stage renal dialysis. The

investigators recognized that veterans younger than 65 years and without disability are not included in Medicare coverage but, to accomplish the study objective, assumed eligibility in the requisite hypothetical Medicare-based system for all veterans who were VA patients, regardless of age or disability.

Other Major Assumptions. Other study assumptions included the following:

- The array of health care services to which veterans are entitled through the VA benefit package would not change if the system were changed to fee-for-service insurance. That is, the practice style would be the same as that leading to the services captured in VA databases.
- The private sector would have sufficient capacity available for the VA to purchase care at current Medicare reimbursement rates; therefore, no price increases would be prompted by additional demand.

Assuming changes in either of those cost factors would have been impractical. Analysts would have had to model how practice styles would supposedly differ in the private sector and the willingness of health care providers to accept VA patients under alternative pricing structures. The assumptions required for either of these modeling exercises could have opened the study to possible charges of bias, no matter what they were.

Summary of Project Organization

The Evaluating VA Costs project was unusual in its reliance on both operations and research staff. The project's central administration at Cincinnati, Ohio, partnered with economists and health services researchers at the Center for Health Quality, Outcomes and Economic Research, a VA Health Services Research and Development Center of Excellence in Bedford, Massachusetts. In addition, study staff included information experts from the VA's headquarters and its Dayton, Ohio, facility.

This core of operations and research experts worked with additional clinical and operations specialists at six sites chosen for the microstudy of VA services. Site staff included coding and computer specialists and managers of each medical center's Decision Support System (DSS). Operations expertise was supplemented, when necessary, by external contractors and divisions of the VA with access to data sets or software applications needed for the estimations.

An advisory committee oversaw the project's progress, which fell into three phases. The first phase focused on data validity and preparation for the capture of services. Phase two was the capture of health care services during FY 1999. The third phase was the estimation of fee-for-service payments under the established methods for that year of services.

Study Setting

The six study sites were moderate-sized hospitals geographically distributed across the United States (Albuquerque, NM; Birmingham, AL; Cincinnati, OH; Kansas City, MO; Milwaukee, WI; and Providence, RI). They were selected for their expertise in health information management, as evidenced by the presence of credentialed department heads, well qualified coding staff with low turnover, and the ability to hire additional coding staff locally. They are geographically diverse and offer a wide range of services.

All sites are affiliated with university teaching services. Two of the sites have an inpatient nursing home, and two have domiciliaries for homeless or geriatric veterans. At the time of the study, none of the sites had a large chronic psychiatric inpatient population; each site had a limited number of outpatient facilities based in the community and a single inpatient facility as opposed to several integrated medical campuses. During FY 1999, the VAMCs collectively admitted 30,209 acute patients for a total of 229,783 acute inpatient days and an average length of stay of 7.6 days. Outpatient utilization exceeded 1.7 million visits.

Validation of Veterans Administration Data

To address concerns that coding accuracy might impact estimated taxpayer cost, an outside firm conducted multiple audits of coding and programmatic content for data validation. The three audits monitored coding at the study's start (summer 1998), at the midpoint (spring 1999), and near the end (summer 1999). Auditors demonstrated that VA coding accuracy and compliance with billing regulations had no greater estimated financial impact than the auditor found in the private sector.[26]

Advisory Committee

A steering committee evaluated data quality, reviewed study progress, and approved the private sector cost estimation strategies used in the project. Economists within and outside the VA and analysts with expertise in Medicare and health services participated in this committee. Mark C. Hornbrook, Associate Director, Kaiser Permanente Center for Health Research, chaired the meetings. The members were Paul Barnett, Director, VA Health Economic Resource Center; Denise Hynes, Director, VA Information Resource Center; Linda Harpe, VA Decision Support System; Gerald Kominski, Professor, University of California, Los Angeles, School of Public Health; and William Sobaski (deceased), Health Care Financing Administration (HCFA) Office of Research and Development.

The committee met three times face-to-face and held additional telephone conferences as needed over the two and a half years of the project. At each meeting, study staff reviewed methods of estimating payments and presented preliminary data pertaining to the various components of the study. The committee, in turn, provided information about Medicare reimbursement methodology, suggested alternative methods in cases in which Medicare rules did not apply, and required specific methodologic refinements.

For example, the final VA cost figure includes the opportunity cost of the VA's assets, valued as the interest on undepreciated capital. Although this amount represents no real expenditure under the current VA budget, the committee insisted on its inclusion so that the comparison with other payment rates (in which interest is a cost component) would not appear biased in favor of the VA. Similarly, they required that payment for room and board be included in the estimates for partial hospitalization services because the VA benefit gives veterans a place to stay while they receive treatment through a domiciliary program or certain other programs. The assumption that the VA benefit would remain the same under a new organization required that the payment estimate include all the current services.

Limitations of the Study

The study assumed that care provided for veterans in a fee-for-service model would be the same as that provided at VA facilities. This assumption is problematic for at least two related reasons: (1) private sector market forces and medical practice patterns likely differ from those in the VA, and (2) analysts are not able to document and compare absolutely all care delivered by the VA. With respect to the first limitation, Petersen et al[10] report significant differences in practice patterns for acute myocardial infarction in VA compared with non-VA medical centers. They evaluated care provided to elderly veterans for acute myocardial infarction in two settings: community hospitals (identified through Medicare claims data) and VA medical centers. Despite the absence of any difference in mortality, they found that veterans receiving care paid for under Medicare were more likely to have invasive procedures including cardiac catheterization, coronary bypass surgery, and percutaneous transluminal angioplasty than the VA index patients.

On the other hand, VA physicians may be likely to provide more services in both inpatient and outpatient settings in terms of diagnostic tests, medical (as opposed to surgical) care, more extensive visits, education, and so forth, than their counterparts in private practice. Without the collection of microlevel data, the exact mix of services in any setting (VA or non-VA) could not be ascertained.

The VA has tended to keep inpatients longer than private sector providers, but lengths of stay have fallen over time.[27] Longer stays may reflect greater inpatient severity, the financial incentives for private sector hospitals, or the VA's lack of distinction between acute and nonacute portions of a hospitalization that includes medical, surgical, rehabilitation, and extended care without discharge and readmission. The use of diagnosis-related group (DRG) rates for the VA's acute care in this study focuses the comparison on the taxpayers' cost per discharge, however. Differences in lengths of stay do not affect these payments.

Reimbursement to nonfederal providers for care to veterans under a hypothetical VA Medicare-based reimbursement system may be understated because of differences in practice patterns. For example, the practice in the private sector is to discharge and then later readmit a patient for surgical procedures identified during a medical inpatient stay. This practice allows separate reimbursement for the medical and surgical problems. VA facilities currently have no incentive to discharge and readmit, and they may be more likely

to transfer the patient to surgery for the procedure identified during a medical stay.[28] Undocumented practice differences may have contributed to possible overestimates of the private sector payments, however. For example, the project assumed that all outpatient care would be provided in a hospital setting, and estimations included facility fees.[29] Medicare claims indicate that 80% of outpatient claims are from doctors' offices. Modeling this distribution of services would have lowered estimates of facility fees and raised those for professional fees for a net reduction of an unknown amount.

Transition and Administration Costs

Developing controls and monitoring systems necessary to implement a VA fee-for-service model of health care would be costly, even if VA benefits were incorporated into the Medicare program. The study's estimates do not include the 3% of payments that Medicare incurs for administering benefits. The study also did not address the costs required for setting up a VA fee-for-service or voucher model.

Outline of Supplement

The articles that follow describe the strategies and methods used in the Evaluating VA Costs project to capture workload and develop payment estimates for this research effort. All have been subjected to peer reviews. The articles are arranged under two general topics: pricing VA products, and process issues.

All these articles discuss in detail the methods underlying the study's primary estimation or other analyses that have been or will be reported elsewhere. Authors have also tried to present supporting results that are not available in other project reports or articles.

Each article is organized not only to help readers understand the Evaluating Costs project but also to provide other researchers with methods they may apply in their own work. To this end, each describes the methods used and findings. The authors list assumptions and improvements over other approaches and explain why the method was chosen, describing advantages and limitations. In addition to interpreting findings, discussion sections provide the methods' limitations.

Methods for Pricing Veterans Health Administration Products

Seven articles summarize the basic pricing methodologies and databases used in the Evaluating VA Costs project. They tend to have the same general format: how to obtain or construct the relevant price estimates and what workload to count. In general, the lessons for researchers pertain to the complexities of the Medicare reimbursement regulations. Medicare regulations are vast and are subject to annual changes. Further research will need to update and expand on the information presented here. For example, the nursing home payment basis is already changing.[30,31]

These seven articles cover all major VA health care services except for dentistry. For these seven categories of care, Medicare regulations formed the starting point for the estimates. Render, Roselle, Franchi, and Nugent[32] discuss payments for acute care under Medicare's prospective payment system based on DRGs. These hospital stays are generally paid under beneficiaries' Medicare Part A coverage. The reimbursement amounts are unique to each private sector hospital because they include not only the base rates but also payments for the hospital's own indirect medical education costs, capital, and disproportionate share of low-income patients.[33] Our approach used an area-wide weighted average from a proprietary database to reflect Medicare patients' actual admission patterns.

The DRG payment estimates necessarily exclude professional fees paid for services delivered in hospitals, which are estimated in conjunction with professional fees for outpatient services as described by Nugent, Roselle, Franchi and Render.[34] The project made a special effort to capture the ambulatory surgery workload, but the inpatient surgeries were sparsely coded. As few as 1% of the surgeries had codes for the procedures, and these did not include surgical assistants. The estimates omitted reimbursement for anesthesia, which depends on both the difficulty and duration of the anesthesia, rather than the surgery. Outpatient mental health and substance abuse programs were included in the estimates described in this article. These services are important to the VA's health care mission but are also covered by Medicare, with a 50% coinsurance rate.

Estimates of outpatient professional fees are predicated on the delivery of outpatient care in hospital-based clinics rather than physicians' offices. The reasons for this assumption and a discussion of the financial impact are included in Nugent, Roselle, Nugent, and Render's[29] discussion of facility fees. This assumption leads to overestimation of hypothetical fee-for-service payments, but it represents the simplest assumption that could be made about the provision of care under the hypothetical system.

The article on payments for VA specialized inpatient care by Hendricks, Whitford, and Nugent[35] covers rehabilitation, psychiatric care, and other care for which Medicare pays institutions largely exempt from prospective payment system rules. Medicare payments for these services are determined under the Tax Equity and Fiscal Responsibility Act of 1982 and are subject to limits. VA researchers and managers need to exercise care in pricing these services because they are often provided in VA acute care settings and can be mistakenly counted in acute lengths of stay rather than treated as separate inpatient services.

Together, the four articles on DRGs, professional and facility fees, and special services cover care that represents roughly 80 to 85% of annual Medicare expenditures.[36] In the VA budget for the six sites, after adjustment for estimated malpractice costs, those same services account for 70% of medical budgeted expenditures. The reason for this difference in relative expense is the greater VA benefit for nursing home care[30] and outpatient pharmacy.[37]

Hendricks, Whitford, and Nugent[30] found that the hypothetical cost of VA patients' nursing home care would depend on the types of nursing homes in which the veterans were placed and whether Medicare or Medicaid rates were used as the basis for reimbursements. The most costly option (hospital-based facilities with cost exemptions under Medicare) would cost 3.5 times the least costly. Only Medicaid-based rates would be less than the VA's own budgets.

Render, Nowak, Hammond, and Roselle[37] describe the steps for pricing each study site's pharmacy data using National Drug Codes (NDCs) and Redbook average wholesale prices.

To correct coding problems (eg, outdated NDCs, bulk purchases), staff at the Pharmacy Benefits Management center merged the VA site database with the VA's prime vendor purchase database by station number and VA product name. Products without NDC numbers were manually matched to actual NDC numbers by listing in the Redbook.

The final discussion by Render, Taylor, Plunkett, and Nugent[38] of pricing methods concerns prosthetics, an area of special focus within the VA, given its concern for veterans disabled while on military service. This cost category also includes durable medical equipment and supplies such as oxygen. A major challenge in this area of costs is defining the services so that they are comparable in the VA and Medicare pricing schedules.

Process Issues

Three articles in this issue describe additional methodologies important to the cost evaluation. Nugent, Grippen, Parris, and Mitchell,[39] chief executive and financial officers at the study sites, made suggestions for reconfiguring the VA's cost distribution report to improve its usefulness to researchers and managers. These suggestions derive from the steps that were necessary to have cost categories that were comparable with Medicare benefits.

To establish the representativeness of the six study sites for other VA medical centers, Rosen, Loveland, and Anderson[40] used diagnostic cost groups to classify patients and compare those treated at the study sites with the VA national population and with Medicare patients. They found a range of scores among the study sites that was similar to the distribution in the VA as a whole. Score differences (eg, the higher score at Cincinnati or the greater prevalence of diabetes and heart disease at Albuquerque) reflect differences in medical centers' roles within the VA (Cincinnati is a referral center for other Ohio VA hospitals) or population differences (older patients in Albuquerque).

Shen[28] used 3M's All Patient Refined Diagnosis Related Groups software (Wallingford, CT) to assess severity for VA inpatients in 1997 and 1998. This analysis found the study sites similar in average severity and length of stay to other VA centers for most of 63 major diagnosis groups. For mental-related or alcohol-related All Patient Refined Diagnosis Related Groups, in particular, study sites had significantly shorter length of stay and higher severity than other short-term VA facilities, perhaps reflecting the VA's referral of acute inpatients to these sites but provision of more chronic care at other VA locations.

Finally, a different perspective on cost comparison issues comes from examining the DSS as the source of VA costs.[41] This analysis revisits issues of workload comparability and demonstrates the detail necessary to derive encounter-level cost averages even remotely comparable with estimates of Medicare reimbursement amounts. DSS is not designed for make or buy decisions within VA, but analysts tempted to use it in that way need to consider a number of issues.

Conclusions

This supplement extends the VA's understanding of the similarities and differences between its programs and data sets and those for Medicare services in the private sector. These descriptions of methods are useful for other VA researchers interested in costs and payments for a variety of studies and for non-VA researchers or policy makers, especially those interested in the health care of elderly and disabled populations. To these colleagues, we offer the following 11 articles in the hope that descriptions of our approaches will help them avoid reinventing the wheel.

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References

1. **U.S. General Accounting Office.** VA health care: issues affecting eligibility reform efforts. Report to the Chairman, Committee on Veterans Affairs, U.S. Senate; September 1996. Report GAO/HEHS96–160.

2. **Gardner J.** The VHA on the firing line. Mod Healthc, November 23, 1998;28:48–50.

3. **Reinhardt U.** Letter to the editor. New York Times, August 3, 1999; Sec A:14.

4. **Anonymous.** Mission creep. Washington Monthly, April 1997;29:33–37.

5. **Too much and not enough.** [Editorial]. Barrons, June 28, 1999;79:63.

6. **A PriVHAte war.** Mod Healthc 1998;28:48–50.

7. **Gardner J.** VHA on the spot: care quality, oversight to be probed by Congress. Mod Healthc, February 2, 1998;28:39.

8. **Kizer KW, Fonseca ML, Long LL.** The veterans health care system: preparing for the twenty-first century. Hosp Health Serv Adm 1997;42:283.

9. **Molloy M, Sorrell MJ, Bower RH, et al.** Patterns of morbidity and resource consumption associated with laparoscopic cholecystectomy in a VA medical center. J Surg Res 1999;81:15–20.

10. **Petersen LA, Normand SLT, Daley J, et al.** Outcome of myocardial infarction in Veterans Health Administration patients as compared with Medicare patients. N Engl J Med 2000;343:1934–1935.

11. **Fihn SD.** Does VA health care measure up? N Engl J Med 2000;343:1963–1965.

12. **Office of Finance, Veterans Health Administration.** Collections. Available at: http://www.va.gov/revenue/collections/. Accessed April 3, 2003.

13. **Barnett PG.** Review of methods to determine VA health care costs. Med Care 1999;37(Suppl):AS9.

14. **Hynes D, Reda D, Giobbie-Hurder A, et al.** Measuring costs in multisite randomized controlled trials: lessons from the VA cooperative studies program. Med Care 1999;37(Suppl):AS63.

15. **Menke TJ, Wray ND.** Use of a cost accounting system to evaluate costs of a VA special program. Med Care 1999;37(Suppl):AS45.

16. **Prashker MJ, Anderson JJ, Cahill LA, et al.** Nursing Home Cost Study: A Comparison of VA Nursing Homes and Contract Nursing Homes. Washington, DC: Office of Geriatrics and Extended Care, Veterans Health Administration. August 1996.

17. **O'Connor W.** Cost Comparison of the Veterans Administration and Community Medical System for Episodes of Acute Inpatient Medical and Surgical Care. Washington, DC: Veterans Administration, Department of Medical and Surgical Care; 1997.

18. **Graham NA.** Comparative Cost of Inpatient Hospital Care: The Veterans Administration and the Private Sector. Washington, DC: Veterans Administration, Department of Medicine and Surgery, Allocation Development Service; 1986.

19. **Hendricks A, Remler D, Prashker M.** More or less? methods to compare VA and non-VA health care costs. Med Care 1999;37(Suppl):AS54.

20. **Swindle RW Jr, Beattie MC, Barnett PG.** The quality of cost data: a caution from the Department of Veterans Affairs experience. Med Care 1996;34:MS83.

21. **Barnett PG, Rodgers J.** Use of the decision support system for VA cost-effectiveness research. Med Care 1999;37(Suppl):AS63.

22. **Murphy PA, Cowper DC, Seppala G, et al.** Veterans Health Administration inpatient and outpatient care data: an overview. Effective Clin Prac [serial online] May/June 2002. Available at: http://www.acponline.org/journals/ecp/majun02/murphy.htm. Accessed October 25, 2002.

23. **Chapko MK, Ehreth JL, Hedrick S.** Methods of determining the cost of health care in the Department of Veterans Affairs medical centers and other non-priced settings. Eval Health Prof 1991;14:282.

24. **Shen Y, Hendricks AM, Kazis L, et al.** Health Insurance and Use of Services by Veterans, 1999 Large Health Survey of Veteran Enrollees, Executive Report. Washington, DC: Office of Quality and Performance (10Q), Veterans Health Administration; 2001.

25. **Medicare Basics: Initial Enrollment Package.** Baltimore, MD: Department of Health and Human Services, Center for Medicare and Medicaid Services; 2000. SSA Publication 05–11069; ICN 480390. Available at: http://www.medicare.gov/Basics/EnrollmentPackage.asp. Accessed August 21, 2001.

26. **Nugent G, Franchi E, Nugent LB, et al.** Third party billing in the VHA: a look at cost and policy. Fed Pract 2000;11:31–41.

27. **Menke TJ, Ashton CM, Petersen NJ, et al.** Impact of an all-inclusive diagnosis-related group payment system on inpatient utilization. Med Care 1998;36:1126–1137.

28. **Shen Y.** Applying the 3M APR-DRG grouper to measure inpatient severity in VA. Med Care 2003;41(Suppl):II-103–II-110.

29. **Nugent G, Roselle G, Nugent LB, et al.** Methods to determine private sector payments for VA outpatient services: institutional payments to providers. Med Care 2003;41(Suppl):II-33–II-42.

30. **Hendricks A, Whitford J, Nugent G.** What would VA nursing home care cost? methods for estimating private sector payments. Med Care 2003;41(Suppl):II-52–II-60.

31. **Grimaldi PL.** Prospective per diem rates for skilled nursing care. J Health Care Finance 2002;28:49–62.

32. **Render M, Roselle G, Franchi E, et al.** Methods for estimating private sector payments for VA acute inpatient stays. Med Care 2003;41(Suppl):II-11–II-22.

33. **Baker JJ.** Medicare payment system for hospital inpatients: diagnosis-related groups. J Health Care Finance 2002;28:1–13.

34. **Nugent G, Roselle G, Franchi E, et al.** Estimating private sector professional fees for VA providers. Med Care 2003;41(Suppl):II-23–II-32.

35. **Hendricks A, Whitford J, Nugent L.** Estimating private sector payments for VA specialized inpatient care. Med Care 2003;41(Suppl):II-43–II-51.

36. **US Bureau of the Census.** Statistical Abstract of the United States 2000. 120th ed. Washington, DC: US Government Printing Office; 2000.

37. **Render M, Nowak J, Hammond EK, et al.** Method for valuing outpatient drug benefit for VA patients. Med Care 2003;41(Suppl):II-61–II-69.

38. **Render ML, Taylor P, Plunkett J, et al.** Methods to compare VA expenditures for assistive devices to Medicare payments. Med Care 2003;41(Suppl):II-70–II-79.

39. **Nugent G, Grippen G, Parris YC, et al.** Using the cost distribution report in estimating private sector payments: what adjustments should researchers make? Med Care 2003;41(Suppl):II-80–II-90.

40. **Rosen AK, Loveland S, Anderson J.** Applying DCGs to examine the disease burden of VA facilities: comparing the six "Evaluating VA Costs" study sites to other VA sites and Medicare. Med Care 2003;41(Suppl):II-91–II-102.

41. **Hendricks AM, Lotchin TR, Hutterer J, et al.** Evaluating VA patient-level expenditures: DSS estimates and Medicare rates. Med Care 2003;41(Suppl):II-111–II-117.

Comparing VA and Private Sector Healthcare Costs for End-stage Renal Disease

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Background: Healthcare for end-stage renal disease (ESRD) is intensive, expensive, and provided in both the public and private sector. Using a societal perspective, we examined healthcare costs and health outcomes for Department of Veterans Affairs (VA) ESRD patients comparing those who received hemodialysis care at VA versus private sector facilities.

Methods: Dialysis patients were recruited from 8 VA medical centers from 2001 through 2003 and followed for 12 months in a prospective cohort study. Patient demographics, clinical characteristics, quality of life, healthcare use, and cost data were collected. Healthcare data included utilization (VA), claims (Medicare), and patient self-report. Costs included VA calculated costs, Medicare dialysis facility reports and reimbursement rates, and patient self-report. Multivariable regression was used to compare costs between patients receiving dialysis at VA versus private sector facilities.

Results: The cohort comprised 334 patients: 170 patients in the VA dialysis group and 164 patients in the private sector group. The VA dialysis group had more comorbidities at baseline, outpatient and emergency visits, prescriptions, and longer hospital stays; they also had more conservative anemia management and lower baseline urea reduction ratio (67% vs. 72%; $P < 0.001$), although levels were consistent with guidelines ($Kt/V \geq 1.2$). In adjusted analysis, the VA dialysis group had $36,431 higher costs than those in the private sector dialysis group ($P < 0.001$).

Conclusions: Continued research addressing costs and effectiveness of care across public and private sector settings is critical in informing health policy options for patients with complex chronic illnesses such as ESRD.

Key Words: costs, outcomes, end-stage renal disease, dialysis, Veterans, Medicare

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The Department of Veterans Affairs (VA) operates the largest public managed care system in the United States serving more than 6 million Veterans per year.[1] Patients with end-stage renal disease (ESRD) is one of the most resource intensive patient populations the VA treats. ESRD, which requires transplant or dialysis to replace the lost kidney function, is associated with substantial morbidity, mortality, hospitalizations, and healthcare costs.[2] On average, ESRD patients incur 12 days of inpatient care per year and annual rates of death exceeding 150/1000 patient-years.[3] Medicare ESRD costs have increased from $5 billion in 1991 to about $21.1 billion in 2007.[3] As most ESRD patients are eligible for Medicare coverage, regardless of age, VA patients may have the option of receiving care from VA, from the private sector, or some combination depending on eligibility and local VA sharing agreements based on VA resources.[4]

It is unknown whether ESRD patients would be better served by restructuring VA dialysis care. Although the majority of VA ESRD patients can qualify for the Medicare ESRD program regardless of age, following a 3-month waiting period, about 30% still receive VA dialysis care.[5] The remaining ESRD patients receive dialysis care in the private sector through the VA Fee-Basis program (38%) or the Medicare program (32%).[5] Despite the dialysis venue, many patients still use some VA services for nondialysis healthcare.

Previous research about costs and outcomes of ESRD patients has focused mainly on for-profit dialysis facilities and excluded public facilities.[6,7] In this study, we report on a prospective study to examine the healthcare costs and outcomes of Veterans with ESRD receiving dialysis at VA compared with private sector facilities.

METHODS

Setting and Patients

We conducted a prospective observational study of chronic dialysis patients who were receiving hemodialysis and had received any care at 1 of 8 VA facilities within the prior 3 years. Enrollment was from August 2001 through December 2003. Patients were excluded primarily if they (1) had a live kidney donor identified; (2) required skilled nursing facility care; or (3) had a life expectancy less than 1 year as determined by a nephrologist.

Institutional review board approval was obtained from all 8 sites. Patients were recruited through letter communication or in-person. For interested patients, site coordinators obtained informed consent.

Conceptual Framework

We used the Andersen-Newman health behavior model,[8] economic theory,[9,10] and earlier research to guide the study. The Andersen-Newman model provides a framework for analyzing factors that influence healthcare utilization, including predisposing factors (eg, demographics), enabling factors (eg, family and community resources), need factors (eg, factors related to measured or perceived level of illness), environmental factors (eg, availability of providers in the community), and provider-related factors (eg, physician or facility characteristics). We focused on the association of dialysis venue (provider factors) with healthcare utilization, costs, and outcomes. We also examined predisposing factors (age, sex, race, and ethnicity), enabling/environmental factors that might impact availability and access to healthcare (marital status, educational level, income, insurance coverage, geographic region), and clinical need factors related to patients' health status and specific to ESRD care[11,12] (length of time since beginning of dialysis, quality of well-being, and comorbidities).[11,12]

Data Collection and Sources

Site coordinators interviewed patients at baseline and monthly during their observation period. Self-reported baseline data included age, sex, race, marital status, income, insurance coverage, and number of months on dialysis and quality of life. Monthly self-report data included healthcare utilization, estimates of time and travel for healthcare, and caregiver time. Any changes in dialysis care since the last contact were recorded. We used national VA healthcare use[13–15] and Medicare claims databases[16] to identify comorbidities based on the International Classification of Disease, 9th revision codes during the 12-month period before enrollment in the study.[17,18]

Clinical Measures

Clinical parameters at baseline and at 6 months related to dialysis, including urea reduction ratio (URR), serum albumin, and hemoglobin, were obtained from VA electronic health records or were reported by private sector dialysis facilities. We also examined length of time since beginning of dialysis, months on dialysis, and mortality.

Quality of Life and Quality of Well-Being

We assessed health-related quality of life using 2 instruments: Kidney Disease Quality of Life and Quality of Well-Being (QWB). We described their use in our previous study[19,20] and they have been well described by other studies.[21,22] The results of the Kidney Disease Quality of Life and the QWB were collected at baseline and at 6 months. By carrying the last value forward, the QWB scores were used to calculate quality-adjusted life years over 12 months.[9]

Healthcare Utilization and Cost

Utilization of in-center dialysis care, home dialysis care, nondialysis outpatient care, inpatient care, and pharmacy and durable medical equipment (DME) was determined. The direct healthcare cost for each of these sources of care was estimated separately. Nondirect healthcare costs (time, travel, and caregiver costs) were also estimated. These nondirect healthcare costs were combined with total direct healthcare costs to estimate total costs from a societal perspective. All costs were adjusted to 2006 dollars using the Consumer Price Index.[23]

In-Center Outpatient Hemodialysis

The number of outpatient dialysis sessions was determined from national VA and Medicare databases or self-report for patients enrolled in a Medicare managed care plan (n = 4) or covered by private health insurance (N = 8). To estimate the costs of in-center outpatient dialysis care, the number of hemodialysis treatments was multiplied by a cost per treatment. The cost per hemodialysis session was estimated separately for VA and private sector facilities.

VA Facilities

Data were collected from fiscal year 2002 through microcosting assessments of in-center VA dialysis facilities, including staff salaries, supplies and medications (including erythropoiesis stimulating agents [ESAs]), laboratory, and equipment (based on prorated acquisition costs), and overhead costs (estimated as 51% of direct costs).[24] We calculated a cost per outpatient hemodialysis session for each of our 8 facilities, and multiplied this facility-specific average cost by the number of outpatient dialysis sessions to estimate outpatient hemodialysis costs for each patient (see Appendix for details).

Private Sector Facilities

Cost per hemodialysis session for private sector dialysis facilities was estimated using the Centers for Medicare and Medicaid Services Medicare Renal Dialysis Facility Cost Reports or the Medicare Hospital Cost Reports.[25] These annual Centers for Medicare and Medicaid Services reports include the facilities costs for dialysis treatment, including salaries for direct patient care (excluding nephrologists),

routine supplies, and other separately billable drugs including ESAs. For private sector facilities with missing facility cost reports or missing data in their reports (11%), a cost was estimated based on the average cost from all Medicare Renal Dialysis Facility Cost Reports in the patient's state of residence for the appropriate year.

As the facility cost reports did not contain information on nephrologist costs, a per treatment nephrologist cost for each patient was based on the sum of all payments made to physicians recorded in the Medicare Carrier file or the physician charges in the VA Fee-Basis file related to dialysis supervision. For patients in Medicare managed care plans (N=4) or patients covered by private health insurance (N=8), we estimated nephrologist cost per treatment based on the average per treatment from the Carrier claims for dialysis in our sample.

Each patient's nephrologist cost and facility-specific cost per hemodialysis session were used to estimate a total cost per hemodialysis session for each patient.

Home Hemodialysis and Home Peritoneal Dialysis

For patients who were transferred from in-center hemodialysis to either home hemodialysis or peritoneal dialysis (5% of our study sample), the cost of dialysis was based on equipment and supply costs from Medicare's DME claims files and estimated costs for an assistant (for home hemodialysis patients only) from a VA home dialysis program. When there were no DME claims, costs were imputed based on Medicare's maximum billing allowance for 1 month for equipment and supplies: $1,974.45 for peritoneal dialysis and $1,490.85 for home hemodialysis.[26]

Nondialysis Outpatient Care, Inpatient Care, and Pharmacy

Utilization and costs for nondialysis outpatient care and inpatient care at VA facilities were obtained from the VA Inpatient and Outpatient Medical SAS files[13–15] and the Health Economic Resource Center average costs datasets.[27–29]

Utilization of private sector nondialysis outpatient care and inpatient care covered by Medicare was obtained from Medicare Part A (MedPAR, inpatient) and Medicare Part B (outpatient, carrier and DME) claims data.[16] Costs were estimated by summing all payments made to healthcare providers recorded in the Medicare claims. Utilization and costs of private sector nondialysis outpatient and inpatient care reimbursed by VA were obtained from the VA Fee-Basis datasets.[30]

For a small percentage of private sector care obtained outside VA or Medicare fee-for-service auspices (ie, Medicare HMO, Medicaid, or privately paid care), we estimated the cost of self-reported outpatient and emergency department visits (n=20 events, <0.002% of outpatient events) based on Medicare allowable charges per relative value unit for those types of care. We estimated the cost of self-reported hospital admissions or nursing home stays (n=5 events, 0.015% of events) based on Health Economic Resource Center-provided VA median costs for inpatient admissions or long-term care stays,[29] using the self-reported length of stay.

Pharmacy and DME utilization and costs not related to outpatient dialysis care were obtained from the VA's Pharmacy Benefit Management files,[31] Medicare's DME files,[16] and patient self-report. Prescriptions were reported as 30-day equivalent supplies (eg, one 90-day supply of medication is three 30-day equivalent supplies).

Time, Travel, and Caregiver Costs

We also calculated time, travel, and caregiver costs. For outpatient dialysis care, costs for time and travel were based on self-report, used in conjunction with the previously described determination of number of outpatient dialysis visits over the 12-month period. For nondialysis care, travel costs were based on self-reported information. Time costs were based on an assumption of 1 hour for each outpatient visit, and for inpatient care, were calculated from VA and Medicare databases by converting days in the hospital to hours, based on 16 hours per hospital day.[32]

For estimating time costs for travel to and receipt of health care, average hourly wages for the year were used to assign a cost to the self-reported time.[33] Travel costs were estimated using Internal Revenue Service standard business reimbursement rates for travel by private automobile[34] or site-specific costs for the other modes of transportation (eg, public transportation, ambulance, Medicare).[35–39]

Costs of informal caregivers were estimated using average hourly wages in the United States.[33] Hourly rates for private sector agency caregivers were valued at the average wage for health aides (except nursing) in the United States.[40]

Statistical Analysis

Bivariate and multivariable analyses were conducted using SAS version 9.2[41] and STATA MP 11.2.[42] Differences in predisposing, enabling, and clinical need characteristics were tested using t tests or χ^2 tests. We used negative binomial or zero-inflated negative binomial models[43] to compare healthcare utilization (number of hospital admissions, hospital days, dialysis sessions, nondialysis outpatient, emergency department visits, and outpatient prescriptions received) between the VA and private sector dialysis groups, adjusting for factors described above. To compare healthcare costs between the dialysis care groups, we used generalized linear models (GLM),[10] adjusting for factors described above and fixed effects to control for unobserved site-level differences, with distribution functions based on the modified Park tests and a link function based on the Box-Cox tests.[44] In sensitivity analyses, GLM analyses were performed excluding patients who had switched their venue of dialysis during the study period and excluding VA fee basis sites in the private sector group.

RESULTS

Characteristics of Study Patients

Three hundred sixty-four patients consented to participate in the study, and 334 were subsequently included in our analyses: 170 patients in the VA dialysis group and 164

TABLE 1. Predisposing, Enabling/Environmental, and Clinical Need Characteristics of Patients at Baseline by Dialysis Venue Group

	N (%)			
	Dialysis Group			
Variable	Total Cohort (n = 334)	VA (n = 170)	Private Sector (n = 164)	*P*
Predisposing, enabling/environmental factors				
Age, mean (SD), y	62.22 (11.4)	60.6 (11.8)	63.9 (10.8)	0.009
Male sex	326 (98)	167 (98)	159 (97)	0.44
African American race	166 (50)	97 (57)	69 (42)	0.006
Married	294 (88)	148 (87)	146 (89)	0.58
>High school education	192 (57)	100 (59)	92 (56)	0.61
Distance to nearest VA hospital, mean (SD), miles	14.5 (16.4)	9.5 (7.6)	19.6 (20.9)	<0.001
Income				
Missing	12 (4)	3 (2)	9 (5)	
$0–10,000	78 (23)	43 (25)	35 (21)	
$10–20,000	112 (34)	55 (32)	57 (35)	0.40
$20–30,000	67 (20)	35 (21)	32 (20)	
>$30,000	65 (19)	34 (20)	31 (19)	
Insurance groups				
VA only	51 (15)	39 (23)	12 (7)	
VA plus Medicare Part B only (with or without Part A)	156 (47)	94 (55)	62 (38)	
VA plus Medicaid (with or without Medicare Part A and/or Part B)	57 (17)	21 (12)	36 (22)	<0.001
VA plus private (with or without Medicare Part An and/or Part B)	70 (21)	16 (9)	54 (33)	
Clinical need factors				
Months on dialysis, mean (SD)	29.3 (33.5)	25.6 (31.4)	33.2 (35.3)	0.04
Incident dialysis patients	84 (25)	62 (36)	22 (13)	< 0.001
Comorbidities				
Mood Disorder	29 (9)	19 (11)	10 (6)	0.1
Psychotic disorder	36 (11)	21 (12)	15 (9)	0.34
Other psychiatric diagnosis	124 (37)	71 (42)	53 (32)	0.07
COPD	47 (14)	26 (15)	21 (13)	0.51
Diabetes	167 (50)	84 (49)	83 (51)	0.83
Diabetes with complications	131 (39)	69 (41)	62 (38)	0.60
CHF	98 (29)	52 (31)	46 (28)	0.61
Cerebrovascular disease	28 (8)	17 (10)	11 (8)	0.28
Acute myocardial infarction	18 (5)	11 (6)	7 (4)	0.37
Modified Charlson				
0	84 (25)	44 (26)	40 (24)	
1	60 (18)	29 (17)	31 (19)	0.006
2	78 (23)	28 (16)	50 (30)	
>2	112 (34)	69 (41)	43 (26)	

CHF indicates congestive heart failure; COPD, chronic obstructive pulmonary disease; VA, Department of Veterans Affairs.

in the private sector dialysis group, and 30 patients were lost to follow-up or did not meet inclusion criteria. The VA dialysis group included patients who were transferred from a VA facility to home dialysis under VA supervision (n = 18). The private sector dialysis group included patients whose dialysis was paid for through the VA Fee-Basis program (n = 36 for >50% of their care). Patients who switched from VA to private sector facilities (n = 17) and vice versa (n = 3) during the study period were included, for analytic purposes, in the group where they received >50% of their dialysis care.

Compared with patients dialyzing at private sector facilities, the VA group was younger ($P = 0.009$), more likely to be African American ($P = 0.006$), and lived closer to a VA facility ($P < 0.001$) (Table 1). Compared with the private sector dialysis group, VA dialysis patients were more likely to have VA coverage only and less likely to have Medicaid or private insurance ($P < 0.001$). At the time of study enrollment, the patients in the VA dialysis group had been on dialysis for a shorter period of time ($P = 0.04$). In addition, VA dialysis patients were more likely to have a modified Charlson comorbidity index score of 2 or more ($P = 0.006$).

Healthcare use

VA dialysis patients had more nondialysis outpatient visits, emergency room visits, and 30-day supplies of prescriptions ($P = 0.02$, 0.04, and 0.02, respectively) (Table 2). Even though private sector dialysis patients were receiving dialysis outside of the VA, they received 61% of their nondialysis outpatient visits at VA facilities; VA dialysis patients received 98% of nondialysis outpatient care at VA facilities (data not shown).

The overall number of inpatient admissions for acute medical or surgical care was higher for VA than private sector dialysis patients (2.7 vs. 1.9, respectively; $P = 0.02$), and VA dialysis patients had more hospital days (25.8 vs. 10.7; $P < 0.001$). However, nonacute admissions and days of care were similar between the dialysis groups.

TABLE 2. Healthcare Utilization and Costs Over 12 Months

Categories of Healthcare Utilization and Cost	Utilization and Costs*			
	VA Dialysis	Private Sector Dialysis	Difference (95% Confidence Interval)	*P*
Inpatient utilization				
Acute admissions				
Admissions, mean	2.7	1.9	0.8 (0.1–1.5)	0.02
Days, mean	25.8	10.7	15.1 (8.4–22.5)	<0.001
Nonacute admissions†				
Admissions, mean	0.4	0.3	0.1 (−0.1 to 0.3)	0.19
Days, mean	11.5	5.1	6.4 (−0.3 to 13.8)	0.06
Outpatient utilization				
Dialysis sessions, mean	133.4	138.8	−5.4 (−8.3 to −2.4)	<0.001
Nondialysis clinic visits, mean	31.4	21.6	9.8 (1.3–18.3)	0.02
Emergency room visits, mean	2.7	1.9	0.8 (0.02–1.5)	0.04
Prescriptions, mean‡	113.8	85.3	28.5 (3.5–50.6)	0.02
Travel, time, and caregiver				
Miles traveled for dialysis care, mean	3562	2307	1256 (208–2360)	0.02
Hours spent for transportation to and receipt of health care, mean	1126	855	271 (23–520)	0.03
Proportion with caregiver	0.16	0.12	0.04 (−0.02 to 0.09)	0.16
Inpatient costs, $ mean				
Acute inpatient costs	35,033	24,833	10,200 (2145–18,728)	0.01
Nonacute inpatient costs†	6143	2887	3256 (−6884 to 13,533)	0.64
Outpatient cost, $ mean				
Dialysis costs	50,522	41,357	9165 (3598–14,732)	0.001
Dialysis	45,281	32,898	12,383 (7789–16,976)	<0.001
ESA	5165	8667	−3502 (−5173 to −1912)	<0.001
Nondialysis cost	10,440	10,645	−205 (−2050 to 1640)	0.82
Pharmacy/DME costs	2568	2278	290 (−534 to 1114)	0.52
Total direct healthcare costs, $ mean	106,126	79,922	26,204 (12,939–40,011)	<0.001
Nondirect costs, $ mean				
Travel§	4652	2586	2066 (820–3287)	0.001
Time§	22,151	17,260	4891 (122–9732)	0.04
Caregiver§	2683	1591	1092 (−3778 to 6102)	0.65
Nondirect costs, $ mean	30,605	20,410	10,195 (4815–15,775)	<0.001
Total costs, $ mean	136,207	99,776	36,431 (19,753–53,769)	<0.001

*Utilization values were adjusted for factors included in Table 1 using multivariable negative binomial (number of dialysis sessions and nondialysis clinic visits) zero-inflated negative binomial count (inpatient utilization, emergency room visits, and prescriptions) models, generalized linear models with a γ (miles traveled for dialysis) or Poisson (hours spent receiving care) distribution, or logistic regression (proportion with caregiver), and cost values were adjusted for factors included in Table 1 using multivariable generalized linear models with a Poisson distribution (acute inpatient, ESA, and pharmacy/DME, and time costs), a γ distribution (nonacute inpatient, total dialysis, dialysis, nondialysis, travel, caregiver, and total costs), or an inverse Gaussian distribution (total direct and total nondirect) based on modified Park tests. Specific variables included in the adjustment models are available on request from the authors.

†Includes VA rehabilitation, mental health care, and long-term care stays, Medicare long stays and skilled nursing facility (SNF), Medicare hospice, and PS nursing home stays.

‡Reported as 30-day equivalent supplies (eg, one 90-day supplies is three 30-day equivalent supplies).

§Costs estimated from patient self-reported utilization.

DME indicates durable medical equipment; ESA, erythropoiesis stimulating agents; VA, Department of Veterans Affairs.

Healthcare Costs

Adjusted 12-month total (direct and nondirect) healthcare costs were 37% ($36,431) higher among patients in the VA dialysis group than among patients in the private sector dialysis group after adjusting for covariates in GLM analysis (95% confidence interval: $19,753 to $53,769; $P < 0.001$) (Tables 2, 3). This difference was due in part to higher utilization and costs for inpatient care. Acute inpatient costs for the VA dialysis group were $10,200 higher than for the private sector group ($P = 0.01$) (Table 2).

The higher total costs for VA dialysis patients were also due to the 22% higher average costs for dialysis treatments (Table 2). Dialysis costs for nonphysician labor and laboratory services were each higher in VA dialysis facilities ($P < 0.001$). Indirect/overhead costs for VA dialysis patients were also 74% higher than for Private Sector dialysis patients. However, costs were lower for the VA group for physicians' services and administering ESAs. ESA costs represented 10% of total dialysis costs for VA dialysis patients, compared with 21% of total outpatient dialysis costs for private sector dialysis patients (Table 4).

In addition, nondirect costs were nearly 50% higher for VA dialysis patients due to higher time and travel costs (Table 2).

Quality of Life, Clinical Outcomes, and Mortality

Quality-of-life measures were similar among the VA and private sector dialysis groups over time (Table 5). Mortality at 1 year was not significantly different between the VA and private sector dialysis groups (15.9% vs. 9.8%;

TABLE 3. Association of Patient Characteristics With Total Costs from Multivariable GLM Model for N = 334

Variable	Marginal Effect $*	95% Confidence Interval $	P
VA dialysis group	36,431	19,753 to 53,769	<0.001
Age	3	−581 to 588	0.99
African American race	9246	−10,488 to 28,980	0.36
Male	29,798	5069 to 54,526	0.02
Married	13,241	−916 to 27,399	0.07
Education (<high school or less as reference)			
Greater than high school education	−4876	−19,311 to 9559	0.51
Income (<$10,000 as reference)			
$10,000–20,000	−15,877	−24,284 to −7470	<0.001
$20,000–30,000	−8281	-30,571 to −14,008	0.47
>$30,000	−26,601	−41,423 to −11,778	<0.001
Missing	−14,729	−30,319 to 860	0.06
Insurance groups (VA only as reference)			
VA and Medicare Part B insurance	19,581	−1114 to 40,276	0.06
VA and Medicaid (with or without Medicare Part B)	21,433	2130 to 40,736	0.03
VA and private insurance (with or without Medicare Part B)	14,927	−2729 to 32,582	0.10
Months on dialysis	98	−55 to 251	0.21
Comorbities			
Mood disorder	11,586	−12,071 to 35,242	0.34
Psychotic disorder	9263	−11,593 to 30,120	0.38
Other psychiatric	−11,958	−22,862 to −1055	0.03
COPD	14,894	−10,420 to 40,208	0.25
Diabetes	−1623	−14,973 to 11,727	0.81
Diabetes with complications	8763	−10,331 to 27,857	0.37
Cerebrovascular disease	12,515	−25,787 to 50,817	0.52
Acute myocardial infarction	−1077	−33,574 to 31,419	0.95
CHF	3089	−16,831 to 23,008	0.76
Quality of Well Being at Baseline (0 to ≤0.25 as reference)			
>0.25 to ≤0.50	−30,131	−71,148 to 10,886	0.15
>0.50 to ≤0.75	−47,455	−90,885 to −4025	0.03
>0.75 to ≤1	−64,483	−114,576 to −14,391	0.1
Follow-up time in months	3452	114–6790	0.04

*For dichotomous or categorical variables this is the difference in costs (in dollars) associated with the presence of the characteristic, and for continuous variables this is the difference in costs (in dollars) associated with a unit increase in the variable.

CHF indicates congestive heart failure; COPD, chronic obstructive pulmonary disease; VA, Department of Veterans Affairs.

$P = 0.10$). Moreover, quality-adjusted life years at 1 year were similar between dialysis groups.

Although the number of patients for whom laboratory values were available decreased at 6 months, hemoglobin, *Kt/V*, URR and serum albumin remained significantly lower among the VA dialysis group.

Sensitivity Analyses

Total costs remained higher for VA dialysis patients when the 41 patients who switched venues of dialysis were removed from the GLM analyses ($142,509 vs. $99,255; $P < 0.001$). Moreover, total costs remained higher for VA dialysis patients when the 36 patients who received >50%

TABLE 4. Dialysis Component Costs, Mean $ (SD)

	Dialysis Group				
Variable	Total Cohort (N = 334)	VA (N = 170)	Private Sector (N = 164)	Difference (95% Confidence Interval)	P
Pharmacy and supplies (without ESAs)	46.42 (13.93)	46.44 (13.86)	46.40 (14.04)	0.04 (−2.96 to 3.04)	0.99
ESA per treatment	50.38 (17.35)	44.95 (15.75)	56.02 (17.17)	−11.07 (−14.61 to −7.52)	<0.001
Labs	3.65 (2.90)	5.89 (2.18)	1.32 (1.24)	4.58 (4.20 to 4.96)	<0.001
Nonphysician labor	109.40 (35.48)	136.61 (21.82)	81.19 (22.48)	55.42 (50.65 to 60.19)	<0.001
Physicians	52.41 (71.44)	40.16 (16.28)	65.11 (99.16)	−24.96 (−40.44 to −9.48)	0.002
Equipment	13.01 (8.90)	12.33 (2.48)	13.72 (12.43)	−1.38 (−3.33 to 0.57)	0.16
Indirect/overhead	97.03 (34.81)	122.73 (17.84)	70.39 (27.25)	52.34 (47.36 to 57.32)	<0.001
Total cost per treatment	372.30 (95.78)	409.11 (58.70)	334.14 (110.87)	74.97 (55.75 to 94.19)	<0.001

ESA indicates erythropoiesis stimulating agents.

TABLE 5. Quality of Life, Clinical Outcomes, and Mortality

	At Baseline			At 6 mo		
Variable	**VA**	**Private Sector**	***P***	**VA**	**Private Sector**	***P***
QWB, mean	0.50 N=166	0.48 N=164	0.17	0.52 N=146	0.50 N=145	0.45
SF-36, mean						
Physical	34.08 N=162	32.87 N=163	0.21	34.08 N=142	33.40 N=133	0.59
Mental	50.82 N=162	52.51 N=163	0.17	51.57 N=142	53.67 N=133	0.09
Kidney disease component score, mean	65.62 N=162	65.25 N=163	0.79	66.75 N=142	65.87 N=133	0.57
Hemoglobin, mean	11.49 N=169	12.04 N=148	0.002	11.63 N=150	11.89 N=124	0.16
Kt/V, mean	1.44 N=77	1.56 N=109	0.10	1.41 N=88	1.58 N=86	0.01
URR, mean	67.33 N=154	71.55 N=140	<0.001	68.76 N=140	71.95 N=116	0.01
Albumin, mean	3.50 N=169	3.79 N=147	<0.001	3.54 N=150	3.84 N=124	<0.001
	At 1 y					
Died, N (%)	27 (15.88%)	16 (9.76%)	0.10			
Quality adjusted life years, mean	0.48 N=166	0.46 N=166	0.37			

Kt/V indicates dialyzer clearance (*K*) during time (*t*) per volume of water a patient's body contains (*V*); QWB, Quality of Well Being; SF-36, Short Form 36 item health-related quality-of-life instrument; URR, urea reduction ratio.

dialysis care through the Fee-Basis program were removed from the GLM analyses ($132,100 vs. $106,260; $P=0.001$).

DISCUSSION

We found the cost of care for patients with ESRD to be higher for Veterans receiving dialysis care at VA facilities compared with Veterans receiving private sector dialysis care ($136,207 vs. $99,776 in 2006 dollars). Controlling for other factors, VA dialysis patients had healthcare total costs that were 37% higher than costs for those receiving private sector dialysis. With an estimated 6,000 dialysis patients at VA dialysis centers per year,[5] this difference translates into an estimated $219 million per year in additional costs. These differences in costs were due in large part to higher costs for dialysis care, greater acute inpatient care use and costs, and greater time and travel costs by the VA group.

The largest component of dialysis costs were for nonphysician labor and indirect costs, and these components were where the greatest differences occurred. The higher cost of nonphysician labor may be related to VA dialysis units being hospital-based as opposed to the typical free-standing private sector dialysis units.[7] Although our micro-costing approach separated chronic outpatient dialysis from the inpatient dialysis treatments, costs for VA chronic outpatient dialysis were still higher than costs for private sector. Staffing ratios in the VA may be higher to support these other types of dialysis. Whether efficiencies could be gained, such as through more flexible staffing, would require further examination of labor and capital inputs across the spectrum of dialysis care.[45]

The indirect costs were higher because of the hospital basis of the VA dialysis units, where indirect costs are derived from costs for the entire hospital not just the dialysis unit, and these results are consistent with earlier research.[7] By eliminating VA outpatient dialysis care and shifting patients to Fee-Basis dialysis or restructuring VA Fee-Basis care reimbursement, some of these indirect costs might be reduced.[46] Nonetheless it is uncertain how such reimbursement restructuring might affect referral patterns or overall care costs for VA dialysis patients. Moreover, the overall impact on indirect costs is uncertain unless provision of inpatient dialysis care is also addressed.

Inpatient costs were greater for the VA dialysis group patients due to longer hospital stays per hospital admission at both VA and private sector facilities. This longer length of stay for VA dialysis patients may reflect an intrinsically worse health status for these Veterans and it could be argued that hospital-based dialysis care (ie, VA dialysis) may be appropriate for these patients. VA dialysis patients experienced greater comorbidity, more psychiatric diagnoses, and lower albumin levels at baseline. Alternatively, this greater length of stay may reflect differences in the quality of dialysis care between these 2 groups. The URR was also significantly lower for VA dialysis patients at baseline compared with their private sector counterparts (67% vs. 71%; $P < 0.001$). However, translating a URR of 67% into a *Kt/V* meets the Kidney Disease Outcomes Quality Initiative standard for dialysis adequacy ($Kt/V \geq 1.2$), consistent with good quality care.[47]

Anemia management among the VA dialysis patients indicated maintenance of lower hemoglobin levels and less use of and lower costs for ESAs compared with private

sector dialysis patients. These findings are consistent with our earlier analysis[48] describing specifically lower use of intravenous administration and lower doses and costs of ESAs in the VA group. Moreover, in light of recent concerns regarding frequency of adverse outcomes if higher hemoglobin levels are targeted, this conservative use of ESAs may be advantageous from a health outcomes perspective.[49–51]

As an observational study, our study has limitations including unobserved factors that may contribute to total costs; incomplete cost valuation due to use of secondary data for cost attribution and patient self-report. However, data validation of patient self-report was performed and sensitivity analyses were conducted to examine whether results would have been different if potentially influential cases were excluded (ie, VA Fee-Basis program dialysis patients, and those who switched dialysis venues) and results were comparable.

Although our study describes care provided from 2001 through 2004, the cost disparities we observed are central to current approaches under consideration[46] or already in early implementation focused on changing the payment structure for dialysis care in an attempt to decrease costs in the VA and in Medicare.[52] The new Medicare bundled prospective payment system for ESRD (ESRD PPS) implemented in 2011 bundles costs for a dialysis session, replacing the previous composite system and the reimbursement of separately billable items and services. The ESRD PPS provides a single payment to ESRD facilities that covers all the resources used in providing an outpatient dialysis treatment.[53] Although the ESRD PPS does not directly affect the VA dialysis centers, there may be impacts on care coordination for VA patients who use private sector dialysis. For example, the private sector dialysis facilities may bundle costs for the ESRD PPS patients but narrow the services delivered, such as by restricting services to only dialysis and referring patients back to the VA for laboratory work or medications, therefore potentially shifting healthcare costs to the VA and patients for the additional visits, time, and travel costs. Although impacts of new VA and Medicare reimbursement strategies on overall ESRD costs and quality of care remain uncertain, our study provides a basis for comparison of such changes on the care of Veterans with ESRD.

CONCLUSIONS

ESRD patients are complex and require extensive inpatient care. Efforts to control hospital-based dialysis care costs and inpatient costs while maintaining quality may offer the best approach to reduce overall costs for ESRD patient care. Future research should also consider the increasingly diverse and complex financing of dialysis care that may affect real costs to patients and society.

APPENDIX

Microcosting Methods

We obtained cost estimates for providing outpatient dialysis care at VA dialysis facilities using a microcosting approach. We conducted site visits to each of the 8 VA medical centers whose dialysis units were sites participating in this study. We collected information on workload at each dialysis facility and costs of providing dialysis care at those facilities during fiscal year 2002 (October 1, 2001 to September 30, 2002). During the site visits information was obtained about (1) staffing, including dialysis supervision by a nephrologist; (2) supplies and pharmacy, including ESAs, used; (3) routine labs performed; and (4) equipment used. Information about the costs associated with these components of dialysis care was collected at the sites or from VA national fiscal data.

Workload

Each of the dialysis unit nurse managers provided information from their dialysis unit records on the number of dialysis treatments provided at that dialysis facility during fiscal year 2002. As VA dialysis facilities provide dialysis services for outpatients who come to the dialysis unit from outside of the facility, for inpatients who come to the dialysis unit from within the hospital facility, and for inpatients who remain in the intensive care unit, we obtained information about the number of dialysis treatments provided for each of these types of care. We also gathered information about the facility's home dialysis program and Fee-Basis program.

Staffing

Staffing information was provided by the nurse manager of the dialysis unit. The nurse manager reported the number of dialysis unit staff (eg, nurses and other direct care providers, dietitians, pharmacists) and their percentage of effort dedicated to the dialysis unit. Costs of the staff for providing VA outpatient dialysis (taking into account the different staffing ratio for outpatient care) was estimated based on salaries available in the VA's Fiscal Management Service records for the particular VA site for fiscal year 2002 and the number of outpatient dialysis treatments that was reported.

Supplies and Pharmacy

The costs of supplies for the dialysis unit at each facility were obtained from the accounting department of each VA medical center during the site visit. Pharmacy costs for the dialysis unit were obtained from either the VA medical centers' accounting departments or the pharmacist involved with the dialysis unit. Cost and use of ESAs were itemized separately.

Labs

Lists of routine labs were collected from the dialysis unit nurse managers. We obtained costs for labs from the lab administrator at Hines VA Hospital and used these figures to estimate costs at all 8 of our VA sites.

Equipment

Information was obtained during the site visits about the year of purchase and cost of all the unit's dialysis machines, as well as other major equipment. Annual costs of the equipment were then estimated by prorating the purchase price over the useful life of the equipment. In addition, we

obtained information about the costs of maintenance for all equipment during the year.

After obtaining annual costs for staffing, supplies and pharmacy, labs, and equipment, we divided the costs by the number of dialysis treatments during fiscal year 2002 (adjusting for different staffing ratios) and then obtained a direct cost per outpatient dialysis treatment at each VA dialysis facility. To this amount we added overhead costs, which were estimated to be 51% of direct costs.[24]

REFERENCES

1. US Department of Veteran Affairs. National Center for Veterans Analysis and Statistics. Available at: http://www.va.gov/vetdata/docs/Quickfacts/Spring2011.pdf. Accessed June 6, 2011.
2. O'Hare A, Bertenthal D, Covinsky K, et al. Mortality risk stratification in chronic kidney disease: one size for all ages? *J Am Soc Nephrol.* 2006;17:846–853.
3. Renal US, Data System. USRDS 2007 Annual Data Report: Atlas of End-Stage Renal Disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2007. Available at: http://www.usrds.org/adr_2007.htm. Accessed June 6, 2011.
4. Hynes DM, Koelling K, Stroupe K, Arnold N, Sohn M, et al. Access and Use of Medicare and VA Services by Veterans. *Med Care.* 2007;45:214–223.
5. Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, Purchase of Non-VA Hemodialysis Treatments 2009.
6. Garg PP, Frick KD, Diener-West M, et al. Effect of the ownership of dialysis facilities on patients' survival and referral for transplantation. *N Eng J Med.* 1999;341:1653–1660.
7. Hirth RA, Held PJ, Orzol SM, et al. Practice patterns, case mix, Medicare payment policy, and dialysis facility costs. *Health Serv Res.* 1999;33:1567–1592.
8. Phillips KA, Morrison KR, Andersen R, et al. Understanding the context of healthcare utilization: assessing environmental and provider-related variables in the behavioral model of utilization. *Health Serv Res.* 1998;33(3 Pt 1):571–596.
9. Gold MR, Siegel JE, Russell LB, et al. *Cost-effectiveness in Health and Medicine.* New York, NY: Oxford University Press; 1996.
10. Barber J, Thompson S. Multiple regression of cost data: use of generalized linear models. *J Health Serv Res Policy.* 2004;9:197–205.
11. Frankenfield DL, Rocco MV, Frederick PR, et al. Racial ethnic analyses of selected intermediate outcomes for hemodialysis patients: results from the 1997 ESRD Core Indicators Project. *Am J Kidney Dis.* 1999;34:721–730.
12. McClellan WM, Soucie JM, Flanders WD. Mortality in end-stage renal disease is associated with facility-to-facility differences in adequacy of hemodialysis. *J Am Soc Nephrol.* 1998;9:1940–1947.
13. Murphy PA, Cowper DC, Seppala G, et al. Veterans Health Administration inpatient and outpatient care data: an overview. *Eff Clin Pract.* 2002;5(3 Suppl):E4.
14. *VIReC Research User Guide: Fiscal Year 2009 VHA Medical SAS Outpatient Datasets and Inpatient Encounter Dataset.* US Department of Veteran Affairs, 2011. Available at: http://www.virec.research.va.gov/DataSourcesName/Medical-SAS-Datasets/MedSAS-Outpt-RUG/MedSAS-RUG-Outpt09er.pdf. Accessed June 6, 2011.
15. *VIReC Research User Guide: Fiscal Year 2009 VHA Medical SAS Inpatient Datasets.* US Department of Veteran Affairs, 2011. Available at: http://www.virec.research.va.gov/DataSourcesName/Medical-SAS-Datasets/MedSAS-Inpt-RUG/MedSAS-RUG-Inpt09er.pdf. Accessed June 6, 2011.
16. Research Data Assistance Center. Medicare Data Documentation. Research Identifiable Files (RIF). Available at: http://www.resdac.org/ddvh/Index.asp. Accessed June 6, 2011.
17. Deyo R, Cherkin D, Ciol M. Adapting a clinical comorbidity index for use with ICD-9 administrative databases. *J Clin Epidemiol.* 1992;45:613–619.
18. Romano PS, Roos LL, Jollis JG. Adapting a clinical comorbidity index for use with ICD-9-CM administrative data: Differing perspectives. *J Clin Epidemiol.* 1993;46:1075–1079.
19. Saban KL, Stroupe KT, Bryant FB, et al. *Qual Life Res.* 2008;17:1103–1105.
20. Saban KL, Bryant FB, Reda DJ, et al, *Health Qual Life Outcomes.* 2010;8:120. Available at: http://www.hqlo.com/content/8/1/120. Accessed June 6, 2011.
21. Hays RD, Kallich JD, Mapes DL, et al. Development of the Kidney Disease Quality of Life (KDQOL) instrument. *Qual Life Res.* 1994;3:329–38.
22. Kaplan R M, Sieber W J, Ganiats T G. The quality of well-being scale: comparison of the interviewer-administered version with a self-administered questionnaire. *Psychol Health.* 1997;12:783–791.
23. US Department of Labor, Bureau of Labor Statistics: consumer Price Index. Available at: ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt. (http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=CUSR0000SA0&output_view=pct_1mth). Accessed June 6, 2011.
24. Smith MW, Richardson SS. HERC Technical Report #17: Dialysis Treatment Use and Costs Reported in VA Administrative Databases. Health Economics Resource Center of Health Service R&D Services, Department of Veterans Affairs, Menlo Park, CA; 2007.
25. US Department of Health & Human Services, Centers for Medicare & Medicaid Services, Renal Facility Cost Reports. Available at: http://www.cms.gov/CostReports/04_RenalFacility.asp#TopOfPage. Accessed June 6, 2011.
26. Homes Dialysis Central, Medicare FAQs for Professionals, updated June 2011. Available at: http://www.homedialysis.org/professionals/medicare. Accessed June 6, 2011.
27. Phibbs CS, Bhandari A, Yu W, et al. Estimating the costs of VA ambulatory care. *Med Care Res Rev.* 2003;60:54S–73S.
28. Wagner TH, Chow A, Barnett PG, HERC's Average Cost Datasets for VA Inpatient Care FY1998 - FY2009. Guidebook. Menlo Park CA. VA Palo Alto, Health Economics Resource Center; 2010. Available at: http://www.herc.research.va.gov/files/BOOK_503.pdf. Accessed February 1, 2011.
29. Yu W, Wagner TH, Chen S, et al. Average cost of VA rehabilitation, mental health, and long-term hospital stays. *Med Care Res Rev.* 2003;60:40S–53S.
30. Smith MW, Chow A, Fee-Basis Data: A Guide for Researchers. Menlo Park CA. VA Palo Alto, Health Economics Resource Center; 2010. Available at: http://www.herc.research.va.gov/files/BOOK_648.pdf. Accessed February 1, 2011.
31. *VIReC Research User Guide: VHA Pharmacy Prescription Data,* 2nd Edition. US Department of Veteran Affairs, 2008. Available at: http://www.virec.research.va.gov/References/RUG/RUG-Pharmacy-2nd-Ed-er.pdf. Accessed June 6, 2011.
32. Yabroff KR, Warren JL, Knopf K, et al. Estimating patient time costs associated with colorectal cancer care. *Med Care.* 2005;43:640–648.
33. US Department of Labor, Bureau of Labor Statistics. National Compensation Survey. All United States Area; All Occupations; Overall Occupation Average (No Work Level). Available at: http://data.bls.gov/PDQ/outside.jsp?survey=nc. Accessed June 6, 2011.
34. Internal Revenue Service. Internal Revenue Bulletin: 2004-49, Rev. Proc. 2004-64. Sections 5.03 and 7.03. December 6, 2004. Available at: http://www.irs.gov/irb/2004-49_IRB/ar11.html. Accessed June 6, 2011.
35. National Transit Database. 2001 National Transit Database Data Tables. Table 11: Transit Operating Expenses by Mode and Function: Details by Transit Agency. Available at: http://www.ntdprogram.gov/ntdprogram/data.htm. Accessed June 6, 2011.
36. National Transit Database. 2001 National Transit Database Data Tables. Table 28: Transit Operating Statistics: Service Supplied and Service Consumed: Details by Transit Agency Directly Operated and Purchased Transportation Service. Available at: http://www.ntdprogram.gov/ntdprogram/data.htm. Accessed June 6, 2011.
37. National Transit Database. 2002 National Transit Database Data Tables. Table 27: Service Supplied and Consumed Ratios: Details by Transit Agency. Available at: http://www.ntdprogram.gov/ntdprogram/data.htm. Accessed June 6, 2011.
38. National Transit Database. 2003 National Transit Database Data Tables. Table 27: Service Supplied and Consumed Ratios: Details by Transit Agency. Available at: http://www.ntdprogram.gov/ntdprogram/data.htm. Accessed June 6, 2011.

39. Centers for Medicaid and Medicare Services. Ambulance Fee Schedule Public Use File. 2003. Available at: Available at: http://www.cms.gov/AmbulanceFeeSchedule/01_overview.asp. Accessed June 6, 2011.
40. US Department of Labor, Bureau of Labor Statistics. National Compensation Survey. All United States Area; Health Aides, exc. Nursing Occupation; Overall Occupation Average (No Work Level). Available at: http://data.bls.gov/PDQ/outside.jsp?survey=nc. Accessed June 6, 2011.
41. SAS software, Version 9.2 of the SAS System for Windows. Copyright © 2009 SAS Institute Inc. Cary, NC, USA.
42. STATA software, Version 11.2 of the STATA MP System for Windows. Copyright © 1996-2011 StataCorp LP, College Station, TX, USA.
43. Vuong Q. Likelihood ratio tests for model selection and non-nested hypotheses. *Econometrica*. 1989;57:307–333.
44. Manning WG, Mullahy J. Estimating log models: To transform or not to transform? *J Health Economics*.20:; 2001:461–494.
45. Griffiths RI, Powe NR, Gaskin DJ, et al. The production of dialysis by for-profit versus not-for-profit freestanding renal dialysis facilities. *Health Serv Res*. 1994;29:473–487.
46. Department of Veteran Affairs National Dialysis Pilot Study, January 12, 2010, Personal communication, April 12, 2011.
47. National Kidney Foundation. K/DOQI clinical practice guidelines for hemodialysis adequacy, 2000. *Am J Kidney Dis*. 2001;37(suppl 1): S7–S64.
48. Hynes DM, Stroupe KT, Kaufman JS, et al. Adherence to guidelines for end-stage renal disease anemia management. *Am J Kidney Diseases*. 2006;47:455–61.
49. US House of Representatives, Committee on Ways and Means, December 6, 2006. *Hearing on Patient Safety and Quality Issues in End Stage Renal Disease Treatment*. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_house_hearings&docid=f:35773.pdf. Accessed June 6, 2011.
50. US House of Representatives, Committee on Ways and Means, Subcommittee on Health, June 26, 2007. *Hearing on Ensuring Kidney Patients Receive Safe and Appropriate Anemia Management Care*. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_house_hearings&docid=f:49981.pdf. Accessed June 6, 2011.
51. FDA Advisory Committee Briefing Document, Joint Meeting of the Cardiovascular and Renal Drugs Advisory Committee and the Drug Safety and Risk Management Committee, September 11, 2007. Reassessment of the Risks of Erythropoiesis-Stimulating Agents (ESAs) Administered for the Treatment of Anemia Associated With Chronic Renal Failure. Available at: http://www.fda.gov/ohrms/dockets/ac/07/briefing/2007-4315b1-01-FDA.pdf. Accessed June 6, 2011.
52. US Department of Veterans Affairs, National Fee Program Office, Chief Business Office, Veterans Health Administration. Available at: http://www.nonvacare.va.gov/. Accessed June 6, 2011.
53. US Department of Health & Human Services, Centers for Medicare & Medicaid Services. CMS Manual System. Publication 100-04 Medicare Claims Processing End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services, August 20, 2010. Available at: http://www.cms.gov/transmittals/downloads/R2134CP.pdf. Accessed June 6, 2011.

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: September 19, 2013

From: Thomas G. Lynch, MD, Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)

Subj: Information Bulletin: Care and Services for Veterans Who Experienced Military Sexual Trauma

To: Network Directors (10N1-23)

On July 19, 2013, the Congressional House Veterans' Affairs Committee held a hearing on the Veterans Health Administration's (VHA) services for Veterans who experienced sexual assault or sexual harassment during their military service (also known as "military sexual trauma" or "MST"). This hearing provides an opportune time to remind Network and Facility Directors of the importance of ensuring that all VHA facilities are in compliance with policies related to MST, as delineated in VHA Handbook 1160.01 and VHA Directives 2010-033 and 2012-004.

Specific attention should be paid to the following issues, in order to ensure that all Veterans who experienced MST receive sensitive, compassionate care targeted to their needs.

1. Sufficient protected time for the MST Coordinator role. VHA Directive 2010-033 requires all VHA facilities to have a designated MST Coordinator to assist with implementation of MST-related policies and to serve as a point person and problem-solver for MST-related issues at the facility. To fulfill the responsibilities of this important role, MST Coordinators must be given adequate unscheduled clinical time that is independent of any time the MST Coordinator spends providing clinical care to MST survivors as part of duties associated with other roles. The amount of protected time required will vary across facilities, based on factors such as facility size and complexity, number of associated CBOCs, the size of the facility's catchment area, and the size of the local MST population. Network and Facility leadership must ensure MST Coordinators have this time available and should encourage MST Coordinators' direct supervisors to solicit feedback regularly from Coordinators about the adequacy of the time provided to allow them to meet their designated responsibilities.

2. Sufficient capacity to provide care. Facilities must ensure they have adequate MST-related treatment services to meet the demand for care. Care must be provided in a timely fashion, by staff with appropriate training. Non-VA fee basis MST-related care can, and should, be provided when there will be a delay in the facility's ability to meet a Veteran's treatment needs, or if it is otherwise clinically indicated for the MST-related care to be delivered outside of the VA facility. Other options that may be appropriate include care via clinical video teleconferencing (telemental health) or a referral to a nearby Vet Center.

3. Sensitivity to the needs of all Veterans who have experienced MST. In FY2012, 43% of the Veterans seen in VHA who had experienced MST were men. It is thus crucial that facilities ensure they have appropriate specialized services available to meet the treatment needs of both men and women Veterans who experienced MST. To do so, MST-related mental health care must always be defined administratively as a service that is gender neutral (i.e., is not administratively under the umbrella of women's mental health or women's health) and treatment environments should be sensitive to gender-specific concerns (e.g., men should not need to meet with providers in a "women's clinic"). There are potential clinical benefits to both single-gender and mixed-gender treatment services. Facilities should examine their current programming to ensure both types of services are available as appropriate.

4. Shared responsibility and coordination of care. MST is not an issue just for mental health providers. Veterans may have both mental and physical health conditions related to their experiences of MST and, as such, may be seen in a range of medical and mental health clinics. Effective care requires a concerted effort to coordinate care across the different services a Veteran is receiving, to ensure that all providers involved in his/her care attend to the ways in which his/her history of MST may impact treatment. This includes adapting care as needed to avoid situations that might be retraumatizating. Veterans' perceptions of VHA's sensitivity to MST-related issues are often impacted by their experiences with frontline staff, such as telephone operators and clerks. All staff must understand their responsibility to provide appropriate, sensitive assistance to all Veterans, but they must be particularly aware of the impact their interactions can have on Veterans' recovery from experiences such as MST.

5. Training. VHA staff must receive education and training about MST-related issues appropriate to their role with Veterans. All primary care and mental health providers must complete the one-time mandatory training on MST specified in VHA Directive 2012-004. At a minimum, clerks and other frontline staff must be familiar with the terms "military sexual trauma" and "MST", readily able to identify and direct Veterans to the MST Coordinator, and attentive to privacy concerns and the need for sensitivity when assisting Veterans. Depending on their role (e.g., assisting Veterans with eligibility issues), other nonclinical staff may need also to be aware of national, VISN-level, and facility policies specific to MST.

6. **Services provided by trainees.** Given that interpersonal betrayal is often a component of MST, establishing trusting relationships with others may be difficult for some Veterans who experienced MST. Frequent or abrupt changes in health care providers may be particularly disruptive to their recovery. Facilities must take these issues into consideration when involving residents, interns, or other trainees in MST-related care, ensuring that transitions between trainees or other providers is seamless, compassionate, and promotes continuity in care. Also, trainees are required to alert Veterans to their unlicensed status and provide the name and contact information for

the licensed professional who is the attending and/or supervising practitioner. Trainees must obtain a Veteran's verbal consent regarding their willingness to engage in treatment with the trainee, and this consent must be documented in the Veteran's medical record. Licensed attending and/or supervising practitioners are responsible for ensuring the treatment provided by trainees is compliant with these and other VHA policies.

Every VISN has a VISN-level Point of Contact (POC) for MST. Network Directors may wish to consult with their VISN-level MST POC about the extent to which the above issues have been adequately addressed within the VISN. In general, POCs should be regularly included in Network-level discussions about MST-related issues.

Additional information and resources related to MST are available on the VA intranet's MST Resource Homepage at http://vaww.mst.va.gov. The current directives on MST Programming (VHA 2010-033) and on Mandatory Training (Directive 2012-004) are attached for your convenience.

The national point of contact for MST-related issues is Susan McCutcheon, R.N., Ed.D., National Director of Family Services, Women's Mental Health, and MST for Office of Patient Care Services, Mental Health Services (10P4M) at 202-340-4192 and susan.mccutcheon@va.gov.

Attachments

DEPARTMENT OF VETERANS AFFAIRS

The Military Sexual Trauma (MST) Clinical Reminder: The User Guide

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National MST Support Team

March 2014

This guide provides a compendium of resources on the MST Clinical Reminder.

Table of Contents

Section 1: The importance of the MST Clinical Reminder

Hello! The MST Clinical Reminder is the main mechanism to document a Veteran's eligibility for free MST-related care.

The MST Clinical Reminder can also be:

- The first *conversation* a Veteran has about military sexual trauma
- An opportunity for an *empathic, supportive response* that makes a powerful positive impact
- A *chance to educate* the Veteran on MST and how to access free MST-related care
- A *warm hand off* between primary care and mental health services

The MST Clinical Reminder aims to:

(a) standardize the MST screening and referral process nationwide

(b) facilitate Veterans' comfort with the screening process and disclosure

(c) provide an opportunity for both Veterans and providers to learn about MST and the availability of free MST-related care

(d) provide national data to assist VA in monitoring access to MST-related services

(e) rescreen Veterans who previously answered 'no' to the MST Clinical Reminder, if they have served additional time in the military

Section 2: The MST Clinical Reminder, step by step

1. Introduce the screen

Now I'm going to ask about some things that may have happened to you while you were in the military. We ask all Veterans these questions because VA offers free care related to these experiences. You can decline to answer these questions if you prefer or you may simply say 'yes' or 'no.'

2. Ask the screening questions

1. When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)?

2. When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

Please check off the appropriate box below based on the Veteran's responses to the above questions.

- NO - denies prior military sexual trauma (MST)
  - (answered 'NO' to BOTH questions)
- YES - reports military sexual trauma (MST) in the past
  - (answered 'YES' to AT LEAST ONE question)
- DECLINE Patient declined to answer question regarding MST

3. Offer a referral

[IF YES] *VA refers to this type of experience as 'military sexual trauma' or 'MST' and VA offers free MST-related care for both physical and mental health concerns. Would you like to speak to a provider about this care?*

4. Offer MST Factsheet

Link to MST Factsheet on the Internet:
http://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf

- YES
  - Veteran requested mental health services. Referral was made and explained to Veteran (see additional information below).
- NO
  - Veteran declined a referral for Mental Health services at this time. Veteran was made aware that services are available if needed in the future.
  - Veteran is currently in treatment with a Mental Health provider.

5. Progress note text

[IF YES] Language auto-populated in note:

"MST Screening:

Patient reports experiencing military sexual trauma (MST) in the past.

The Veteran's subjective experience is sufficient for a positive screen. Verification or additional detail is not necessary. MST can occur on or off base and while a Veteran was on or off duty. Perpetrators can be anyone: men or women, military personnel or civilians, strangers, friends, or intimate partners. Examples of MST include a wide range of unwanted sexual experiences, including offensive behavior or remarks, unwanted sexual attention, or any unwanted sexual touching or other activity that occurred while the Veteran was unable to refuse, coerced (i.e. implied special treatment or hazardous duty or other negative consequences), threatened, or forced. Physical force may or may not be used and compliance does not indicate consent. All health care services (inpatient, outpatient, and pharmaceutical care) for physical and mental health conditions related to MST are provided free of charge."

Additional information on referrals for MST-related services

- Many MST Clinical Reminders will be completed in primary care settings and within the Patient Aligned Care Teams (PACT). When a Veteran screens positive for MST and requests a referral for mental health services, primary care team members are encouraged to complete the referral process and provide a warm hand-off to a mental health provider. If a mental health provider is not available for a warm hand-off, the PACT team member who completed the MST Clinical Reminder should follow the procedure supported in the referral question, such as generating a consult or contacting the party who will receive the referral.
- The provider who is completing the MST Clinical Reminder should explain the referral process to the Veteran and what the Veteran can expect next.
- If a Veteran reports that he or she would not like mental health services at this time, the Veteran should be made aware that services are available in the future if they are needed.
- Because the referral question prompt mentions physical health concerns, Veterans may say 'yes' to the referral question for mental health services but actually intend to request a referral for physical health conditions. Because the MST Clinical Reminder is only programmed to assist with mental health referrals, it will be a provider's responsibility to determine appropriate MST-related physical health referrals. These physical health referrals will occur outside of the MST Clinical Reminder.

Section 3: Additional resources on the MST Clinical Reminder

1. The following **PowerPoint presentations** focus on the MST Clinical Reminder and other common MST documentation issues. Each brief presentation can be reviewed in ten to thirty minutes and can be found in the 'Monitoring' section of the MST Resource Homepage.
   a. *The MST Clinical Reminder revisions:* An introduction to the revised MST Clinical Reminder. This also includes information on the principles of sensitive MST screening.
   b. *Changing MST status in CPRS*: This presentation provides instructions for changing the MST Clinical Reminder response after the MST Clinical Reminder is initially completed. It is critical to change the MST Clinical Reminder response within the electronic medical record if the Veteran subsequently discloses MST, to ensure that he/she has access to free MST-related care.
   c. *Documenting MST-related care:* This presentation reviews existing Revenue Utilization Review policy regarding appropriate clinical documentation of MST-related care.
2. The following **one page handouts** can be used when screening a Veteran for experiences of MST using the MST Clinical Reminder.
   a. **For providers:** This handout shows the screening script in an easy to read format. This handout can be found in the 'Monitoring' section of the MST Resource Homepage and is in the Appendix of this document. This handout can be used by providers who want to avoid reading the MST Clinical Reminder directly from the computer screen.
   b. **For Veterans:** This printable MST Factsheet reviews the definition of MST, how MST can affect Veterans, and how Veterans can get help. This handout is available at VA's MST Internet website and within the MST Clinical Reminder.

Thank you for all the work you do to serve Veterans who have experienced MST. Please contact your local MST Coordinator as questions arise.

Section 4: The FY 2014 revision to the MST Clinical Reminder

Original MST Clinical Reminder (prior to FY14)

1. When you were in the military, did you ever receive uninvited or unwanted sexual attention (i.e., touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc…)?

2. When you were in the military, did anyone ever use force or the threat of force to have sex against your will?

Please check off the appropriate box below based on the patient's responses to the above questions:

- NO - denies prior MST
  - (answered 'NO' to both questions)
- YES - reports military sexual trauma (MST) in the past
  - (answered 'YES' to one or both questions)
- Patient declined to answer question regarding MST.

[IF YES] Language auto-populated in note:

"MST Screening:

Patient reports experiencing military sexual trauma (MST) in the past.

Description of the FY 2014 changes to the MST Clinical Reminder

1. ***Introduction***
   - An explicit option to "decline" was added, to allow Veterans to choose when and with whom they would prefer to discuss this topic. Veterans who "decline" are automatically re-screened again in a year.
   - Although the intent of these changes is to facilitate disclosure, the revised Reminder language also capitalizes on screening as an opportunity to provide all Veterans with information about VHA's specialized MST services, regardless of whether or not they disclose having experienced MST.
2. ***Revised MST screening questions***
   - Examples of coercion or inability to consent were added, as these are types of military sexual trauma that are relatively common.
3. ***IF YES: Addition of a mental health care referral question***
4. ***IF YES: Addition of a link to a printable MST Factsheet for Veterans***
   - The printable MST Factsheet addresses the definition of MST, how MST can affect Veterans, and how Veterans can get help. This allows providers to give Veterans information on MST at the time of screening.

5. ***Text in progress note:***

   - Auto-populated progress note text provides a more detailed definition of MST. The text also notes that all health care services (inpatient, outpatient, and pharmaceutical care) for physical and mental health conditions related to MST are provided free of charge.

6. ***Revision of the reminder definition***

   - Veterans who are re-deployed or otherwise returned to military service are again at risk for MST experiences.
   - The MST Clinical Reminder definition has been revised to ensure Veterans who do not already have a positive MST screen are rescreened if their most recent separation from service date is after the date of their completed MST screening.
   - Because the MST Clinical Reminder functions mainly to document eligibility for free MST-related care, Veterans who have disclosed an experience of MST will not be rescreened with additional military service.

Tools for learning more about the MST Clinical Reminder revision

If you're interested in even more information about MST Clinical Reminder revision, you can access a number of presentations that were given during the initial roll out. The following presentations provided information about the MST Clinical Reminder revision to a variety of audiences.

Two presentations were given to MST Coordinators:

i) A brief overview of the major changes to the MST Clinical Reminder was first discussed at the Annual MST Training Conference on 10/16/13. The archived slides can be found in the 'Training Opportunities' section of the MST Resource Homepage.

ii) Next, the MST Clinical Reminder revision was reviewed in more detail in a MST Teleconference Training Series call on 2/6/14. This presentation discussed the MST Clinical Reminder revision in depth with a special emphasis on Coordinators' role in implementation and training for providers. The archived slides can be found in the 'Monitoring' section of the MST Resource Homepage.

Presentations discussing the MST Clinical Reminder revision are also archived on the PACT Communities of Practice SharePoint and the National Clinical Reminders SharePoint.

Appendix

Veteran Handout

*Within electronic file, double click image below to open PDF file. First page of handout displayed below.

How can MST affect Veterans?

MST is an experience, not a diagnosis or a mental health condition, and as with other forms of trauma, there are a variety of reactions that Veterans can have in response to MST. The type, severity, and duration of a Veteran's difficulties will all vary based on factors like whether he/she has a prior history of trauma, the types of responses from others he/she received at the time of the MST, and whether the MST happened once or was repeated over time. Although the reactions men and women have to MST are similar in some ways, they may also struggle with different issues. Race/ethnicity, religion, sexual orientation, and other cultural variables can also affect the impact of MST.

Although trauma can be a life-changing event, people are often remarkably resilient after experiencing trauma. Many individuals recover without professional help; others may generally function well in their life, but continue to experience some level of difficulties or have strong reactions in certain situations. For some Veterans, the experience of MST may continue to affect their mental and physical health in significant ways, even many years later. Some of the experiences both female and male survivors of MST may have include:

Strong emotions: feeling depressed; having intense, sudden emotional reactions to things; feeling angry or irritable all the time

Feelings of numbness: feeling emotionally 'flat'; difficulty experiencing emotions like love or happiness

Trouble sleeping: trouble falling or staying asleep; disturbing nightmares

Difficulties with attention, concentration, and memory: trouble staying focused; frequently finding their mind wandering; having a hard time remembering things

Problems with alcohol or other drugs: drinking to excess or using drugs daily; getting intoxicated or "high" to cope with memories or emotional reactions; drinking to fall asleep

Difficulty with things that remind them of their experiences of sexual trauma: feeling on edge or 'jumpy' all the time; difficulty feeling safe; going out of their way to avoid reminders of their experiences

Difficulties in relationships: feeling isolated or disconnected from others; abusive relationships; trouble with employers or authority figures; difficulty trusting others

Physical health problems: sexual difficulties; chronic pain; weight or eating problems; gastrointestinal problems

Although posttraumatic stress disorder (PTSD) is commonly associated with MST, it is not the only diagnosis that can result from MST. For example, VA medical record data indicate that in addition to PTSD, the diagnoses most frequently associated with MST among users of VA health care are depression and other mood disorders, and substance use disorders.

Fortunately, people can recover from experiences of trauma, and VA has effective services to help Veterans do this.

September, 2013

Provider Handout

*Within electronic file, double click image below to open PDF file.

The Revised Military Sexual Trauma (MST) Clinical Reminder

1. Introduction script
*Script provides a rationale for MST Screening
*Veteran may answer with yes, no, or decline
*Veterans who "decline" are automatically re-screened again in a year

2. Screening questions
*"Yes" to either question is sufficient for a positive MST screen

3. If a Veteran discloses MST
*Ask referral question to connect Veteran to MST-related mental health services
*Physical health referrals occur outside the MST Clinical Reminder
*Offer the printable MST Fact Sheet embedded in the MST Clinical Reminder

4. Progress note text
*Text provides more information on the definition of MST

Now I'm going to ask about some things that may have happened to you while you were in the military. We ask all Veterans these questions because VA offers free care related to these experiences. You can choose not to answer these questions if you prefer or you may simply say 'yes' or 'no'.

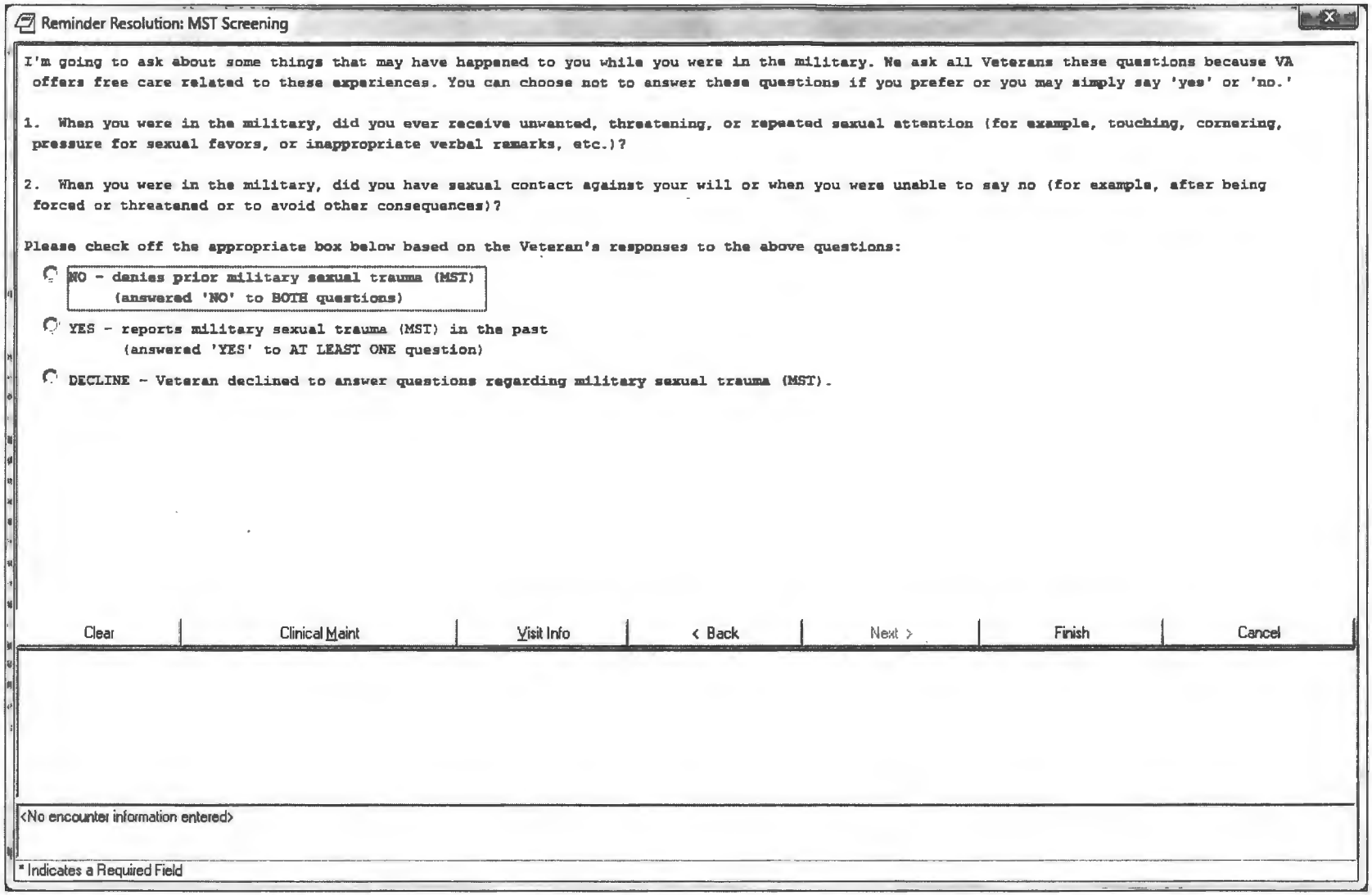
1. When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc...)?
2. When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

VA refers to this type of experience as 'military sexual trauma' or 'MST' and VA offers free MST-related care for both physical and mental health concerns. Would you like to speak to a provider about this care?

For more information, please contact your facility's MST Coordinator or visit **http:/vaww.mst.va.gov**

mst support team

CPRS screenshot of the MST Clinical Reminder



The Revised Military Sexual Trauma (MST) Clinical Reminder

1. Introduction script

*Script provides a rationale for MST Screening

*Veteran may answer with **yes, no, or decline**

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*Offer the printable MST Fact Sheet embedded in the MST Clinical Reminder

4. Progress note text

*Text provides more information on the definition of MST

Now I'm going to ask about some things that may have happened to you while you were in the military. We ask all Veterans these questions because VA offers free care related to these experiences. You can choose not to answer these questions if you prefer or you may simply say 'yes' or 'no.'

1. When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc...)?
2. When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

VA refers to this type of experience as 'military sexual trauma' or 'MST' and VA offers free MST-related care for both physical and mental health concerns. Would you like to speak to a provider about this care?

For more information, please contact your facility's MST Coordinator or visit **http:/vaww.mst.va.gov**

mst support team

The Military Sexual Trauma Clinical Reminder *Revision*

2014

VA Cares About Military Sexual Trauma

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Screening for Military Sexual Trauma

- Universal screening for MST implemented in FY 2002
  - Universal screening ensures that all Veterans who receive health services are screened for MST and can be directed to free MST-related care if desired
- All Veterans are screened for MST using the MST Clinical Reminder in CPRS
  - Veterans are screened once
  - Veterans who decline to respond are screened again in 1 year
  - With revision, Clinical Reminder will reset if additional military service
- A provider can alter the reminder response at a later date
  - For example, the reminder can be changed to 'MST Yes' if a Veteran responds 'No' initially then discloses an MST experience later in treatment

The MST Clinical Reminder revision

- The MST Clinical Reminder can be:
  - The first *conversation* a Veteran has about military sexual trauma
  - An opportunity for an *empathic, supportive response* that makes a powerful positive impact
  - A *chance to educate* the Veteran on MST and how to access free MST-related care
  - A *warm hand off* between primary care and mental health services

The Revised MST Clinical Reminder

- Five revisions to the MST Clinical Reminder but the major change is the addition of a referral question.
- The referral question will help facilitate access to MST-related services for Veterans who desire care and provide national data to assist VA in monitoring access to MST-related services.
- MST CR revision will go live by the end of Fiscal Year 2014 (no earlier than 4/30/14).

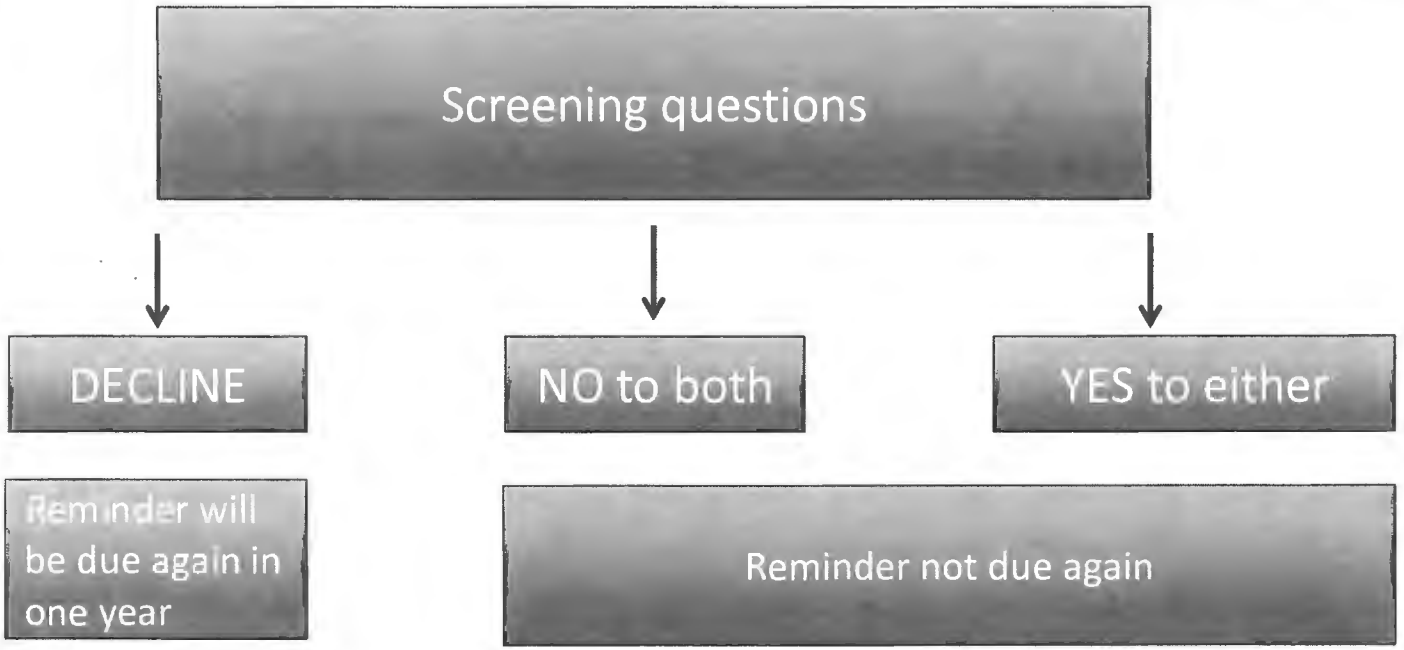
Who should complete the MST Clinical Reminder?

- Screening should typically be done by a licensed professional or someone with appropriate clinical training
- If the screening is completed in Primary Care, the Veteran's Primary Care Provider should always review the Veteran's response and initiate a follow-up discussion with him/her, if needed
- *It is recommended that any staff involved in MST screening complete the 'Military Sexual Trauma Training for Medical Providers' in TMS if they haven't already done the training*
- It is not appropriate to have clerks screen for MST

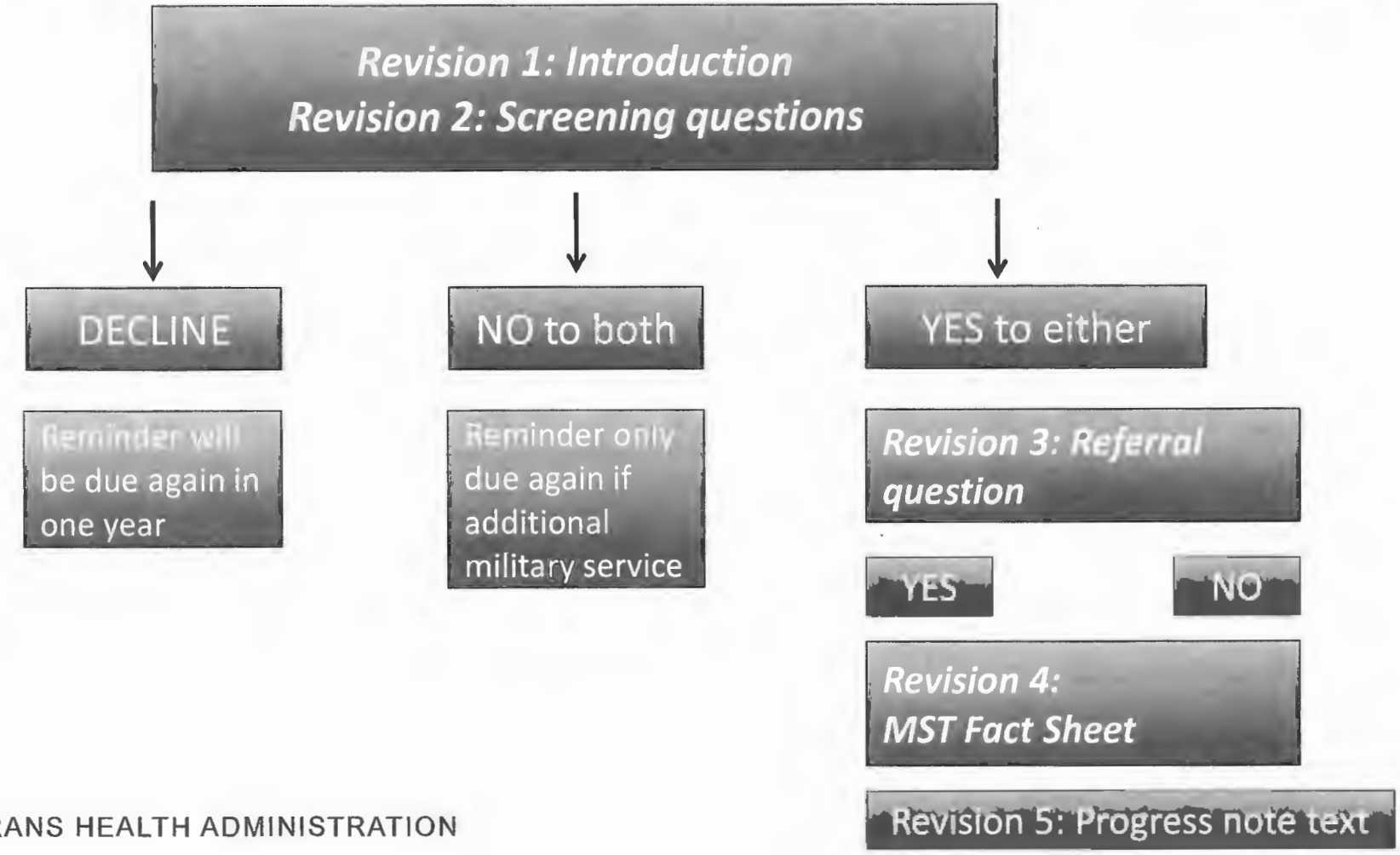
How to begin the MST Screening process

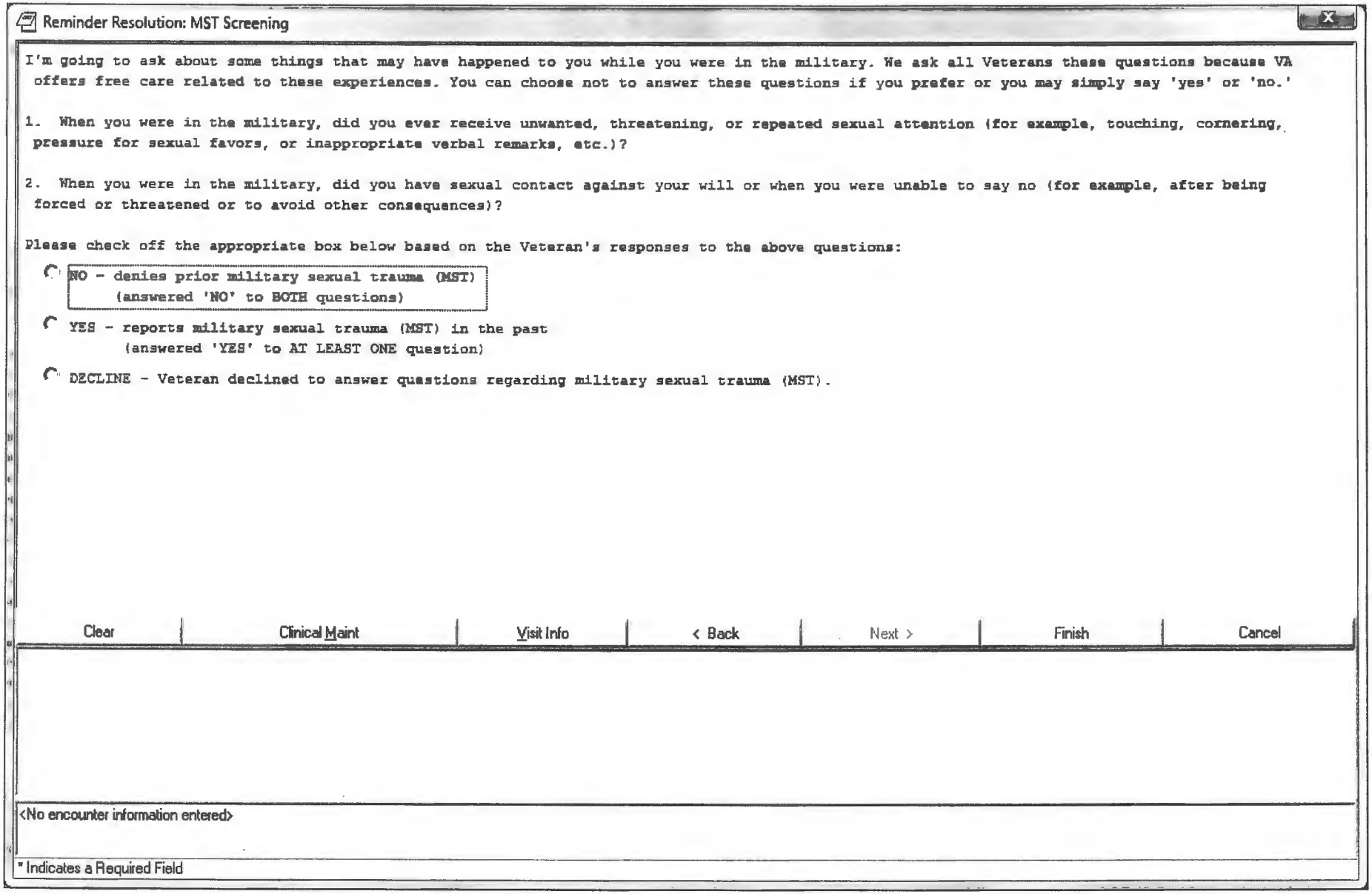
- Screen or offer a paper and pencil screener in a private setting where you will not be interrupted
- When completing the screening or reviewing the paper screener, have the MST Clinical Reminder open on the screen so the language is visible
- Stop what you are doing, turn away from the computer, and talk directly to the Veteran using unhurried speech and good eye contact
  - You may want to glance back to the computer to check the screening script in the MST Clinical Reminder

Original MST Clinical Reminder snapshot

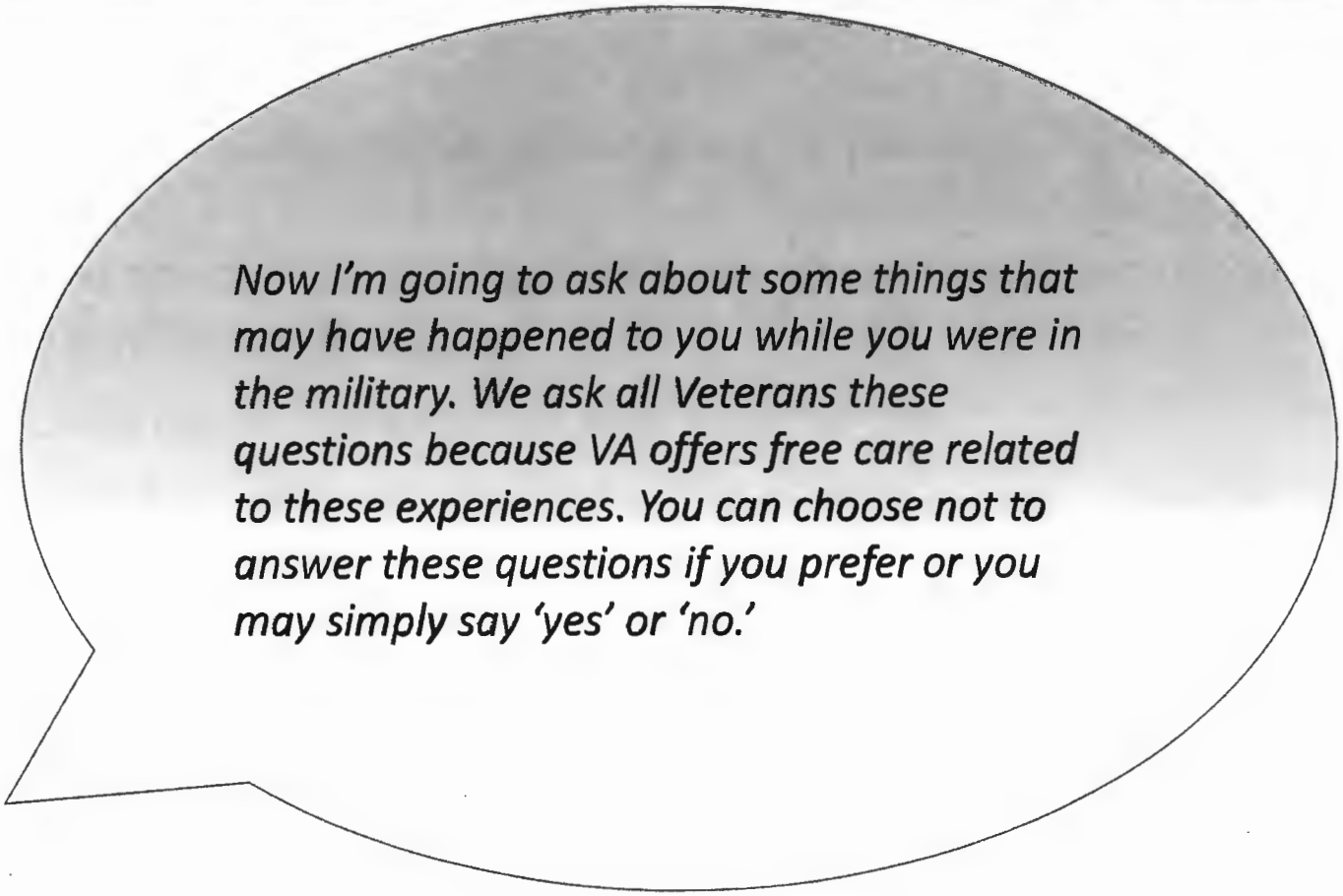


Revised MST Clinical Reminder snapshot




Reminder Resolution: MST Screening
I'm going to ask about some things that may have happened to you while you were in the military. We ask all Veterans these questions because VA offers free care related to these experiences. You can choose not to answer these questions if you prefer or you may simply say 'yes' or 'no.'
1. When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)?
2. When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?
Please check off the appropriate box below based on the Veteran's responses to the above questions:
NO - denies prior military sexual trauma (MST)
(answered 'NO' to BOTH questions)
YES - reports military sexual trauma (MST) in the past
(answered 'YES' to AT LEAST ONE question)
DECLINE - Veteran declined to answer questions regarding military sexual trauma (MST).
Clear
Clinical Maint
Visit Info
< Back
Next >
Finish
Cancel
<No encounter information entered>
* Indicates a Required Field

Revision 1 of 5: Introduction in the MST Clinical Reminder



Introduction in the revised MST Clinical Reminder

- New introduction provides a rationale for MST screening
  - Everyone is screened
  - Screening is used to help Veterans access free care
- Veteran can disclose experience with a simple 'yes'
- Veteran can decline to answer
  - Veteran can choose when and with whom they would prefer to disclose their experience
  - If declined, the MST Clinical Reminder will be due again in one year

Revision 2 of 5: MST Screening Questions

1. When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc…)?

2. When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

- Minor changes to each question
- Adjectives 'repeated' and 'threatening' were added to reflect language in Public Law 106-117
- Revised wording increases behavioral specificity
- Revised text includes examples of coercion or inability to consent

MST Clinical Reminder responses

- No: Veterans says 'No' to **both** questions
- Yes: Veteran answers 'Yes' to **one or both** questions

- Decline: Veteran declined to answer MST screening questions
  - resets the Clinical Reminder to become due again in one year

MST Clinical Reminder response: NO

- Many Veterans have not experienced MST.
- If a Veteran discloses an MST experience after the MST Clinical Reminder is completed, a provider may update the MST Clinical Reminder response at a later date.

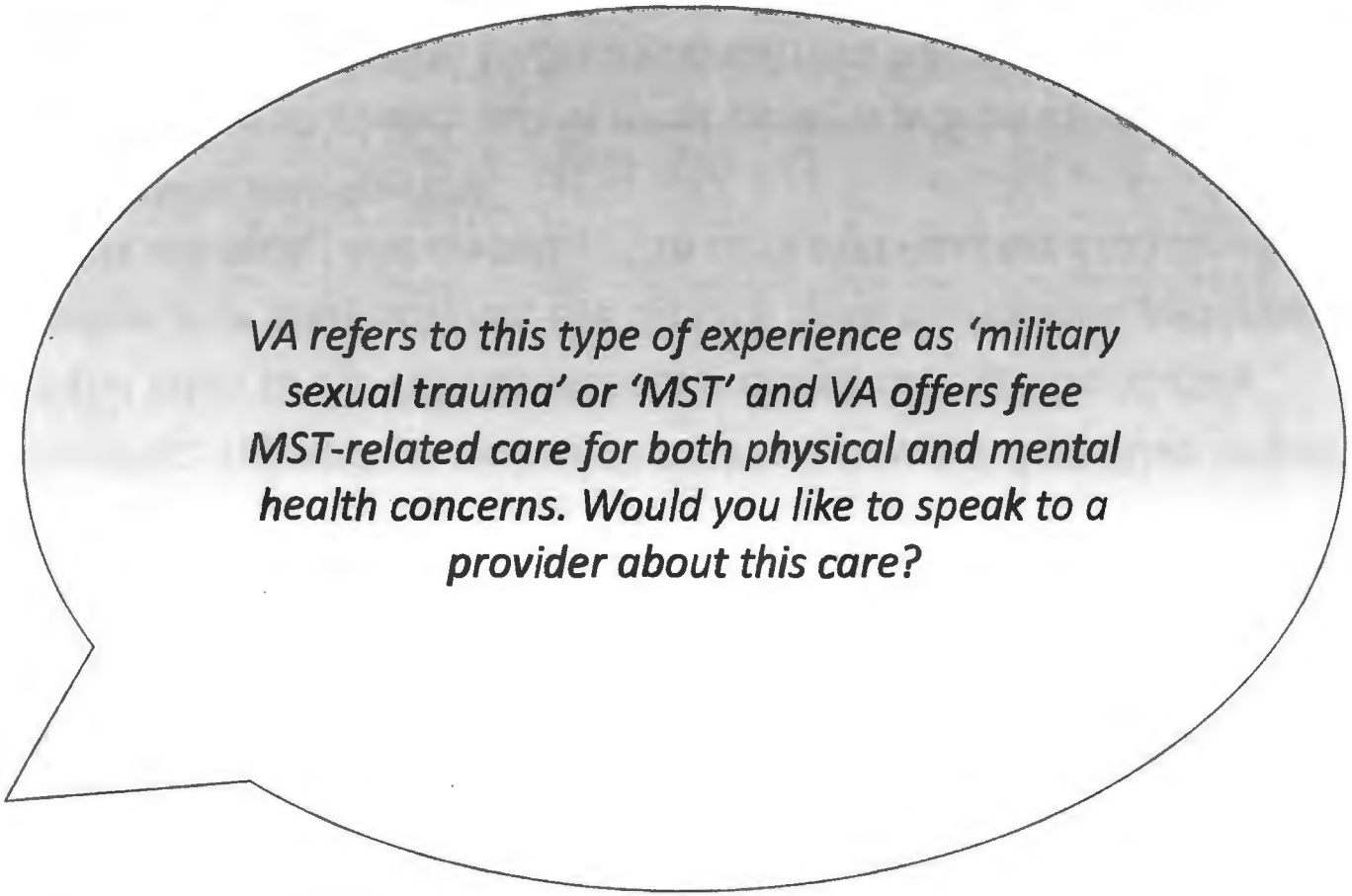
MST Clinical Reminder response: DECLINE

- The 'decline' option allows Veterans to chose when and with whom they would prefer to disclose their experience.
- Some may not feel comfortable disclosing their MST experience during the initial screening for a variety of reasons, such as:
  - Shame or self-blame
  - Fear of becoming emotionally overwhelmed
  - Societal stigma associated with sexual trauma, especially for men
  - Unsupportive and/or blaming responses to previous disclosures
- Veterans who decline to answer will be screened again in one year.
- Leave the door open for future disclosure. Based on your clinical judgment, you may want to:
  - Inform the Veteran that they can answer the questions at a later date
  - Provide education on MST-related services if needed in the future *"As I mentioned, VA offers free care for physical and mental health conditions related to MST."*

MST Clinical Reminder response: YES

- You may be the first person the Veteran has ever told about his or her experiences
- An empathic, supportive response makes a powerful positive impact
  - Sit and listen to the Veteran without problem-solving immediately
  - Monitor your body position, eye contact, facial expressions, and tone of voice
  - Provide validation and empathy: *"I'm sorry that happened to you while you were serving your country."*
- Follow the Veteran's lead, but in most cases it will be clinically appropriate to shape the conversation to focus on current functioning, treatment needs, and the Veteran's interest in a referral for MST-related mental health services.

Revision 3 of 5: Referral question



Referral question, Veteran responds No

- Reasons why a Veteran may respond no:
  - Veteran may already be in treatment with a Mental Health provider
  - Veteran may not need or be interested in Mental Health services at this time

- Veteran should be made aware that services for both physical and mental health conditions are available if needed in the future: *"If you ever change your mind and would like to speak to a provider about MST-related care, just let me know."*

Referral question, Veteran responds Yes

- Referral to mental health occurs through YES to referral question
  - Facilities will vary on how mental health referrals are handled
  - Veterans who request a referral should be connected to mental health services in a timely manner
  - Provider should explain the referral process to Veteran and what they can expect next
- Referral for physical health issues
  - Veterans may say 'yes' to the referral question but intend to request a referral for physical health conditions
  - The MST clinical reminder is only programmed to assist with mental health referrals
  - It is the provider's responsibility to assess and make appropriate referrals for MST-related physical health conditions
  - Physical health referrals will occur outside of the MST Clinical Reminder

EXAMPLE SLIDE

- MST Coordinators, you may want to insert information here about the referral process at your facility.
- Who or what clinic will receive the referral for MST-related mental health services?
- How will the referral be processed (for example, via a consult)?

- When a Veteran screens positive for MST and requests a referral for mental health services in primary care, primary care team members are encouraged to provide a warm hand-off to a mental health provider.
- If a mental health provider is not available for a warm hand-off, the PACT team member who completed the MST Clinical Reminder should follow the procedure supported in the referral question.

Revision 4 of 5: MST Fact Sheet When a Veteran Discloses

- MST Fact Sheet link embedded in MST Clinical Reminder:

  "Would you like a fact sheet on MST? It describes what MST is, how MST may affect you, and how to get help if you would like it. Also, every facility has an MST Coordinator who is a point person for Veterans on MST-related issues. This facility's MST Coordinator is _____."

Military Sexual Trauma

What is military sexual trauma (MST)?

Military sexual trauma, or MST, is the term used by VA to refer to experiences of sexual assault or repeated, threatening sexual harassment that a Veteran experienced during his or her military service. The definition used by the VA comes from Federal law (Title 38 U.S. Code 1720D) and is "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."

More concretely, MST includes any sexual activity where a Servicemember is involved against his or her will -- he or she may have been pressured into sexual activities (for example, with threats of negative consequences for refusing to be sexually cooperative or with implied better treatment in exchange for sex), may have been unable to consent to sexual activities (for example, when intoxicated), or may have been physically forced into sexual activities. Other experiences that fall into the category of MST include unwanted sexual touching or grabbing; threatening, offensive remarks about a person's body or sexual activities; and threatening and unwelcome sexual advances. The identity or characteristics of the perpetrator, whether the Servicemember was on or off duty at the time, and whether he or she was on or off base at the time do not matter. If these experiences occurred while an individual was on active duty or active duty for training, they are considered by VA to be MST.

How common is MST?

VA's national screening program, in which every Veteran seen for health care is asked whether he or she experienced MST, provides data on how common MST is among Veterans seen in VA. National data from this program reveal that about 1 in 5 women and 1 in 100 men respond "yes," that they experienced MST, when screened by their VA provider. Although rates of MST are higher among women, because there are so many more men than women in the military, there are actually significant numbers of women and men seen in VA who have experienced MST.

It's important to keep in mind that these data speak only to the rate of MST among Veterans who have chosen to seek VA health care; they cannot be used to make an estimate of the actual rates of sexual assault and harassment experiences among all individuals serving in the U.S. Military. Also, although Veterans who respond "yes" when screened are asked if they are interested in learning about MST-related services available, not every Veteran who responds "yes" necessarily needs or is interested in treatment. MST is an experience, not a diagnosis, and Veterans' current treatment needs will vary.

September, 2013

Revision 5 of 5: MST Progress note text for MST YES

- Language auto-populated in note provides more information on the definition of MST
  - The Veteran's subjective experience is sufficient for a positive screen
  - Can occur on or off base, while a Veteran was on or off duty
  - Perpetrator identity does not matter
- Notes that all health care services (inpatient, outpatient, and pharmaceutical care) for physical and mental health conditions related to MST are provided free of charge

To review, the Revised MST Clinical Reminder snapshot

Revision 1: Introduction
Revision 2: Screening questions

DECLINE

Reminder will be due again in one year

NO to both

Reminder only due again if additional military service

YES to either

Revision 3: Referral question

YES **NO**

Revision 4: MST Fact Sheet

Revision 5: Progress note text

After the MST Clinical Reminder is completed
Additional opportunities for disclosure

- Veterans may not feel comfortable disclosing their MST experience during the initial screening
- Providing additional opportunities for disclosure is important
  - Trauma assessment in mental health clinics as part of a clinician's standard assessment of social and military history
  - Providers should be knowledgeable about MST and know how to contact MST Coordinator
  - Extensive outreach efforts help to ensure Veterans are aware of MST-related care and ways to access that care
- A provider can alter the reminder response at a later date
  - For example, the reminder can be changed to 'MST Yes' if a Veteran responds no initially then discloses an MST experience later in treatment

Thank you!

- If you have any additional questions, please contact your facility's MST Coordinator
- More information on changing a Veteran's MST Status and other MST topics is available on the **MST Resource Homepage**: vaww.mst.va.gov

Implementation of the Opioid Safety Initiative (OSI)

Veterans Integrated Service Network (VISN) Director Responsibilities VHA Pain Management Directive 2009-053	Date Completed
☐ Implementation of the VHA Pain Management Strategy at the VISN and facility level is evaluated according to performance measures established by the National Pain Management Program Office ☐ Stepped Care Pain Management Model ▪ Step One, Primary Care • Primary care workforce (including behavioral health) • Utilize interdisciplinary teams, supported by primary care Pain Champions, to manage common pain conditions. Relies on system supports, family and patient education programs, collaboration with integrative mental health-primary care teams, and post-deployment programs ▪ Step Two, Secondary Consultation (timely access, defined by urgency of clinical need) • Pain medicine teams • Physical medicine and rehabilitation • Polytrauma programs and teams • Pain psychology • Inpatient pain medicine • Collaboration of pain and palliative care ▪ Step Three, Tertiary, Interdisciplinary Care • Access to VISN and/or facility: o Advanced pain medicine diagnostics and interventions o Commission on Accreditation of Rehabilitation Facilities (CARF) pain rehabilitation programs ☐ Integrated Care/CAM is available or considered as an alternative to chronic opioid monotherapy for routine pain management such as, but not limited to, acupuncture	
VISN OSI Points of Contact (POC)	
☐ Appoint the VISN Chief Medical Officer or designee NOTE: The OSI POC may or may not be the VISN Pain POC as identified in VHA Directive 2009-053 ☐ Appoint at least one licensed prescribing physician from each facility in	

the VISN ☐ Establish a process at the VISN to ensure all POCs have submitted the required data access request forms to gain access to the OSI dashboard ☐ Establish a process at the VISN to review and communicate changes in the POCs to the "VHAPBH PBM BI Question" e-mail group on a quarterly basis. ☐ Develop a plan to transfer the responsibilities of the OSI POC to the VISN Pain POC when the OSI is successfully deployed throughout the VISN. ☐ VISN and Facility POCs have been provided and encouraged to access the link below for Opioid Safety Initiative educational/training materials. https://vaww.cmopnational.va.gov/cmop/PBM/Opioid%20Safety%20Initiative/Forms/AllItems.aspx	
VISN OSI Committees/Reports	
☐ Establish a VISN committee that consists of, but is not limited to, the following individuals: VISN OSI POC, Facility POCs, QMO and a Pain Subject Matter Expert. NOTE: Once the OSI is successfully deployed throughout the VISN, the VISN Pain POC shall chair the OSI committee ☐ Frequency of meetings: At least quarterly ☐ Develop an OSI implementation plan to include measureable goals that focus on: ☐ The OSI dashboard reports • Average dose/day for select opioids • Opioid Utilization over Time • Concomitant use of opioids and benzodiazepines • Patients on Long-Term Opioids who have completed Urine Drug Screens • Education on pain management ☐ Quarterly trend reports from the OSI dashboard will be incorporated into the Network Directors performance evaluation with the DUSHOM ☐ This OSI trend report shall be incorporated into the annual VISN Director's report to DUSHOM on the implementation of the VHA Pain Management Strategy	

Facility Director's Responsibilities VHA Pain Management Directive 2009-053	Date Completed
☐ Implementation of the VHA Pain Management Strategy at the facility level is evaluated according to performance measures established by the National Pain Management Program Office ☐ Stepped Care Pain Management Model	

▪ Step One, Primary Care • Primary care workforce (including behavioral health) • Utilize interdisciplinary teams to manage common pain conditions and relies on system supports, family and patient education programs, collaboration with integrative mental health-primary care teams, and post-deployment programs ▪ Step Two, Secondary Consultation (timely access, defined by urgency of clinical need) • Pain medicine teams • Physical medicine and rehabilitation • Polytrauma programs and teams • Pain psychology • Inpatient pain medicine • Collaboration of pain and palliative care ▪ Step Three, Tertiary, Interdisciplinary Care • Advanced pain medicine diagnostics and interventions—referral or treatment, depending on facility ☐ Integrated Care/CAM is available or considered to chronic opioid monotherapy for routine pain management, such as, but not limited to, acupuncture	
Facility OSI Points of Contact	
☐ Recommend at least one licensed prescribing physician ☐ Ensure all POCs have submitted the required data access request forms to gain access to the OSI dashboard ☐ Establish a process at the facility to review and communicate changes in the POCs to the VISN POC ☐ VISN and Facility POCs have been provided and encouraged to access the link below for Opioid Safety Initiative educational/training materials. https://vaww.cmopnational.va.gov/cmop/PBM/Opioid%20Safety%20Initiative/Forms/AllItems.aspx	
Facility OSI Committees/Reports	
☐ Establish a facility committee that consists of, but is not limited to the following individuals: Facility POCs, Pain Subject matter Experts, Primary Care, Mental Health, Pharmacy, Nursing, Patient Advocate. ☐ Frequency of meetings: At least monthly ☐ Develop an OSI implementation plan to include measureable goals that focus on: ☐ The OSI dashboard reports • Average dose/day for select opioids	

• Opioid Utilization over Time • Concomitant use of opioids and benzodiazepines • Patients on Long-Term Opioids who have completed Urine Drug Screens • Education on pain management ☐ The committee shall provide quarterly trend reports to the facility Chief of Staff on the OSI dashboard report parameters described above ☐ This OSI trend report shall be included into the annual Facility Director's report to the VISN on the implementation of the VHA Pain Management Strategy	

Systematic Review

Comparison of the Quality of Medical Care in Veterans Affairs and Non-Veterans Affairs Settings

Amal N. Trivedi, MD, MPH,† Sierra Matula, MD,‡ Isomi Miake-Lye, BA,‡§*
Peter A. Glassman, MBBS, MSc,‡§¶ Paul Shekelle, MD, PhD,‡§¶ and Steven Asch, MD, MPH‡§¶

Background: The Veterans Health Administration, the nation's largest integrated delivery system, launched an organizational transformation in the mid 1990s to improve the quality of its care.
Purpose: To synthesize the evidence comparing the quality of medical and other nonsurgical care in Veterans Affairs (VA) and non-VA settings.
Data Sources: MEDLINE database and bibliographies of retrieved studies.
Study Selection: Studies comparing the technical quality of nonsurgical care in VA and US non-VA settings published between 1990 and August 2009.
Data Extraction: Two physicians independently reviewed 175 unique studies identified using the search strategy and abstracted data related to 6 domains of study quality.
Data Synthesis: Thirty-six studies met the inclusion criteria. All 9 general comparative studies showed greater adherence to accepted processes of care or better health outcomes in the VA compared with care delivered outside the VA. Five studies of mortality following an acute coronary event found no clear survival differences between VA and non-VA settings. Three studies of care processes after an acute myocardial infarction found greater rates of evidence-based drug therapy in VA, and 1 found lower use of clinically-appropriate angiography in the VA. Three studies of diabetes care processes demonstrated a performance advantage for the VA. Studies of hospital mortality found similar risk-adjusted mortality rates in VA and non-VA hospitals.
Limitations: Most studies used decade-old data, assessed self-reported service use, or included only a few VA or non-VA sites.
Conclusions: Studies that assessed recommended processes of care almost always demonstrated that the VA performed better than non-VA comparison groups. Studies that assessed risk-adjusted mortality generally found similar rates for patients in VA and non-VA settings.

Key Words: veterans; quality of health care; hospitals, veterans; outcomes and process assessment (health care)

(*Med Care* 2011;49: 76–88)

The Veterans Affairs health care system (VA), the nation's largest health care system, provides comprehensive health care services to veterans of US military service. Many veterans receive priority to enroll in the VA by having a disability arising during military service or a low income.

The VA receives funding from a congressional appropriation of general tax revenues and predominantly delivers care in government-operated facilities by salaried federal employees. This degree of government involvement in the delivery of health care is uncommon in the United States, as most Americans enroll in private health insurance plans or receive care in privately-owned hospitals and clinics.[1]

In response to concerns by some stakeholders that the VA provides care of inferior quality, the VA launched an organizational transformation in the mid 1990s to improve clinical performance.[1–3] Since this transformation, there have been both favorable and unfavorable reports of the quality of VA care published in the peer-reviewed literature[4,5] and lay media.[6,7] To better understand the totality of the evidence, we undertook a systematic review of studies that compared quality in VA and non-VA settings in the United States.

METHODS

Data Sources/Study Selection

We searched the MEDLINE database for published studies between January of 1990 and August of 2009, using the following Medical Subject Headings (MeSH): hospitals, veterans, and United States Department of Veterans Affairs. For each

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Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.lww-medicalcare.com).

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of these MeSH, we also included the following descriptor terms: standards, statistical and numerical data, and utilization.

These articles were then screened by 2 physicians trained in the critical analysis of literature. The initial screening form collected the following information about the VA and non-VA samples: years of data collection, sources of data, geographical areas, clinical conditions, measures of quality (structure, process and outcome), and comparability of quality indicators in the VA and non-VA samples (Appendix 1, Supplementary Digital Content, available at: http://links.lww.com/MLR/A125).

We restricted the review to articles that presented a comparison of quality of care for medical or nonsurgical conditions in VA and non-VA settings in the United States, using data from after January 1990. We focused on the technical quality of care using the classic Donabedian triad of structure, process, and outcome, and excluded studies that exclusively focused on patient satisfaction.[8] All articles were reviewed by 2 physicians (A.T. and S.M.). When the 2 reviewers disagreed about inclusion of an article, the articles were discussed with all other members of the study team (S.A., P.G., and P.S.) to reach consensus. Among studies that met the inclusion criteria, we reviewed the bibliographies to identify additional articles for screening.

All articles that met the inclusion criteria received a secondary screening. The following data were abstracted in the secondary screening: sample size for both VA and non-VA sources, years of data collection covered for both VA and non-VA sources; control variables; primary outcomes; and secondary or associated findings. (Appendix 2, Supplementary Digital Content, available at: http://links.lww.com/MLR/A125).

Quality Assessment

Because we were unable to identify prior frameworks for assessing evidence comparing the quality of care across health systems, we developed a conceptual framework for grading studies comparing quality in VA and non-VA settings. Through an iterative process, we identified 6 elements of a high-quality comparison study: (1) evaluation of similar performance measures with comparable assessment methods in the VA and non-VA samples; (2) contemporaneous time frames; (3) representative or national study populations; (4) assessments of well-established clinical outcomes or processes that are strongly associated with better clinical outcomes; (5) inclusion of a broad number of indicators with high clinical or public health significance; (6) sufficient sample size and appropriate statistical methods to confirm or refute study hypotheses.

We graded each article on the basis of the 6 elements described in the conceptual framework above. Each of these elements was assigned a grade (A, B, or C) based on the data abstraction grading guidelines we developed. (Appendix 3, Supplementary Digital Content, available at: http://links.lww.com/MLR/A125). We assigned an overall grade based on a global assessment of the article, considering (but not averaging) the individual components. Thus an article that had a critical flaw in methodology would be rated a "C," even if other issues were satisfactory. Disagreements about grading of the articles were resolved in discussions with the research team to reach consensus.

Data Synthesis

We grouped articles according to clinical content area (eg, preventive care, cardiovascular care) or the Donabedian categories of process and outcomes (no studies that exclusively focused on structure were identified).Within these categories, study outcomes and non-VA comparison groups were heterogeneous which precluded pooled meta-analysis. Consequently, our synthesis is narrative. For further description of our rationale to not pursue pooled meta-analyses, (Appendix 4, Supplementary Digital Content, available at: http://links.lww.com/MLR/A125).

RESULTS

Our search identified 222 articles (Fig. 1). After reviewing titles, 47 duplicates were eliminated. Of the remaining 175 studies, articles were rejected for the following reasons: no comparison of quality in VA and non-VA settings in the United States (98); collection of study data before the cutoff date of 1990 (4); exclusive focus on patient satisfaction (2) or surgical care (16); and receipt of an overall grade of C (19). Of the articles that received a grade of C, 4 were excluded because they presented a comparison of health outcomes without adjustment for severity of illness, 4 examined differences in utilization without assessing clinical appropriateness, 4 had an inadequate sample size, 3 did not present quantitative results, 2 presented data from other earlier studies, and 2 compared measures of health status rather than explicit measures of quality. Therefore, 36 studies formed the basis of our analysis (Table 1).

Of these, 9 studies (classified into a "general" category) assessed care processes for multiple medical conditions, primary preventive services, or health outcomes (including risk-adjusted mortality)[4,9–16]; 8 studies assessed cardiovascular condi-

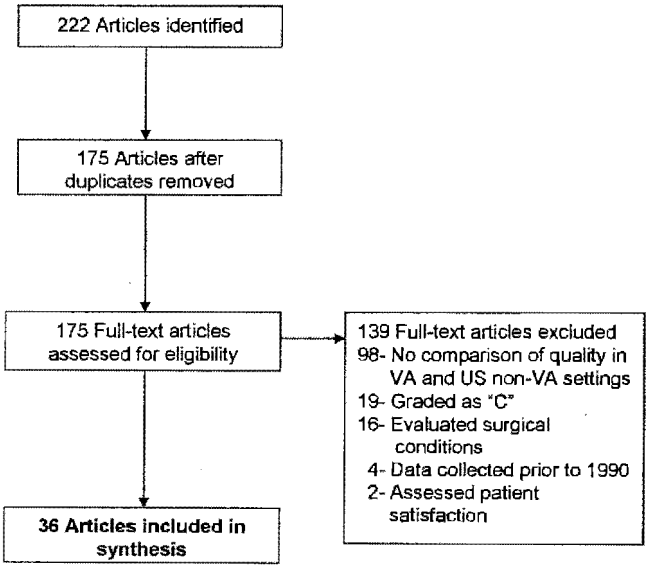

FIGURE 1. Search Flow for Published Evidence Comparing Quality of Medical Care in VA and Non-VA Settings.

TABLE 1. Evidence Table of Included Studies

Author	Conditions	Quality Measure(s)	VA Data: Years Collected	VA Data: Data Level	VA Data: Sample Size	Non-VA Data: Years Collected	Non-VA Data: Data Level	Non-VA Data: Sample Size	Principal Findings	Final Grade
General studies, multiple conditions										
Asch et al[4]	Multiple	Adherence to 348 process of care indicators targeting 26 conditions	1997–1999	Multiple VISNs	596	1996–2000	National	992	The VA scored better on adjusted overall quality (67% vs. 51%); chronic disease care (72% vs. 59%) and preventive care (64% vs. 44%), but not acute care.	A
Jha et al[10]	Multiple	Adherence to 3 preventive, 3 diabetes, 5 MI, and 2 CHF process of care measures	1994–2000	National	48,505–84,503 per year	1997–2001	National	Difficult to ascertain	The VA outperformed the medicare fee-for-service program on all 11 similar indicators from 1997 to 1999 and of 12 of 13 indicators in 2000.	A
Ross et al[13]	DM, IHD, HTN, Preventive care	Use of 17 recommended health care services including cancer prevention, cardiovascular risk reduction, diabetes management and infection prevention	2000–2004	National	10,007	2000–2004	National	393,873	VA care was associated with greater use of 6 of 17 recommended services in 2000 and 12 of 17 recommended services in 2004.	B
General studies, prevention										
Chi et al[9]	Preventive care	Influenza and pneumococcal vaccination	2003	National	3265	2003	National	10,677 veteran non-VA users, 40,331 non-veterans	Among veterans, influenza and vaccination rates were higher for VA users compared to non-users. For veterans, VA care was independently associated with influenza vaccination (adjusted OR, 1.8; [95% CI, 1.5–2.2] and pneumococcal vaccination (adjusted OR, 2.4 [95% CI, 2.0–2.9]).	A
Jha et al[11]	Preventive care	Influenza and pneumococcal vaccination	1995–2003	National	33,504–74,250 per yr	1995–2003	National	Not reported	Rates of influenza and pneumococcal vaccination in the VA were lower than rates reported in a national sample of community dwellers. From 1999 to 2003, VA enrollees were more likely to have been vaccinated for influenza and pneumococcus than were community dwellers outside VA.	A

(*Continued*)

TABLE 1. *(Continued)*

Author	Conditions	Quality Measure(s)	VA Data: Years Collected	VA Data: Data Level	VA Data: Sample Size	Non-VA Data: Years Collected	Non-VA Data: Data Level	Non-VA Data: Sample Size	Principal Findings	Final Grade
Keyhani et al[12]	Preventive care	Influenza and pneumococcal vaccination; serum cholesterol screening	2000–2003	National	171 sole VA users, 1009 dual users of VA and Medicare fee-for-service, 145 dual users of VA and Medicare HMOs	2000–2003	National	3552 Medicare fee-for-service enrollees, 576 Medicare HMO enrollees	Veterans receiving care through VA reported 10% greater use of influenza vaccination ($P < 0.05$), 14% greater use of pneumococcal vaccination ($P < 0.01$), and a nonsignificant 6% greater use of serum cholesterol screening ($P = 0.1$), than did veterans receiving care through Medicare HMOs. Veterans receiving care through Medicare FFS reported less use of all 4 preventive measures ($P < 0.01$) than did veterans receiving care through Medicare HMOs.	B
General studies, mortality and health status										
Selim et al[14]	Multiple	Mortality	1999–2004	National	420,514	1998–2004	National	584,294	After adjusting for case-mix, the HR for mortality for enrollees in Medicare Advantage plans was significantly higher than that for enrollees in the VA (HR, 1.40 [95% CI, 1.38–1.43]).	B
Selim et al[15]	None	2 yr mortality, change in physical and mental health status	1998–2000	National	12177	1998–2000	National	26,225	There was a lower risk-adjusted 2 yr mortality rate in the VA (7.6%) compared to Medicare Advantage (9.2%). There were no significant differences in the probability of being alive with the same or better physical health except for the South (VA 65.8% vs. Medicare Advantage 62.5%, $P = 0.001$).VA patients had a slightly higher probability than Medicare Advantage patients of being alive with the same or better mental health (71.8% vs. 70.1%, $P = 0.002$).	B
Selim et al[16]	Multiple	3 yr mortality rate	1999–2000	National	2361	1999–2000	National	1912	The adjusted HR of mortality among MA dual enrollees was significantly higher than among VHA dual enrollees (HR, 1.26 [95% CI, 1.04–1.52]).	B

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TABLE 1. *(Continued)*

Author	Conditions	Quality Measure(s)	VA Data: Years Collected	VA Data: Data Level	VA Data: Sample Size	Non-VA Data: Years Collected	Non-VA Data: Data Level	Non-VA Data: Sample Size	Principal Findings	Final Grade
Cardiovascular studies										
Bansal et al[17]	Ischemic heart disease	Use of aspirin, beta-blockers, ace-inhibitors, heparin, gp2a3b inhibitors among pts with MI	2002	Single center	92	2002	National	Not described	Use of all agents was higher in the Little Rock VA compared to the rest of Arkansas and the entire US.	B
Landrum et al[18]	IHD	30 d and 1 yr mortality	1996–1999	National	13,129	1996–1999	National	384,470	VA points had significantly higher 1 yr mortality rates across all years studied; 30 d mortality rates were higher in VA in 1997 however 30 d mortality rates decreased overtime and were comparable between the 2 sites by 1999.	B
Petersen et al[19]	IHD	30 d and 1 yr mortality	1994–1995	National	2486	1994–1995	National	29,249	Adjusted rates of mortality at 30 d and 1 yr were not significantly different among VA and Medicare patients after AMI (OR, 0.94 [95% CI, 0.82–1.07] and OR, 0.94 [95% CI, 0.84–1.05] respectively).	A
Petersen et al[21]	IHD	Use of thrombolytics, beta-blockers, ACE inhibitors, or aspirin among ideal candidates following an AMI	1994–1995	National	2486	1994–1995	National	29,249	Ideal VA candidates were more likely to undergo thrombolytic therapy at arrival (OR, [VA relative to Medicare] 1.40 [95% CI, 1.05, 1.74]) or to receive ACE inhibitors (OR, 1.67 [95% CI, 1.12, 2.45]) or aspirin (OR, 2.32 [95% CI, 1.81, 3.01]) at discharge and equally likely to receive beta-blockers (OR, 1.09 [95% CI, 1.03, 1.40]) at discharge.	A
Petersen et al[5]	IHD	Mortality and use of clinically-appropriate angiography following an AMI	1994–1995	National	1665	1994–1995	National	19,305	After accounting for patient characteristics and need for angiography, VA pts were significantly less likely to receive angiography (43.9 vs. 51%, OR, 0.75 [95% CI, 0.57–0.96]). After accounting for hospital and capability of cardiac interventions, underuse of angiography and mortality did not differ significantly between patient groups.	A

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TABLE 1. *(Continued)*

Author	Conditions	Quality Measure(s)	VA Data: Years Collected	VA Data: Data Level	VA Data: Sample Size	Non-VA Data: Years Collected	Non-VA Data: Data Level	Non-VA Data: Sample Size	Principal Findings	Final Grade
Rehman et al[20]	HTN	Control of blood pressure below 140/90	2001–2003	1 VISN	12,366	2001–2003	Large geographic region	7734	Blood pressure control to below 140/90 mm Hg was comparable among white hypertensive men at VA (55.6%) and non-VA (54.2%) settings ($P = 0.12$). Blood pressure control was higher among African American hypertensive men at VA (49.4%) compared with non-VA (44.0%) settings ($P < 0.01$). This result persisted after controlling for age, co-morbid conditions, and rural-urban location.	A
Ritchie et al[22]	IHD	10 and 30 d mortality, 10 and 30 d use of cardiac bypass surgery	1993–1994	1 VISN	8326	1993–1994	Large geographic area	6666	Overall mortality and same-admission bypass surgery rates were similar for patients undergoing PTCA in the VA and Washington State hospitals.	B
Wright et al[23]	IHD	30 d and 1 yr mortality rates	1992–1995	National	14,853	1992–1995	National	32,745	The odds of 30-d mortality were not significantly different between patients admitted to VA basic service hospitals (reference) and patients admitted to any other type of hospital within either system of care. The odds of 1-yr mortality were slightly lower in paticuts admitted to Medicare cardiac surgery hospitals (OR, 0.88 [95% CI, 0.79–0.98]) compared to patients admitted to VA basic service hospitals.	B
Diabetes studies										
Kerr et al[24]	Diabetes	7 diabetes care processes and 3 diabetes intermediate outcomes	2000–2001	Multiple VISNs	1285	2001–2002	Multiple centers	6616	After adjustment, the VA significantly outperformed commercial managed care plans on all process of care measures. Intermediate outcome of blood pressure control was comparable between the VA and commercial managed care plans, however the VA cohort had significantly greater percentage of patients with tight HgbA1C and LDL control.	A
Nelson et al[26]	DM	Use of 5 diabetes self-management practices and preventive services	2000	National	254 with use of some VA care, 281 reporting all VA care	2000	National	10,632	Persons who received care through the VA were more likely to report taking a diabetes education class and receiving HbA1c testing than those covered by private insurance.	B

(Continued)

TABLE 1. (*Continued*)

Author	Conditions	Quality Measure(s)	VA Data: Years Collected	VA Data: Data Level	VA Data: Sample Size	Non-VA Data: Years Collected	Non-VA Data: Data Level	Non-VA Data: Sample Size	Principal Findings	Final Grade
Reiber et al[25]	DM, preventive care	Use of 7 preventive services among patients with diabetes	2000	National	535	2000	National	1848 veterans not using VA care, 9055 non-veterans	Veterans who use VA have higher rates of foot exams, diabetes education, and sigmoidoscopy and a lower rate of a1c testing compared to veterans who did not use the VA. There were non-significant differences in the use of eye exams, blood pressure measurements, cholesterol testing and fecal occult blood testing.	A
Hospital and nursing home care studies										
Berlowitz et al[33]	Multiple	Risk-adjusted rates of pressure ulcer development, functional decline, behavioral decline, and mortality	1997–1999	1 VISN	3802	1997–1999	Large geographic area	961	Veterans in VA nursing homes were less likely to develop a pressure ulcer (OR, 0.62 [95% CI, 0.47–0.83]) but more likely to experience functional decline (OR, 1.6 [95% CI, 1.2–2.1]) compared to veterans in community nursing homes. Risk-adjusted mortality and rates of behavioral decline were not different for veterans in VA and community nursing homes.	A
Gordon et al[32]	Multiple	Risk-adjusted mortality	1993	Single center	5016	1991	National	850,000	Adjusted death rates were similar in the VA and a private sector sample.	B
Kaboli et al[35]	Multiple	Risk-adjusted mortality	1994–1995	Single center	1142	1994–1995	Multiple centers	51,249	Using logistic regression to adjust for severity, the odds of death was similar in VA patients, relative to private sector patients (OR, 1.16 [95% CI, 0.93–1.44]). Using proportional hazards regression and censoring patients at hospital discharge, the risk for death was lower in VA patients (HR, 0.70 [95% CI, 0.59–0.82]).	B
Krein et al[27]	Patient safety	Regular use of specific safety practices to reduce the risk of central venous catheter-related bloodstream infections	2005	National	95 hospitals	2005	National	421 hospitals	Adjusted findings revealed that VA hospitals were significantly more likely to report use of chlorhexadine gluconate on the insertion site (OR, 4.8 [95% CI, 1.6–15.0]) and/or use a composite approach (OR, 2.1, [95% CI, 1.0–4.2]) as compared with non-VA hospitals.	B

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TABLE 1. *(Continued)*

Author	Conditions	Quality Measure(s)	VA Data: Years Collected	VA Data: Data Level	VA Data: Sample Size	Non-VA Data: Years Collected	Non-VA Data: Data Level	Non-VA Data: Sample Size	Principal Findings	Final Grade
Polsky et al[28]	CHF, IHD, Pulmonary Disease, TIA/ Stroke	30 d mortality for white and black males after hospital admission for any of 6 medical conditions	1995–2001	National	369,155	1995–2001	Large geographic region	1,509,891	Racial differences in 30 d mortality rates after admission for 6 medical conditions were similar among VA and non-VA care settings.	B
Rosenthal et al[34]	Multiple	Mortality	1994–1995	Single ctr	1960	1994–1995	Multiple centers	157,147	Risk adjusted in-hospital mortality was similar for VA and private sector patients (OR, 1.07 [95% CI, 0.74–1.54]).	B
Weeks et al[29]	None	Readmission within 30 d	1998–2000	1 VISN	105,026	1998–2000	Large geographic region	163,853	VA care was not a significant predictor of 30 d readmission for veterans <65-yr-old. However, for veterans ≥65 yr of age initial VA hospitalizations was associated with a significantly higher odds of readmission within 30 d than non-VA hospital admissions (OR, 2.79 [95% CI, 1.4–5.6]).	B
Weeks et al[30]	Patient safety indicators	Rates of non-obstetric patient safety indicators	1998–2000	1 VISN	50,429	1998–2000	Large geographic region	74,017	Rates of patient safety indicators were similar in VA and non-VA hospitals for 9 of 15 indicators. Rates of decubitus ulcer, sepsis, iatrogenic infection, postoperative, respiratory failure, and postoperative metabolic derangement were lower in the VA. Mortality rates for low-risk diagnoses were higher in the VA.	B
Mental health care studies										
Busch et al[39]	Depression	Receipt of 84, 140, and 181 d of antidepressant therapy among patients following initial diagnosis of depression	2000–2001	National	27,713	2000–2001	National	4852	The VA slightly outperformed the private sector in the prescription of antidepressants during the first 84 d (85% vs. 81%) and during the first 181 d (54% vs. 51%). The findings persisted after adjustment for age and sex but lost significance after adjustment for co-morbid conditions.	A
Leslie and Rosenheck[36]	Depression, psychosis, schizo-phrenia, other mental health conditions	Readmission rates and outpatient follow-up care following hospitalization for a psychiatric or substance abuse disorder	1993–1997	National	181,132	1993–1995	National	12,163	Private-sector mental health inpatients had lower readmission rates within 14, 30, or 180 d of discharge and higher rates of outpatient visits following discharge compared with VA mental health inpatients. VA patients had higher continuity-of-care scores.	B

(Continued)

TABLE 1. *(Continued)*

Author	Conditions	Quality Measure(s)	VA Data: Years Collected	VA Data: Data Level	VA Data: Sample Size	Non-VA Data: Years Collected	Non-VA Data: Data Level	Non-VA Data: Sample Size	Principal Findings	Final Grade
Leslie and Rosenheck[37]	Psychosis, schizophrenia	Adherence to treatment guidelines for antipsychotic prescribing	2000	National	2636	2000	National	1318	Patients in the VA and private sector were equally likely to receive an antipsychotic regimen that complied with PORT guidelines.	B
Rosenheck et al[38]	Psychosis, schizophrenia	Adherence to schizophrenia patient outcomes research team treatment recommendations	1994–1996	Multiple centers	192 VA inpatients and 274 VA outpatients	1994–1996	Multiple centers	96 non-VA inpatients and 184 non-VA outpatients	On 5 of 26 schizophrenic patient outcomes research team treatment recommendations, a smaller proportion of VA than non-VA patients adhered to standards. Four of these reflected reduced access among VA patients to psychosocial services such as work therapy, job training, or case management services.	B
Other studies										
Barnett et al[40]	Patient safety	Use of potentially inappropriate medications among the elderly	2002–2003	National	123,633	2000–2001	National	157,517	Compared with private sector patients, VA patients were less likely to receive any inappropriate medication (21% vs. 29%, $P < 0.001$), and medications in each of the following classifications: always avoid (2% vs. 5%, $P < 0.001$), rarely appropriate (8% vs. 13%, $P < 0.001$), and some indications (15% vs. 17%, $P < 0.001$).	B
Campling et al[41]	Cancer	Survival following diagnosis of lung cancer	1995–1999	1 VISN	862	1995–1999	Large geographic region	27,936	The median survival was 6.3 mo for VA patients compared with 7.9 mo for patients in the rest of the state, and the 5-yr overall survival rate was 12% for VA patients compared with 15% for patients in the rest of the state. The Cox model showed a hazard ratio for VA patients compared with non-VA patients of 1.22 ($P < 0.001$) after adjusting for age, disease stage, and race.	B
Stineman et al[42]	TIA/stroke	Functional outcomes	1994–1995	National	3056	1995	National	52,382	Stroke patients receiving rehabilitation in the VA setting were discharged with slightly better functional outcomes.	B

VA indicates veterans affairs; VISN, Veterans Integrated Service Networks; AMI, acute myocardial infarction; OR, odds ratio; CI, confidence interval; PTCA, percutaneous transluminal coronary angioplasty; IHD, ischemic health disease; ACE, angiotensin-converting enzyme; CHF, congestive heart failure; TIA, transient ischemic attack; PORT, patient outcomes research team.

tions[5,17–23]; 3 studies assessed diabetes[24–26]; 9 studies assessed hospital and nursing home care[27–35]; 4 studies assessed mental health care[36–39]; and 3 studies assessed other conditions.[40–42]

General

Care Processes for Multiple Medical Conditions and Preventive Care

Six studies compared quality of preventive care or care for multiple acute and chronic medical conditions in VA and non-VA settings.[4,9–13]

Jha et al compared quality of care in the VA and Medicare fee-for-service beneficiaries using 13 equivalent process of care measures.[10] The VA had statistically significant greater performance rates than the Medicare fee-for-service program on all 11 similar indicators from 1997 to 1999 and on 12 of 13 indicators in 2000. In 2000, the absolute performance advantage for the VA in 2000 ranged from 7 percentage points for influenza vaccination to 34 percentage points for smoking cessation counseling for patients with an acute myocardial infarction (AMI). The VA reported lower rates of annual eye examinations for patients with diabetes (67% vs. 74% in Medicare; $P < 0.01$). In 2000, the VA equaled or exceeded 90% on 8 of 13 indicators whereas Medicare's highest performance on any indicator was 84%.

Ross et al compared self-reported use of 17 preventive services for cancer prevention, cardiovascular risk reduction, diabetes mellitus management, and infectious disease prevention among insured adults receiving and not receiving care in the VA.[13] The study found that in 2004 (the most recent year of data), persons receiving VAMC care reported significantly greater use of 12 of the 17 services. Among these 12 services, absolute differences between the VA and the non-VA comparison group ranged from 9 percentage points for cervical cancer screening to 24 percentage points for pneumococcal vaccination for patients with diabetes. There were no services for which rates of use were significantly greater for insured populations outside the VA than for patients using the VA.

Asch et al assessed clinical performance on over 300 process of care indicators in a sample of 596 VA patients in 2 Veterans Integrated Service Networks (VISN) and a random sample of 992 adults from 12 communities that were selected to be representative of nonrural communities in the United States.[4] Overall, VA patients were more likely than patients in the national sample to receive the care specified by the indicators (67% vs. 51%; difference, 16 percentage points [95% CI, 14–18 percentage points]).

Three studies found higher rates of influenza and pneumococcal vaccination for the elderly in the VA compared with samples drawn from outside the VA.[9,11,12]

Outcomes of Care

Selim et al assessed changes in risk-adjusted mortality and health status for elderly VA patients compared with elderly patients enrolled in Medicare Advantage (MA) plans.[14] In adjusted analyses, MA enrollees had a greater risk of 2-year mortality compared with VA patients (9.2% vs. 7.5% HR, 1.36 [95% CI, 1.28–1.46]). The adjusted probability of being alive with the same or better physical and mental health after 2 years was similar in both systems. Two other studies by these authors extended the analysis to an approximately 5-year time frame and to VA and MA enrollees eligible for Medicaid, with similar results.[15,16]

Cardiovascular Conditions

Care Processes

Of the 4 studies that assessed use of processes of care following an AMI, all 3 found greater rates of evidence-based drug therapy in VA,[17,19,21] and 1 study found lower use of clinically-appropriate angiography in the VA.[6]

Studies by Petersen et al were rated highly based on the large and randomly selected samples, clinically-abstracted data, national scope, and rigorous risk-adjustment.[6,19,21] These studies assessed mortality rates, use of clinically-appropriate coronary angiography, and receipt of effective cardiovascular medications following an AMI among male enrollees in the Medicare fee-for-service program compared with elderly male veterans treated in VA facilities during 1994 and 1995. Patients in the VA were less likely to receive angiography when clinically needed (43.9% vs. 51.0%; odds ratio [OR], 0.75 [95% CI, 0.57–0.96]). After controlling for the availability of on-site cardiac procedures, there was no difference in the rate of angiography.[6]

More VA patients than Medicare patients received beta-blockers (49.7% vs. 41.6%, $P < 0.001$), angiotensin-converting-enzyme inhibitors (44.6% vs. 32.5%, $P < 0.001$), or aspirin (77.2% vs. 68.6%, $P < 0.001$) at discharge. Among a subset of patients deemed to be ideal recipients of these medications, VA patients were more likely than Medicare patients to undergo thrombolytic therapy at arrival (OR, 1.40 [1.05–1.74]) or to receive ACE inhibitors (OR, 1.67 [1.12–2.45]) or aspirin (OR, 2.32 [1.81–3.01]) at discharge and equally likely to receive beta-blockers (OR, 1.09 [1.03–1.40]) at discharge.[21]

Outcomes of Care

Five studies of mortality following an AMI or percutaneous coronary transluminal angioplasty found no clear survival differences between VA and non-VA settings.[6,18,19,22,23] For example, in analyses adjusting for demographic and clinical characteristics, Petersen et al found no difference in mortality for Medicare patients compared with the VA at 30 days (OR, 0.94 [95% CI, 0.82–1.07]) and at 1 year (OR, 0.94 [95% CI, 0.84–1.05]).[19]

Rehman et al studied rates of blood pressure control in VA compared with non-VA setting using data from the National Health and Nutrition Examination Survey (NHANES) from 1999 to 2000.[20] The authors found that although blood pressure control to below 140/90 mm Hg was comparable among white hypertensive men at VA (55.6%) and non-VA (54.2%) settings ($P = 0.12$), blood pressure control was higher among African American hypertensive men at VA (49.4%) compared with non-VA (44.0%) settings ($P < 0.01$), even after controlling for age, numerous comorbid conditions, and rural-urban classification.

Diabetes

Three studies of the quality of diabetes care demonstrate a performance advantage on some measures for the VA

compared with commercial managed care and other non-VA populations.[24–26]

Care Processes

A study by Kerr using chart-abstracted clinical data[24] compared the quality of diabetes care in 5 VA medical centers and in 8 commercial managed care organizations in matched geographic regions. The VA outperformed commercial managed care plans on all 7 measures of care processes (glycosylated hemoglobin, lipid, and proteinuria testing, eye and foot examinations, aspirin use counseling, and influenza vaccination). Absolute differences in performance rates between the VA and commercial managed care organizations ranged from 10 percentage points for hemoglobin A1c testing to 37 percentage points for foot examinations.

Two studies analyzed data from the Behavioral Risk Factor Surveillance System to assess self-reported use of preventive services among veterans with self-reported diabetes in the VA compared with diabetic veterans and nonveterans receiving care outside the VA. One study found that veterans who used the VA had higher rates of foot exams, diabetes education, and sigmoidoscopy and a lower rate of A1c testing compared with veterans who did not use the VA. There were nonsignificant differences between these 2 groups in the receipt of eye exams, blood pressure measurements, cholesterol testing, and fecal occult blood testing.[25] Another study found that persons who received care through the VA were more likely to report taking a diabetes education class and receiving hemoglobin a1c testing than those covered by private insurance.[26]

Intermediate Outcomes

Kerr et al found that rates of blood pressure control were comparable for enrollees in the VA and enrollees in commercial health plans. However, the VA cohort had a significantly greater percentage of patients with controlled blood sugar and cholesterol.[24] In the VA, 92% of participants had a glycosylated hemoglobin below 9.5% and 86% had a low-density lipoprotein below 130 mg/dL. In the commercial managed care sample, the corresponding rates were 80% and 72% ($P < 0.01$ for both comparisons).

Hospital and Nursing Home Care

Care Processes

Krein et al assessed the use of central venous catheter bloodstream infection prevention practices in VA and non-VA hospitals, using data from survey of a random sample of infection control coordinators in 516 hospitals.[27] Compared with non-VA hospitals, VA hospitals reported greater use of maximal sterile barrier precautions, chlorhexidine gluconate for insertion site antisepsis, and a composite approach using multiple safety practices.

Outcomes of Care

Three similar studies compared hospital mortality rates in a single VA medical center with mortality rates in different samples of private sector hospitals.[32,34,35] Each found no significant difference in adjusted mortality rates for the VA medical center compared with mortality rates in the non-VA hospital samples.

Weeks et al compared readmission rates and indicators of patient safety for hospitalized VA enrollees who received care in a VA hospital compared with rates for VA enrollees who were hospitalized in non-VA hospitals.[29,30,31] Among persons less than age 65, there were no significant differences in 30 day readmission rates.[31] However, for veterans 65 and older, enrollees initially admitted to a VA hospital had significantly higher odds of readmission within 30 days compared with VA enrollees initially admitted to private-sector hospitals (OR, 2.79 [95% CI, 1.4–5.6]). For 9 of the 15 patient safety indicators, there were no significant differences in rates between VA and non-VA hospitals. The study found lower risk-adjusted rates of decubitus ulcer, postoperative sepsis, nosocomial infection, postoperative respiratory failure, and postoperative metabolic derangement in VA hospitals. The VA performed worse on 1 patient safety indicator: mortality rates for low-risk diagnoses.[30]

Polsky et al examined racial differences in 30-day mortality for patients in VA and non-VA hospitals who were hospitalized for 1 of 6 conditions (pneumonia, congestive heart failure, gastrointestinal bleeding, hip fracture, stroke, or AMI).[28] The study found that racial mortality differences for these conditions were similar in VA and non-VA settings.

In a national study of nursing home outcomes, veterans in VA nursing homes were less likely to develop a pressure ulcer (OR, 0.62 [95% CI, 0.47–0.83]) but more likely to experience functional decline (OR, 1.6 [95% CI, 1.2–2.1]) compared with veterans in community nursing homes.[33] Risk-adjusted mortality and rates of behavioral decline were not different for veterans in VA and community nursing homes.

Mental Health

Four studies of mental health care focused on comparing processes of care in VA and non-VA samples. A study by Busch et al demonstrated that the quality of antidepressant prescribing was slightly better in VA compared with private sector settings.[39] One study of national data found VA patients with schizophrenia were more likely to receive an antipsychotic medication in the outpatient setting, but a study of data from 2 states found VA outpatients were less likely to receive an antipsychotic medication and psychosocial services.[37] Among patients discharged after a hospitalization for schizophrenia, readmission, and outpatient visit follow-up rates were worse in the VA, but continuity of care was better compared with the private sector.[38]

Other Studies

Three additional studies were grouped into an "other" category.[40–42] Elderly VA patients were less likely to be prescribed potentially inappropriate medications than elderly patients in Medicare managed care plans.[40] A study of survival following a diagnosis of lung carcinoma in Pennsylvania found worse survival for VA patients in that state.[41] Stroke patients receiving rehabilitation in VA settings were discharged with better functional outcomes.[42]

Study Characteristics

Of the 14 studies that assessed processes of care for medical conditions, 13 studies demonstrated a performance advantage on more measures for the VA compared with the

non-VA sample. Four studies of the process of care for mental health conditions found mixed results. Only 2 studies assessed intermediate outcomes, making it difficult to draw broad conclusions about performance in this domain of quality. Of the 12 studies that assessed risk-adjusted mortality, 3 demonstrated better outcomes for VA patients, 2 demonstrated better outcomes for the non-VA sample, and 7 reported no statistically significant differences between the VA and non-VA groups.

Twelve of the 36 studies analyzed data after 2000. Aside from 1 survey of infection control practices, no study included data from after 2004.

DISCUSSION

In this systematic review, we identified 36 studies that compared the quality of medical and nonsurgical care in the VA with care quality in a diverse set of non-VA comparison groups, including persons in non-Federal acute care hospitals, commercial health plans, the Medicare fee-for-service program, and in community-based samples. These studies assessed different domains of quality, including evidence-based processes of care, intermediate outcomes (such as control of blood pressure and cholesterol), and mortality. Despite this heterogeneity of designs, outcomes, and sample populations, 2 dominant findings emerged from our evidence synthesis. First, studies that assessed accepted processes of care for medical conditions almost always demonstrated that the VA performed better than non-VA comparison groups. Second, studies that assessed risk-adjusted mortality generally found statistically similar rates for patients in VA and non-VA settings.

The potential disconnect between the VA's better adherence to process measures and equivalent mortality rates may have several explanations. First, as compared with mortality, care processes may be more proximally related to specific quality improvement initiatives and directly controllable by health care providers and systems.[8,43] In contrast, mortality is influenced by many factors outside the realm of medical care. As compared with processes of care, mortality rates may be an insensitive tool to detect provider differences in the quality of care.[44] Therefore, outcomes other than mortality are particularly relevant in comparing the quality of care in VA and non-VA settings, but such nonmortality outcomes were not commonly assessed in the studies we reviewed.

We noted several recurring limitations among the included articles. Studies assessed either a small number of quality measures in a national sample, or a large number of indicators in a sample restricted to a few VA medical centers or non-VA sites. The former may lack comprehensiveness in assessing quality (particularly unreported measures of quality), and the latter may lack external validity. The VA operates in all fifty states, but no study evaluated geographic and interfacility variations in quality. Conclusions about the VA's performance relative to non-VA settings may differ according to the region of the country assessed. Many studies used self reports, rather than clinical and administrative records, to determine exclusive use of the VA and use of recommended preventive services. Self-reports may yield inaccurate assessments of performance as compared with measurements obtained directly from clinical records.[45,46] Most studies of mortality did not use detailed clinical or physiologic data to adjust for differences in health status between VA and non-VA patients. A robust body of literature has established that VA patients have worse health status than the general populations.[47–51] Risk-adjustment methods using administrative records alone may be insufficient to account for greater severity of illness among VA enrollees. Finally, we found relatively few studies using recent data. Because many private-sector organizations have engaged in efforts to improve the quality of care, more recent comparisons of VA and non-VA care are needed.

Our search strategy may have failed to identify important studies that compared VA and non-VA care. Most studies were funded by the VA raising the possibility of publication bias favoring the VA. However, we cannot explain why such a bias would exist for studies of processes and intermediate outcomes but not for analyses of mortality.

Although the totality of evidence suggests that the VA had superior performance on process measures compared with performance in broad non-VA samples, future studies should benchmark the VA to specific high-performing private managed care settings or integrated delivery systems. Future studies should also determine what factors may account for the VA's performance advantage on processes of care and intermediate outcomes measures. Others have suggested that the VA's integration of health care settings, use of performance measures and accountability framework, disease-management practices or electronic medical record and health information technology may explain its performance advantage relative to other settings, but these hypothesized mediators have not been tested empirically.[52,53]

We conclude that the VA, a government-operated integrated delivery system serving poor and disabled veterans of military service, outperforms non-VA settings on quality measures assessing adherence to recommended processes of care. However, most studies have found nonsignificant differences in mortality rates between the VA and non-VA care. Given the urgent need to improve the quality of care in the United States, these results should prompt future studies to understand why the VA has been able to produce superior care processes, determine if this performance gap has increased or attenuated over time, and compare outcomes of VA and non-VA care using a broader set of measures, national samples, recent data, and more robust risk-adjustment methods.

REFERENCES

1. Kizer KW, Dudley RA. Extreme makeover: transformation of the veterans health care system. *Ann Rev Public Health.* 2009;30:313–339.
2. Oliver A. The Veterans health administration: an American success story? *Milbank Q.* 2007;85:5–35.
3. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press; 2001.
4. Asch SM, McGlynn EA, Hogan MM, et al. Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. *Ann Intern Med.* 2004;141:938–945.
5. Petersen LA, Normand SL, Leape LL, et al. Regionalization and the underuse of angiography in the Veterans Affairs Health Care System as compared with a fee-for-service system. *N Engl J Med.* 2003;348:2209–2217.
6. Longman P. The best care anywhere. *Wash Mon.* 2005;37:38.
7. Bogdanich W. Oncologist defends his work at a VA hospital. *New York Times.* June 29, 2009.
8. Donabedian A. *The Definition of Quality: A Conceptual Exploration. The Definition of Quality and Approaches to its Assessment.* Ann Arbor, MI: Health Administration Press; 1980.

9. Chi RC, Reiber GE, Neuzil KM. Influenza and pneumococcal vaccination in older veterans: results from the behavioral risk factor surveillance system. *J Am Geriatr Soc.* 2006;54:217–223.
10. Jha AK, Perlin JB, Kizer KW, et al. Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. *N Engl J Med.* 2003;348:2218–2227.
11. Jha AK, Wright SM, Perlin JB. Performance measures, vaccinations, and pneumonia rates among high-risk patients in Veterans Administration health care. *Am J Public Health.* 2007;97:2167–2172.
12. Keyhani S, Ross JS, Hebert P, et al. Use of preventive care by elderly male veterans receiving care through the Veterans Health Administration, Medicare fee-for-service, and Medicare HMO plans. *Am J Public Health.* 2007;97:2179–2185.
13. Ross JS, Keyhani S, Keenan PS, et al. Use of recommended ambulatory care services: is the Veterans Affairs quality gap narrowing? *Arch Intern Med.* 2008;168:950–958.
14. Selim AJ, Kazis LE, Rogers W, et al. Risk-adjusted mortality as an indicator of outcomes: comparison of the Medicare Advantage Program with the Veterans' Health Administration. *Med Care.* 2006;44:359–365.
15. Selim AJ, Kazis LE, Rogers W, et al. Change in health status and mortality as indicators of outcomes: comparison between the Medicare advantage program and the Veterans Health Administration. *Qual Life Res.* 2007;16:1179–1191.
16. Selim AJ, Kazis LE, Qian S, et al. Differences in risk-adjusted mortality between Medicaid-eligible patients enrolled in Medicare advantage plans and those enrolled in the veterans health administration. *J Ambul Care Manage.* 2009;32:232–240.
17. Bansal D, Gaddam V, Aude YW, et al. Trends in the care of patients with acute myocardial infarction at a university-affiliated Veterans Affairs Medical Center. *J Cardiovasc Pharmacol Ther.* 2005;10:39–44.
18. Landrum MB, Guadagnoli E, Zummo R, et al. Care following acute myocardial infarction in the Veterans Administration medical centers: a comparison with Medicare. *Health Serv Res.* 2004;39:1773–1792.
19. Petersen LA, Normand SL, Daley J, et al. Outcome of myocardial infarction in Veterans Health Administration patients as compared with Medicare patients. *N Engl J Med.* 2000;343:1934–1941.
20. Rehman SU, Hutchison FN, Hendrix K, et al. Ethnic differences in blood pressure control among men at Veterans Affairs clinics and other health care sites. *Arch Intern Med.* 2005;165:1041–1047.
21. Petersen LA, Normand SL, Leape LL, et al. Comparison of use of medications after acute myocardial infarction in the Veterans Health Administration and Medicare. *Circulation.* 2001;104:2898–2904.
22. Ritchie JL, Maynard C, Chapko MK, et al. A comparison of percutaneous transluminal coronary angioplasty in the Department of Veterans Affairs and in the private sector in the State of Washington. *Am J Cardiol.* 1998;81:1094–1099.
23. Wright SM, Petersen LA, Lamkin RP, et al. Increasing use of Medicare services by veterans with acute myocardial infarction. *Med Care.* 1999; 37:529–537.
24. Kerr EA, Gerzoff RB, Krein SL, et al. Diabetes care quality in the Veterans Affairs Health Care System and commercial managed care: the TRIAD study. *Ann Intern Med.* 2004;141:272–281.
25. Reiber GE, Koepsell TD, Maynard C, et al. Diabetes in nonveterans, veterans, and veterans receiving Department of Veterans Affairs health care. *Diabetes Care.* 2004;27:B3–B9.
26. Nelson KM, Chapko MK, Reiber G, et al. The association between health insurance coverage and diabetes care; data from the 2000 behavioral risk factor surveillance system. *Health Serv Res.* 2005;40:361–372.
27. Krein SL, Hofer TP, Kowalski CP, et al. Use of central venous catheter-related bloodstream infection prevention practices by US hospitals. *Mayo Clin Proc.* 2007;82:672–678.
28. Polsky D, Lave J, Klusaritz H, et al. Is lower 30-day mortality posthospital admission among blacks unique to the Veterans Affairs health care system? *Med Care.* 2007;45:1083–1089.
29. Weeks WB, West AN, Wallace AE, et al. Comparing the characteristics, utilization, efficiency, and outcomes of VA and non-VA inpatient care provided to VA enrollees: a case study in New York. *Med Care.* 2008;46:863–871.
30. Weeks WB, West AN, Rosen AK, et al. Comparing measures of patient safety for inpatient care provided to veterans within and outside the VA system in New York. *Qual Saf Health Care.* 2008;17:58–64.
31. Weeks WB, Bott DM, Lamkin RP, et al. Veterans Health Administration and Medicare outpatient health care utilization by older rural and urban New England veterans. *J Rural Health.* 2005;21:167–171.
32. Gordon HS, Aron DC, Fuehrer SM, et al. Using severity-adjusted mortality to compare performance in a Veterans Affairs hospital and in private-sector hospitals. *Am J Med Qual.* 2000;15:207–211.
33. Berlowitz DR, Rosen AK, Wang F, et al. Purchasing or providing nursing home care: can quality of care data provide guidance. *J Am Geriatr Soc.* 2005;53:603–608.
34. Rosenthal GE, Sarrazin MV, Harper DL, et al. Mortality and length of stay in a veterans affairs hospital and private sector hospitals serving a common market. *J Gen Intern Med.* 2003;18:601–608.
35. Kaboli PJ, Barnett MJ, Fuehrer SM, et al. Length of stay as a source of bias in comparing performance in VA and private sector facilities: lessons learned from a regional evaluation of intensive care outcomes. *Med Care.* 2001;39:1014–1024.
36. Leslie DL, Rosenheck RA. Comparing quality of mental health care for public-sector and privately insured populations. *Psychiatr Serv.* 2000; 51:650–655.
37. Leslie DL, Rosenheck RA. Benchmarking the quality of schizophrenia pharmacotherapy: a comparison of the Department of Veterans Affairs and the private sector. *J Ment Health Policy Econ.* 2003;6:113–121.
38. Rosenheck RA, Desai R, Steinwachs D, et al. Benchmarking treatment of schizophrenia: a comparison of service delivery by the national government and by state and local providers. *J Nerv Ment Dis.* 2000; 188:209–216.
39. Busch SH, Leslie DL, Rosenheck RA. Comparing the quality of antidepressant pharmacotherapy in the Department of Veterans Affairs and the private sector. *Psychiatr Serv.* 2004;55:1386–1391.
40. Barnett MJ, Perry PJ, Langstaff JD, et al. Comparison of rates of potentially inappropriate medication use according to the Zhan criteria for VA versus private sector medicare HMOs. *J Manag Care Pharm.* 2006;12:362–370.
41. Campling BG, Hwang WT, Zhang J, et al. A population-based study of lung carcinoma in Pennsylvania: comparison of Veterans Administration and civilian populations. *Cancer.* 2005;104:833–840.
42. Stineman MG, Ross RN, Hamilton BB, et al. Inpatient rehabilitation after stroke: a comparison of lengths of stay and outcomes in the Veterans Affairs and non-Veterans Affairs health care system. *Med Care.* 2001;39:123–137.
43. Brook RH, McGlynn EA, Cleary PD. Quality of health care. Part 2: measuring quality of care. *New Engl J Med.* 1996;335:966–970.
44. Mant J, Hicks N. Detecting differences in quality of care: the sensitivity of measures of process and outcome in treating acute myocardial infarction. *BMJ.* 1995;311:793–796.
45. Brown JB, Adams ME. Patients as reliable reporters of medical care process: recall of ambulatory encounter events. *Med Care.* 1992;30:400–411.
46. Newell SA, Girgis A, Sanson-Fisher RW, et al. The accuracy of self-reported health behaviors and risk factors relating to cancer and cardiovascular disease in the general population: a critical review. *Am J Prev Med.* 1999;17:211–229.
47. Kazis LE, Miller DR, Clark J, et al. Health-related quality of life in patients served by the Department of Veterans Affairs: results from the Veterans Health Study. *Arch Intern Med.* 1998;158:626–632.
48. Agha Z, Lofgren RP, VanRuiswyk JV, et al. Are patients at Veterans Affairs medical centers sicker? A comparative analysis of health status and medical resource use. *Arch Intern Med.* 2000;160:3252–3257.
49. Rogers WH, Kazis LE, Miller DR, et al. Comparing the health status of VA and non-VA ambulatory patients: the veterans' health and medical outcomes studies. *J Ambul Care Manage.* 2004;27:249–262.
50. Selim AJ, Berlowitz DR, Fincke G, et al. The health status of elderly veterans enrollees in the Veterans Health Administration. *J Am Geriatr Soc.* 2004;52:1271–1276.
51. Randall M, Kilpatrick KE, Pendergast JF, et al. Differences in patient characteristics between Veterans Administration and community hospitals: implications for VA planning. *Med Care.* 1987;25:1099–1104.
52. Kerr EA, Fleming B. Making performance indicators work: experiences of US Veterans Health Administration. *BMJ.* 2007;335:971–973.
53. Kupersmith J, Francis J, Kerr E, et al. Advancing evidence-based care for diabetes: lessons from the Veterans Health Administration. *Health Aff (Millwood).* 2007;26:w156–w168.

Reconsidering the Veterans Health Administration: A Model and a Moment for Publicly Funded Health Care Delivery

Since the Veterans Health Administration (VHA) was systemically (and systematically) "reengineered" to follow a more decentralized, managed care template more than 15 years ago (1–3), it has demonstrated accumulating achievements in health and health care delivery, over time outshining not only its own performance but that of others (4–6). In chronic disease management and preventive care, the VHA has surpassed Medicare (7), commercial managed care (8), and various community health systems in adherence to broadly accepted process measures (9).

Furthermore, beneficiaries of the VHA seem to have health outcomes—including mortality—that are the same as or better than those of Medicare (10–12) and private-sector patients (13). These findings are noteworthy given the population served by the VHA, which is recognized to be highly and relatively burdened by socioeconomic disadvantage, comorbid illness, and poor self-reported health (1). It is remarkable that the VHA has been able to attain this superior-quality care at a lower cost than that purchased through Medicare, with expenditures that have increased at a much slower rate (adjusted annual per capita growth rate, 0.3% vs. 4.4%) (14, 15).

In this issue, Keating and colleagues (16) offer the latest report on VHA performance and extend to cancer care what has already been shown for care provided for various other medical conditions. By using process measures that reflect receipt of high-quality care based on national guidelines, this study compares treatment of older male veterans in the VHA system with that of fee-for-service Medicare patients with a diagnosis of colorectal, lung, prostate, or hematologic cancer. Keating and colleagues found that patients treated in the VHA system received care that was equal to or better than that among patients with Medicare coverage treated in the community. Patients in the VHA system had higher rates of curative resection for colon cancer, recommended chemotherapeutic regimens for hematologic neoplasms, and bisphosphonate use for multiple myeloma.

When comparing care delivered in different settings, a major concern is that observed differences may actually reflect differences in patient populations. The authors use state-of-the-art statistical methods to address this issue. By using an analysis weighted by the propensity for each patient to be treated in the VHA, they adjusted for characteristics, such as age, race, and region, that could have a confounding effect if, in addition to being associated with the likelihood of being treated in one setting or the other, they also influence the appropriateness of treatment or whether patients follow through on treatment recommendations.

The propensity score method deals with the selection bias introduced by significant group differences by giving additional weight to Medicare patients who most closely match VHA patients in these characteristics. This weighting balances the distribution of such characteristics and levels the ground for comparisons and estimates on quality of care between the 2 groups. The propensity score approach cannot address bias introduced by variables that are not included in the analysis and may actually increase the confounding effect associated with these factors.

Because the data that the authors examined is administrative in nature, such unmeasured factors are a key limitation. However, the authors attempted to account for this unobserved variable bias by using sensitivity analyses to estimate the potential effect on their results of differences in the prevalence of poor performance status or severe comorbid illness. On the basis of these analyses, the authors conclude that their study may have actually underestimated the quality of care provided in VHA settings compared with non-VHA settings.

The only process measure for which VHA patients had lower scores than Medicare patients was the use of 3-dimensional conformal radiation therapy (3DCRT) versus intensity-modulated external-beam radiation therapy for prostate cancer (61.6% vs. 86.0%; $P < 0.001$). This substantial divergence may reflect varying adoption rates of new technology by 2 distinct health care financing schemes, highlighting the difference between the market-driven practices of the fee-for-service sector and the careful consideration to large capital investments required of systems that must adhere to an annual budget.

The evidence on the benefit of 3DCRT versus conventional radiation therapy before 2001 was limited to data suggesting that it was associated with lower rates of acute toxicity (17, 18). The pivotal study demonstrating improved progression-free survival with higher doses of radiation, which is only feasible with 3DCRT, was published in 2005 and thus was not available when the patients in Keating and colleagues' study were undergoing treatment (19). As such, the observed rates of 3DCRT use in the VHA and Medicare cohorts may reveal overzealous application of new treatment modalities before clear value was proved. If we ever hope to control health care costs as providers and as a nation, policies to encourage high-quality evidence of benefit before rapid dissemination of novel technologies, especially expensive ones, are needed both in the VHA and Medicare settings.

In the wake of legislation to comprehensively reform health care in the United States while preserving its underlying multiple-payer structure, one might be tempted to wistfulness when considering the quality of care in the

VHA. Despite the clamor of special interests, corporate lobbying, and the particular American distaste for government-run institutions, the public option may yet find its voice in the latest round of accomplishments demonstrated by the VHA. "Thanks" to proposals to repeal of the historic Patient Protection and Affordable Care Act, it is ironic that the moment for reconsideration has returned—and with it, the opportunity to celebrate more vociferously the triumphs of the country's largest integrated and publicly funded health care network.

Of course, given the pressing and very real need of uninsured and underinsured persons, the obvious hope is that the proposed repeal remains a symbolic gesture, and a symbolic gesture only. Still, the results of Keating and colleagues' analysis provide a poignant reminder that a vision for a national, integrated, government-run health care system not only exists but is, in fact, successful.

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References

1. **Kizer KW, Demakis JG, Feussner JR.** Reinventing VA health care: systematizing quality improvement and quality innovation. Med Care. 2000;38:I7-16. [PMID: 10843266]
2. **Greenfield S, Kaplan SH.** Creating a culture of quality: the remarkable transformation of the department of Veterans Affairs Health Care System [Editorial]. Ann Intern Med. 2004;141:316-8. [PMID: 15313749]
3. **Oliver A.** The Veterans Health Administration: an American success story? Milbank Q. 2007;85:5-35. [PMID: 17319805]
4. **Ashton CM, Souchek J, Petersen NJ, Menke TJ, Collins TC, Kizer KW, et al.** Hospital use and survival among Veterans Affairs beneficiaries. N Engl J Med. 2003;349:1637-46. [PMID: 14573736]
5. **Neugaard BI, Priest JL, Burch SP, Cantrell CR, Foulis PR.** Quality of care for veterans with chronic diseases: performance on quality indicators, medication use and adherence, and health care utilization. Popul Health Manag. 2011;14:99-106. [PMID: 21091367]
6. **Evans DC, Nichol WP, Perlin JB.** Effect of the implementation of an enterprise-wide Electronic Health Record on productivity in the Veterans Health Administration. Health Econ Policy Law. 2006;1:163-9. [PMID: 18634688]
7. **Jha AK, Perlin JB, Kizer KW, Dudley RA.** Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. N Engl J Med. 2003;348:2218-27. [PMID: 12773650]
8. **Kerr EA, Gerzoff RB, Krein SL, Selby JV, Piette JD, Curb JD, et al.** Diabetes care quality in the Veterans Affairs Health Care System and commercial managed care: the TRIAD study. Ann Intern Med. 2004;141:272-81. [PMID: 15313743]
9. **Asch SM, McGlynn EA, Hogan MM, Hayward RA, Shekelle P, Rubenstein L, et al.** Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. Ann Intern Med. 2004;141:938-45. [PMID: 15611491]
10. **Selim AJ, Berlowitz D, Kazis LE, Rogers W, Wright SM, Qian SX, et al.** Comparison of health outcomes for male seniors in the Veterans Health Administration and Medicare Advantage plans. Health Serv Res. 2010;45:376-96. [PMID: 20050934]
11. **Petersen LA, Normand SL, Daley J, McNeil BJ.** Outcome of myocardial infarction in Veterans Health Administration patients as compared with medicare patients. N Engl J Med. 2000;343:1934-41. [PMID: 11136265]
12. **Fihn SD, Vaughan-Sarrazin M, Lowy E, Popescu I, Maynard C, Rosenthal GE, et al.** Declining mortality following acute myocardial infarction in the Department of Veterans Affairs Health Care System. BMC Cardiovasc Disord. 2009;9:44. [PMID: 19719849]
13. **Rosenthal GE, Sarrazin MV, Harper DL, Fuehrer SM.** Mortality and length of stay in a veterans affairs hospital and private sector hospitals serving a common market. J Gen Intern Med. 2003;18:601-8. [PMID: 12911641]
14. **Nugent GN, Hendricks A, Nugent L, Render ML.** Value for taxpayers' dollars: what VA care would cost at medicare prices. Med Care Res Rev. 2004;61:495-508. [PMID: 15536211]
15. **Congressional Budget Office.** The Health Care System for Veterans: An Interim Report. December 2007. Washington, DC: Congressional Budget Office; 2007. Accessed at www.cbo.gov/doc.cfm?index=8892&zzz=36275 on 11 February 2011.
16. **Keating NL, Landrum MB, Lamont EB, Bozeman SR, Krasnow SH, Shulman LN, et al.** Quality of care for older patients with cancer in the Veterans Health Administration versus the private sector. A cohort study. Ann Intern Med. 2011;154:727-36.
17. **Koper PC, Stroom JC, van Putten WL, Korevaar GA, Heijmen BJ, Wijnmaalen A, et al.** Acute morbidity reduction using 3DCRT for prostate carcinoma: a randomized study. Int J Radiat Oncol Biol Phys. 1999;43:727-34. [PMID: 10098427]
18. **Dearnaley DP, Khoo VS, Norman AR, Meyer L, Nahum A, Tait D, et al.** Comparison of radiation side-effects of conformal and conventional radiotherapy in prostate cancer: a randomised trial. Lancet. 1999;353:267-72. [PMID: 9929018]
19. **Zietman AL, DeSilvio ML, Slater JD, Rossi CJ Jr, Miller DW, Adams JA, et al.** Comparison of conventional-dose vs high-dose conformal radiation therapy in clinically localized adenocarcinoma of the prostate: a randomized controlled trial. JAMA. 2005;294:1233-9. [PMID: 16160131]

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ORIGINAL REPORT

Survival of Older Patients With Cancer in the Veterans Health Administration Versus Fee-for-Service Medicare

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A B S T R A C T

Purpose
The Veterans Health Administration (VHA) provides high-quality preventive chronic care and cancer care, but few studies have documented improved patient outcomes that result from this high-quality care. We compared the survival rates of older patients with cancer in the VHA and fee-for-service (FFS) Medicare and examined whether differences in the stage at diagnosis, receipt of guideline-recommended therapies, and unmeasured characteristics explain survival differences.

Patients and Methods
We used propensity-score methods to compare all-cause and cancer-specific survival rates for men older than age 65 years who were diagnosed or received their first course of treatment for colorectal, lung, lymphoma, or multiple myeloma in VHA hospitals from 2001 to 2004 to similar FFS-Medicare enrollees diagnosed in Surveillance, Epidemiology, and End Results (SEER) areas in the same time frame. We examined the role of unmeasured factors by using sensitivity analyses.

Results
VHA patients versus similar FFS SEER-Medicare patients had higher survival rates of colon cancer (adjusted hazard ratio [HR], 0.87; 95% CI, 0.82 to 0.93) and non–small-cell lung cancer (NSCLC; HR, 0.91; 95% CI, 0.88 to 0.95) and similar survival rates of rectal cancer (HR, 1.05; 95% CI, 0.95 to 1.16), small-cell lung cancer (HR, 0.99; 95% CI, 0.93 to 1.05), diffuse large–B-cell lymphoma (HR, 1.02; 95% CI, 0.89 to 1.18), and multiple myeloma (HR, 0.92; 95% CI, 0.83 to 1.03). The diagnosis of VHA patients at earlier stages explained much of the survival advantages for colon cancer and NSCLC. Sensitivity analyses suggested that additional adjustment for the severity of comorbid disease or performance status could have substantial effects on estimated differences.

Conclusion
The survival rate for older men with cancer in the VHA was better than or equivalent to the survival rate for similar FFS-Medicare beneficiaries. The VHA provision of high-quality care, particularly preventive care, can result in improved patient outcomes.

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INTRODUCTION

The Veterans Health Administration (VHA) is the largest integrated health care system in the United States and serves an estimated 6 million veterans yearly. The VHA underwent a major reorganization in the mid-1990s that emphasized improved primary and outpatient care. Since then, studies have demonstrated the provision of high-quality preventive and chronic care in the VHA.[1-3] Recent evidence showed that the VHA also provides high-quality care for cancer, which is a complex illness that often requires multiple specialty services.[4,5] For example, we recently found higher rates of surgery for colon cancer and recommended chemotherapy for diffuse large–B-cell lymphoma and bisphosphonates for multiple myeloma among older male VHA patients compared with similar men enrolled in FFS Medicare and similar rates of other guideline-recommended therapies for patients with colorectal, prostate, hematologic, and lung cancers.[4]

However, little is known about whether the improved processes of care translate into improved patient outcomes in the VHA. Studies in the early 1990s to mid-1990s found lower rates of recommended invasive care for cardiac patients in the VHA, with mixed findings about the impact for outcomes.[6-8] A recent review of studies published since 1990 found that the survival rate was generally equivalent for VHA patients and patients in other

settings,[3] which raised the question of why improved processes of care have not resulted in better outcomes. However, most of these studies examined care before the VHA reorganization and could not control for clinical or socioeconomic differences between VHA and non-VHA patients.

We examined survival rates for older veterans with lung, colorectal, or hematologic cancers who were diagnosed or treated in the VHA compared with similar patients with cancer enrolled in FFS Medicare. We also examined whether differences in the stage at diagnosis or cancer treatments were mediators of differences in survival rates and explored the role of unmeasured differences between VHA and non-VHA patients in the explanation of outcome differences.

PATIENTS AND METHODS

Data

VHA. The Department of Veterans Affairs (VA) Central Cancer Registry collects uniformly reported information on all patients who were diagnosed with or received their first course of treatment for cancer at a VA Medical Center. We linked registry data with VHA encounter data that covered hospitalizations, outpatient visits, and contracted care. Because previous studies have demonstrated that elderly VHA patients often receive care through Medicare[9-11] as well as the VHA, we also obtained Medicare claims data for inpatient and outpatient care for Medicare-eligible VHA patients.

FFS Medicare. We used the Surveillance, Epidemiology, and End Results (SEER) –Medicare data for this analysis.[12] SEER registrars collect uniformly reported data from population-based cancer registries that cover approximately 28% of the United States.[13] The data are merged with Medicare claims data, which successfully links files for more than 94% of SEER patients age 65 or older.[12]

The study was approved by the Harvard Medical School Committee on Human Studies.

Cohorts

We studied patients with colon, rectal, non–small-cell lung cancer (NSCLC), small-cell lung cancer, diffuse large–B-cell lymphoma, and multiple myeloma. We created disease-specific cohorts by identifying all male patients age 66 years and older with a first diagnosis of the cancer of interest during 2001 to 2004. We excluded patients with histology that suggested a primary cancer other than the cancer of interest, cancers diagnosed at autopsy or by death certificate only or when the reporting source was unknown, and patients with incomplete data (including no administrative data between 45 days before diagnosis through 195 days after diagnosis because we were concerned data were incomplete). For the FFS-Medicare cohort, we also excluded patients who were not enrolled in both parts A and B of Medicare or enrolled in a Medicare health maintenance organization in the year before diagnosis (to ensure complete data on comorbid illness before diagnosis). The numbers of patients excluded for these reasons are included in the Data Supplement.

Survival Rates

For the FFS-Medicare cohorts, dates of death were included in Medicare enrollment and death-certificate data, including the cause of death, from a National Death Index match. For the VA cohort, we obtained vital status data from Medicare enrollment data, the National Death Index (including the cause of death), and VA administrative sources. We computed the time to death as a result of all causes and the time to death as a result of cancer. We censored patients alive as of December 31, 2005 (the last date with complete vital status data available from all sources). In analyses of the time to death as a result of cancer, we censored patients who died as a result of other causes when they died.

Mediating Factors

We examined whether the stage at diagnosis and tumor size, which were obtained from registry data, explained observed survival differences. For diagnoses made in 2001 to 2003, we used the modified American Joint Committee on Cancer stage. Starting in 2004, both VHA and SEER registries used collaborative stage groupings.[14] The stage at diagnosis was collected for patients with lymphoma only in 2004 and was not available for multiple myeloma patients in all years. For small-cell lung cancer patients, we categorized patients with stage I to III cancer as having limited-stage cancer and patients with stage IV cancer as having extensive-stage cancer.

We also examined whether differences in the use of guideline-recommended therapies[15-20] explained survival differences. Specifically, we examined curative surgery for stage I to III colon cancer, stage I to III rectal cancer, and stage I and II NSCLC, adjuvant chemotherapy for stage III colon cancer, adjuvant chemotherapy and radiation therapy for stage II and III rectal cancer, chemotherapy and radiation therapy for limited-stage small-cell lung cancer, and cyclophosphamide, doxorubicin, vincristine, and prednisone chemotherapy for diffuse large–B-cell lymphoma as described elsewhere.[4]

Patient Characteristics

We obtained information about age, race/ethnicity, marital status, and history of previous cancer from registry data. We characterized comorbid illnesses on the basis of inpatient and outpatient encounters during the year before diagnosis by using the Klabunde modification of the Charlson score.[21,22] Information on sociodemographic indicators was obtained from 2000 Census data for the zip code of each patient.

Analyses

Veterans were eligible for care through the VHA primarily because of service-related disabilities or economic disadvantage, and thus, older patients with cancer treated in the VHA differed from FFS-Medicare patients with respect to many important sociodemographic and clinical characteristics. We used a propensity-score[23,24] approach to account for differences in characteristics of patients at the time of their cancer diagnosis to estimate the effect of receiving care through the VHA compared with what would have been obtained had they decided to receive non-VHA care through FFS Medicare.

To conduct the propensity-score adjustment, we first used a logistic regression model to calculate the propensity of being treated in the VHA on the basis of age, race, marital status, Charlson score, previous cancer, census region, quarter-year of diagnosis, and census variables that described socioeconomic conditions in the zip code of the residence of the patient. We used regression coefficients and observed covariates to estimate the propensity for each man to be treated in the VHA (p). We applied a standardized mortality ratio propensity-score weight that equaled 1 for VHA patients and the propensity odds $[p \div (1 - p)]$ for FFS-Medicare patients.[25,26] This application gave additional weight to FFS-Medicare patients who most resemble VHA patients so that the weighted distribution of characteristics in the two cohorts was well balanced and equaled that of the original VHA cohort (Data Supplement). Thus, the standardized mortality ratio–weighted effects estimated the survival rate in a typical VHA patient had they received care under FFS Medicare.

We compared all-cause and cancer-specific survival rates by plotting weighted Kaplan-Meier survival curves for VHA and Medicare patients and tested for differences by using a weighted Cox proportional hazard model with VHA or FFS-Medicare status as the only covariate. CIs were computed by using a robust variance estimator that accounts for unequal weighting of observations and the correlation among patients within treatment settings. We used the hospital that reported the cancer diagnosis as the clustering unit for VHA patients because outpatient care in the VHA tends to occur at clinics associated with inpatient facilities. For FFS-Medicare patients, we used the hospital service area as a proxy for the local practice setting.

Mediating Effects

To investigate the ability of differences in stage at diagnosis or receipt of recommended therapy to mediate the relationship between the treatment setting and survival rates, we replicated the analyses and included these variables in the propensity score analysis. We compared adjusted hazard ratios (HRs) estimated by using the new propensity-score weights to those estimated by using original propensity-score weights to determine whether HRs were attenuated or exacerbated when differences in stage or therapies was equalized between VHA and FFS-Medicare patients.

Table 1. Patient Demographics and Clinical Characteristics by Cohort

Demographic or Clinical Characteristic	Colon Cancer		Rectal Cancer		NSCLC		Small-Cell Lung Cancer		Non-Hodgkin's Lymphoma		Multiple Myeloma	
	VHA	SEER-Medicare	VHA	SEER-Medicare	VHA	SEER-Medicare	VHA	SEER-Medicare	VHA	SEER-Medicare	VHA	SEER-Medicare
N	7,003	20,734	1,757	4,562	13,434	31,868	2,111	4,669	613	3,192	900	3,170
Age, %												
66-69 years	17.8	15.0	18.1	17.8	21.9	18.3	24.4	21.2	16.0	14.4	18.6	16.9
70-74 years	28.0	23.3	30.4	25.6	30.5	27.3	32.6	28.7	24.6	22.6	25.0	24.8
75-79 years	28.5	25.2	28.1	25.3	29.2	26.9	27.6	28.0	29.2	25.9	28.4	25.5
80-84 years	19.2	20.9	18.5	18.5	15.0	18.0	12.4	15.1	23.0	22.7	23.1	19.6
≥ 85 years	6.5	15.7	5.0	12.8	3.4	9.6	3.0	7.1	7.2	14.4	4.9	13.2
Race, %												
White	78.3	90.3	80.8	92.0	80.7	89.4	85.1	91.7	88.8	94.4	64.7	82.9
African American	16.3	8.1	13.7	6.0	17.2	9.1	12.6	6.9	6.2	3.3	27.8	14.6
Hispanic	5.4	1.5	5.5	2.0	2.2	1.5	2.3	1.4	5.0	2.3	6.5	2.4
Missing	2.1	4.9	2.3	5.6	1.5	4.7	1.5	4.0	2.4	5.0	2.1	3.2
Marital status, %												
Single	44.0	29.4	44.8	29.4	47.7	31.9	46.9	30.8	43.4	24.9	39.0	26.5
Married	56.0	70.6	55.2	70.6	52.3	68.1	53.1	69.3	56.6	75.2	61.0	73.5
Missing	2.6	3.1	2.5	3.4	2.3	2.6	1.8	2.3	1.1	3.1	1.9	4.9
Census region, %												
Northeast	17.1	25.1	15.9	24.6	14.6	22.1	13.8	20.5	13.5	23.5	14.6	22.6
Midwest	20.0	15.8	21.1	15.4	21.3	15.8	24.8	17.3	21.5	15.7	21.8	17.6
South	46.2	19.2	45.7	18.8	46.9	23.5	43.9	25.7	42.6	16.5	43.7	19.2
West	16.7	39.9	17.3	41.3	17.2	38.6	17.5	36.5	22.4	44.2	20.0	40.7
Socioeconomic variables*												
With college degree in zip code of residence, %	25.6	31.7	24.6	30.8	24.6	29.7	24.6	28.8	27.6	34.2	26.8	32.4
Professionals in zip code of residence, %	29.5	34.3	28.8	33.6	28.9	32.9	28.8	32.1	31.0	36.1	30.4	34.9
Median household income in zip code of residence, $	44,800	56,500	44,400	55,500	44,500	54,000	45,200	53,000	47,300	59,600	45,300	57,300
Age ≥ 65 years with income < poverty level in zip code of residence, %	12.5	9.2	12.3	9.2	12.2	9.7	11.5	9.8	11.2	8.4	13.0	9.4
Hispanic in zip code of residence, %	12.2	11.7	12.9	12.5	10.3	11.6	10.0	11.5	11.7	11.5	13.0	11.7
African American in zip code of residence, %	16.1	10.1	14.0	9.1	16.8	10.7	14.0	9.8	10.6	7.3	20.2	12.3
Missing census data, %	5.7	2.9	4.7	2.9	4.6	2.9	4.7	2.6	4.6	2.7	6.7	2.8
Charlson comorbidity score, %												
0	44.4	49.0	51.0	57.1	54.1	56.9	53.0	55.2	41.3	50.0	40.1	47.5
1	30.8	26.6	29.7	25.0	25.8	24.4	25.3	24.9	31.5	25.8	25.4	23.2
2	14.1	13.4	11.0	10.0	12.2	10.8	12.4	10.8	14.7	13.0	17.2	14.2
≥ 3	10.7	11.0	8.3	8.0	7.9	8.0	9.3	9.1	12.6	11.2	17.2	15.1
COPD, %					45.0	41.8	44.5	42.9				
Prior cancer, %	16.7	23.5	16.1	23.3	21.3	25.9	19.2	21.7	19.3	25.9	20.0	24.3
Tumor grade, %												
Well differentiated	11.9	10.4	10.4	9.3	6.6	6.7						
Moderately differentiated	72.9	70.5	75.5	73.7	33.4	30.4						
Undifferentiated	15.3	19.2	14.1	17.1	60.1	63.0						
Tumor grade missing, %	13.9	10.1	18.2	13.3	50.8	48.7						
Stage at diagnosis, %												
I	31.7	26.4	38.3	39.7	28.0	23.4			23.8§	33.1§		
II	28.1	31.2	26.9	23.3	7.1	5.6	39.7†	37.7†	12.2§	17.7§		
III	22.7	24.7	19.9	22.1	26.5	29.5			23.2§	15.9§		
IV	17.5	17.6	14.9	14.9	38.4	41.6	60.3‡	62.3‡	40.9§	33.3§		
Stage missing, %	7.7	5.0	11.6	9.4	5.2	9.0	4.6	6.8	9.9§	8.5§		
Tumor size, %¶												
T1	22.3	17.6	24.8	23.9	25.1	21.8						
T2	20.1	17.2	23.7	25.3	38.4	35.4						
T3	51.2	54.7	45.7	45.5	12.1	9.2						
T4	6.5	10.5	5.8	5.3	24.5	33.7						
Tumor size missing, %¶	1.2	1.9	2.4	5.5	12.3	10.1						

Abbreviations: COPD, chronic obstructive pulmonary disease; NSCLC, non–small-cell lung cancer; SEER, Surveillance, Epidemiology, and End Results; VHA, Veterans Health Administration.

*Obtained from 2000 Census by linking to the zip code of the residence of the patient.

†Limited stage.

‡Extensive stage.

§Stage collected in 2004 only.

¶Among stage I/II/III cancers.

Sensitivity Analyses

Because propensity-score analyses can control only for observed characteristics, we examined the robustness of estimated treatment effects to unobserved confounders.[27] To do this, we considered an unobserved variable, such as poor performance status, associated with both care in the VHA and worse survival rates. We updated estimates of the HR by comparing survival rates between VHA and FFS-Medicare patients after adjustment for this confounder under specific assumptions regarding differences between VHA and FFS-Medicare patients in the prevalence of the confounders and the relationship of confounders with survival rates.

We considered the following four potential unmeasured confounders: poor Eastern Cooperative Oncology Group performance status (≥ 2), lack of college education, more severe comorbid illness, and smoking status. We obtained estimates of the relationship between these factors and survival rates from previously published literature.[28-31] We estimated performance-status differences between VHA and non-VHA patients with cancer from clinical trial data for patients with lung cancer.[32] We estimated the prevalence of severe comorbidity in VHA patients from medical record abstraction of a subset of patients. The prevalence of severe comorbidity in FFS-Medicare patients was estimated on the basis of analyses of the Cancer Care Outcomes Research and Surveillance (CanCORS) patients with lung and colorectal cancer.[33,34] We obtained estimates of differences in rates of college education and smoking status between VHA and non-VHA patients with cancer from an analysis of the National Health Interview Survey for population-based cohorts of veterans and nonveterans.[35]

RESULTS

VHA patients were younger, more likely to be African American, more likely to live in areas with lower levels of education and income, and more likely to live in the South compared with FFS-Medicare patients (Table 1). After propensity weighting, the cohorts appeared well balanced (Data Supplement). Median follow-up was 3 years.

VHA patients diagnosed with colon cancer had better all-cause and cancer-specific survival rates (Figs 1A and 1B; all-cause adjusted HR, 0.87; 95% CI, 0.82 to 0.93) as did patients with NSCLC (Figs 1C and 1D; all-cause adjusted HR, 0.91; 95% CI, 0.88 to 0.95). All-cause and cancer-specific survival rates were similar after diagnosis with rectal cancer (HR, 1.05; 95% CI, 0.95 to 1.16), small-cell lung cancer

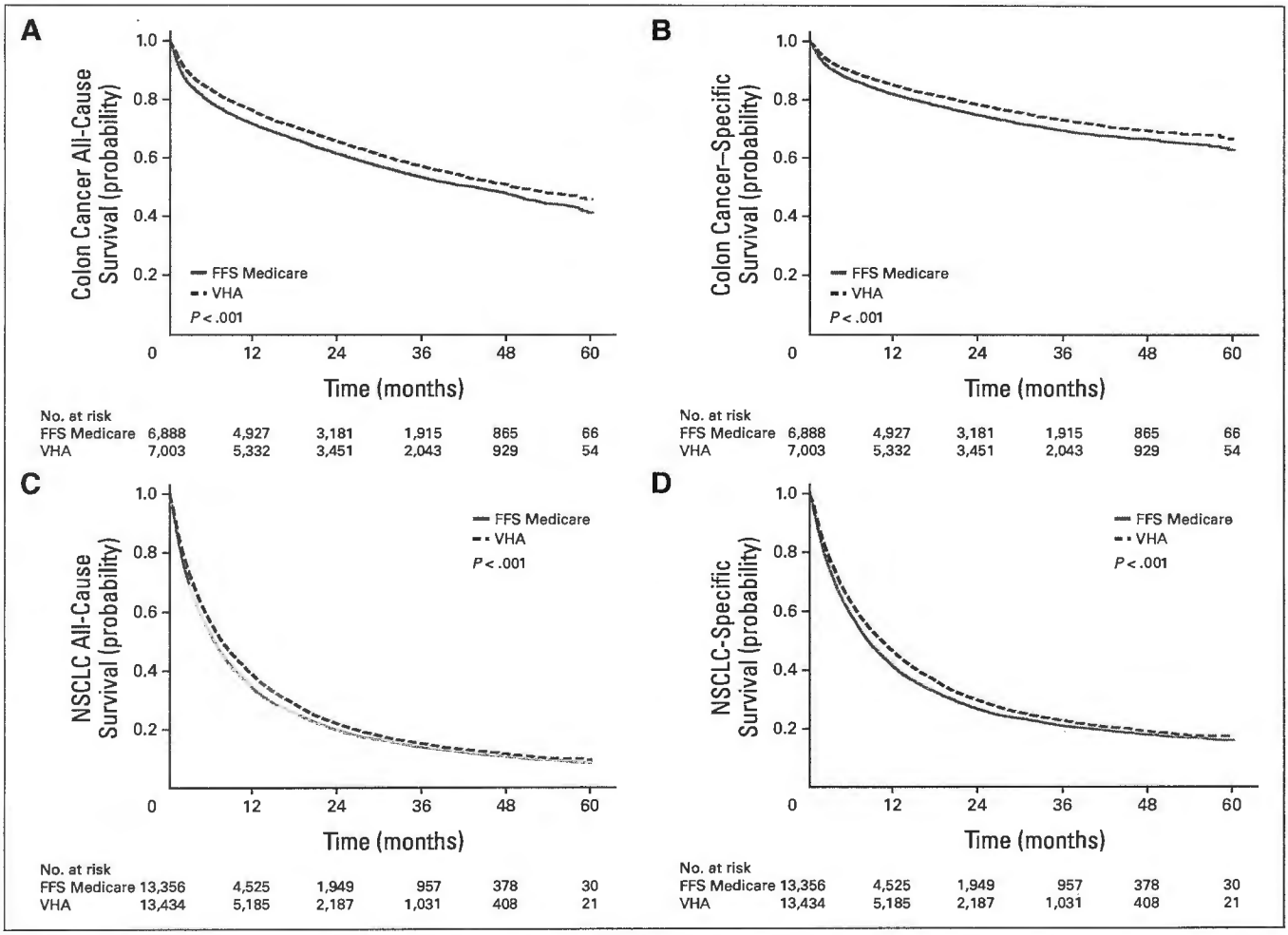

Fig 1. All-cause and cancer-specific mortality. Kaplan-Meier survival curves in Veterans Health Administration (VHA) and fee-for-service (FFS) –Medicare patients are shown. Curves were adjusted by using standardized mortality ratio (SMR) propensity weights. SMR-weighted effects estimate survival rates that a typical VHA patient would experience under FFS Medicare. (A) All-cause survival rates in patients with colon cancer. Adjusted median survival was 49 months in VHA patients versus 43 months in FFS-Medicare patients. (B) Cancer-specific survival rates in patients with colon cancer. (C) All-cause survival rates in patients with non–small-cell lung cancer (NSCLC). The adjusted median survival was 8 months in VHA patients versus 6 months in FFS-Medicare patients. (D) Cancer-specific survival rates in patients with NSCLC.

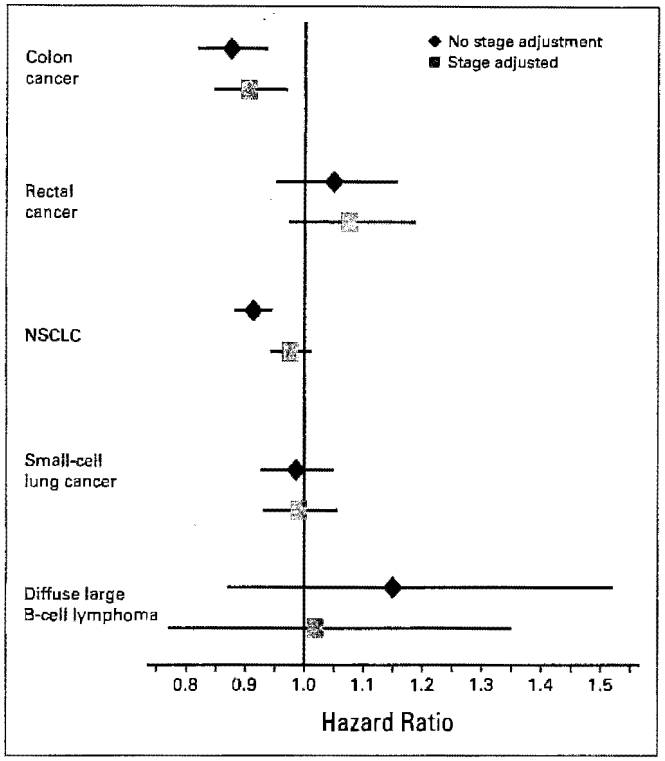

Fig 2. Adjusted hazard ratios (95% CIs) of death in Veterans Health Administration (VHA) versus fee-for-service (FFS)–Medicare patients with cancer with and without adjustment for the stage at diagnosis. Values were adjusted by using a Cox proportional hazard model with standardized mortality ratio (SMR) propensity weights. SMR-weighted effects estimated the survival rate that a typical VHA patient would have experienced in FFS Medicare. Blue diamonds depict hazard ratios that were adjusted only for sociodemographic characteristics and comorbidity. Gold squares depict hazard ratios when the stage and tumor size were also included in the propensity score model. NSCLC, non–small-cell lung cancer.

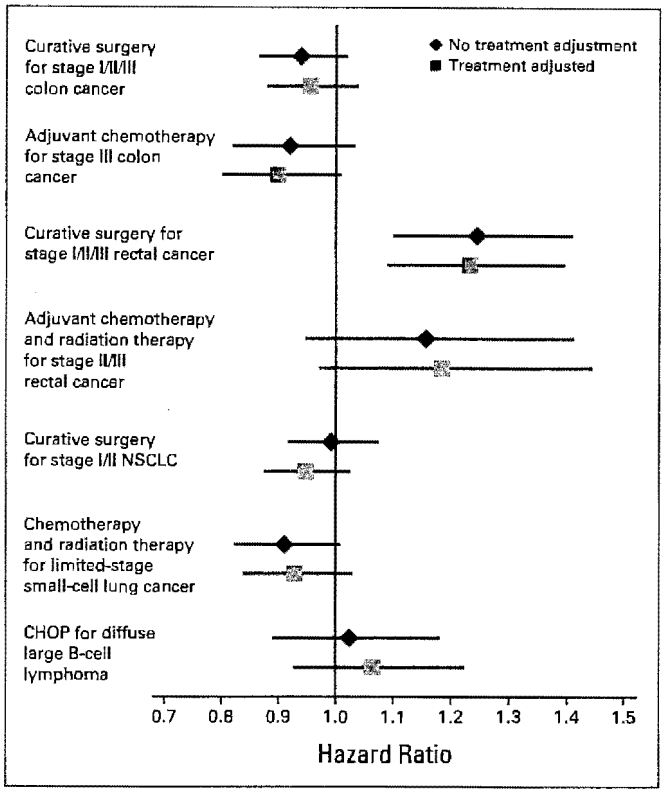

Fig 3. Adjusted hazard ratios (95% CIs) of death in Veterans Health Administration (VHA) versus fee-for-service (FFS)–Medicare patients with cancer with and without adjustment for receipt of guideline-recommended therapy. Values were adjusted by using a Cox proportional hazard model with standardized mortality ratio (SMR) propensity weights. SMR-weighted effects estimated the survival rate that a typical VHA patient would have experienced in FFS Medicare. Blue diamonds depict hazard ratios that were adjusted for sociodemographic characteristics, comorbidity, tumor size, and stage at diagnosis. Gold squares depict hazard ratios when receipt of therapy was also included in the propensity score model. CHOP, cyclophosphamide, doxorubicin, vincristine, and prednisone; NSCLC, non–small-cell lung cancer.

(HR, 0.99; 95% CI, 0.93 to 1.05), diffuse large B-cell lymphoma (HR, 1.02; 95% CI, 0.89 to 1.18), and multiple myeloma (HR, 0.92; 95% CI, 0.83 to 1.03).

VHA patients with colon and NSCLC were diagnosed at earlier stages and with smaller tumors than FFS-Medicare patients (Table 1). An earlier stage at diagnosis explained almost all of the survival advantage in NSCLC patients (Fig 2). Among patients diagnosed at equivalent stages and with similar tumor sizes, the hazard of death was 2% lower (adjusted HR, 0.98; 95% CI, 0.94 to 1.01) in VHA versus FFS-Medicare patients versus 9% lower (adjusted HR, 0.91; 95% CI, 0.88 to 0.94) in cohorts with similar sociodemographic characteristics but without adjustment for stage and tumor size. Accounting for an earlier stage of diagnosis also decreased the survival differences among patients with colon cancer, but even among patients with a similar stage and tumor size, VHA patients had significantly better all-cause (adjusted HR, 0.90; 95% CI, 0.85 to 0.97) and cancer-specific survival rates. Differences in the stage at diagnosis and tumor size shifted the estimated HR among patients with rectal cancer, but larger CIs associated with the smaller number of patients with rectal cancer resulted in a substantial overlap in estimates with and without adjustment for stage. In addition, although in 2004 (the only year in which stage data were available), patients with diffuse large B-cell lymphoma in the VHA were diagnosed at later stages than Medicare FFS, small sample sizes precluded our ability to understand whether such differences affected survival rates in the two settings.

We observed few differences in survival rates between VHA and FFS-Medicare patients among stage-specific cohorts eligible for receipt of specific therapies, with the exception of stages I to III rectal cancer, in which we observed worse survival rates in VHA relative to FFS-Medicare patients (Fig 3). We previously observed similar rates of guideline-recommended therapies in VHA patients compared with similar FFS-Medicare patients for most treatments and higher rates for some treatments.[4] When differences in the use of effective therapies between VHA and FFS-Medicare patients were controlled for, there were small impacts on survival differences (Fig 3).

In sensitivity analyses to evaluate whether unmeasured variables might confound survival differences between VHA and FFS-Medicare patients, we found that adjustment for performance status and severe comorbidity could alter conclusions about survival differences in the two systems (Table 2). For example, when observed characteristics were controlled for, we estimated that patients with small-cell lung cancer in the VHA had similar survival rates compared with FFS-Medicare patients. If we could have also controlled for the severity of

Table 2. Hazard Ratios After Propensity Score Adjustment and Additional Adjustment for Potential Unobserved Variables

	ECOG Performance Status ≥ 2	Severe Comorbidity*	College Education	Current Smoker
Prevalence of unobserved confounder in VHA, %	17[32]	45 for lung and 30 for hematology and colorectal†	17[35]	19[35]
Prevalence of unobserved confounder in FFS Medicare, %	9[32]	28 for lung and 18 for hematology and colorectal[33,34]	23[35]	16[35]
Effect on survival, hazard ratio	2.0[28,32]	2.5[29]	0.75[30]	1.25[31]

	Death in FFS Medicare Relative to VHA With Adjustment for Observed Covariates		Accounting for Differences in Performance Status		Accounting for Differences in Severe Comorbidity		Accounting for Differences in Education		Accounting for Differences in Smoking Status	
	Adjusted Hazard Ratio	95% CI	Adjusted Hazard Ratio	95% CI	Adjusted Hazard Ratio	95% CI	Adjusted Hazard Ratio	95% CI	Adjusted Hazard Ratio	95% CI
Colon cancer	**0.87**	**0.82 to 0.93**	**0.82**	**0.77 to 0.88**	**0.77**	**0.72 to 0.82**	**0.86**	**0.81 to 0.92**	**0.87**	**0.81 to 0.93**
Rectal cancer	1.05	0.95 to 1.16	0.98	0.89 to 1.08	0.92	0.83 to 1.01	1.03	0.94 to 1.14	1.04	0.94 to 1.15
NSCLC	**0.91**	**0.88 to 0.95**	**0.86**	**0.83 to 0.89**	**0.77**	**0.75 to 0.80**	**0.90**	**0.87 to 0.93**	**0.91**	**0.87 to 0.94**
Small-cell lung cancer	0.99	0.93 to 1.05	**0.92**	**0.87 to 0.98**	**0.84**	**0.79 to 0.89**	0.97	0.91 to 1.03	0.98	0.92 to 1.04
Diffuse large B-cell lymphoma	1.02	0.89 to 1.18	0.96	0.84 to 1.10	0.90	0.78 to 1.03	1.01	0.88 to 1.16	1.02	0.88 to 1.17
Multiple myeloma	0.92	0.83 to 1.03	**0.87**	**0.78 to 0.97**	**0.81**	**0.73 to 0.90**	0.91	0.82 to 1.02	0.92	0.82 to 1.02

NOTE. Values < 1 reflect better survival in VHA. Values > 1 reflect better survival in FFS Medicare. Bold values were statistically significant at $P < .05$.
Abbreviations: ECOG, Eastern Cooperative Oncology Group; FFS, fee-for-service; NSCLC, non–small-cell lung cancer; VHA, Veterans Health Administration.
*Measured on the basis of the Adult Comorbidity Evaluation–27 from medical record abstraction or presence of severe chronic obstructive pulmonary disease (forced expiratory volume < 0.75) for patients with lung cancer.
†On the basis of medical record abstraction for a subset of VHA patients with colorectal cancer or NSCLC.

comorbidity, we estimated that we would have observed a 16% lower hazard of death among VHA patients. Adjustment for differences in college education and smoking status had smaller effects.

DISCUSSION

In this large study of survival rates in veterans diagnosed with or treated for cancer in the VHA versus FFS-Medicare patients, we found similar or better survival rates in all six cohorts studied. Diagnosis at earlier stages explained much of the survival advantage in patients with colon cancer and NSCLC.

Although there is growing evidence that the VHA provides excellent preventive and chronic care, few studies have demonstrated improved patient outcomes associated with such care. Our finding of improved colon cancer outcomes in the VHA suggest that the success of the VHA with cancer screening[3] and an earlier stage at diagnosis[4] is associated with improved colon cancer outcomes. Although we expected similar benefits from cancer screening in rectal cancer, we did not observe improved cancer outcomes in patients with rectal cancer. With smaller cohorts and lower survival rates for rectal versus colon cancer, we may have had a low statistical power to detect benefits associated with earlier detection. However, we also observed worse survival rates in patients with early-stage rectal cancer in the VHA versus FFS Medicare. Treatment for rectal cancer is more complex than for colon cancer and requires more careful integration of radiation, surgery, and chemotherapy, and the volume-outcome relationship is stronger for the more technically demanding rectal versus colon surgery.[36] With the more complex treatment, there may be more opportunity for a delay and interruption of treatment in VHA patients with other comorbidity than there is in colon cancer.

We also observed better survival rates after diagnosis with NSCLC in VHA compared with FFS-Medicare patients that was largely explained by the earlier stage at diagnosis. Better follow-up and coordination of care for patients with lung disease in the VHA may have led to an increased detection of early-stage lung cancer. However, although recent evidence on screening with computed tomography is promising,[37] no screening modality has previously been shown to reduce lung cancer mortality. The survival advantage we observed among patients diagnosed with lung cancer in our study may have resulted from an overdiagnosis bias associated with an incidental detection of indolent disease or a lead time bias from an earlier detection of cancers that would have eventually been diagnosed clinically. Our sensitivity analyses shed light on why previous work has not consistently demonstrated a link between an improved quality of care and better patient outcomes in the VHA. VHA patients are economically disadvantaged and have high levels of comorbidity.[38-40] Differences between VHA and non-VHA patients are difficult to adjust for in observational studies because information is typically lacking in available databases. Our sensitivity analyses suggested that these factors can have substantial effects on outcome differences.

We found that differential rates of guideline-recommended therapies had little impact on survival differences. We previously observed higher rates of cyclophosphamide, doxorubicin, vincristine, and prednisone chemotherapy in patients with diffuse large–B-cell lymphoma[4] that would be expected to led to improved survival rates.[20] However, patients with diffuse large–B-cell lymphoma were diagnosed at later

stages in the VHA. We were not able to adjust for these differences because stage data were only collected in the final year of our study.

The strengths of our study included large samples of patients with six cancers and the use of statistical analyses to identify FFS-Medicare patients most similar to VHA patients. However, our study had some limitations. First, FFS-Medicare patients are typically cared for in heterogeneous settings rather than in an integrated delivery system like the VHA. Quality and outcomes may be better in Medicare Advantage patients or in other more integrated systems with quality monitoring. Second, we could not control for many potential confounders, although we performed extensive sensitivity analyses to address this limitation. Third, we matched patients on the basis of characteristics observed at the time of diagnosis, including comorbidity. If care before cancer diagnosis in the VHA system led to better (or worse) noncancer health, this analysis may have understated (or overstated) the impact of VHA care on survival rates after a cancer diagnosis. Fourth, our analyses that tested the sensitivity of our findings to unobserved confounders were based on data from other populations and should be considered exploratory. Fifth, we estimated the impact of the receipt VHA care in a population of typical VHA patients. Other weighting schemes that estimate the impact of VHA treatment on the general population could lead to other conclusions, particularly if VHA treatment is tailored to the VHA population. However, the ability of the VHA to tailor to this unique population has important policy relevance. Finally, with 1 to 5 years of follow-up, we were limited in our ability to assess long-term outcomes. Nevertheless, mortality rates were high for most of the diseases studied.

In conclusion, we found that survival rates for VHA patients with cancer are equivalent to or better than the survival rates of similar patients treated under FFS Medicare. Importantly, improved survival rates in colon cancer appeared to be mediated by earlier stages at cancer diagnosis, which is a finding that was likely related to improved preventive care in the VHA compared with FFS Medicare. Because these findings may reflect the positive effects of an integrated, coordinated system of care on outcomes for a complex patient population, the VHA system might serve as a model for care delivery as health care reform is implemented.[41] Our sensitivity analyses highlight the importance of factors that are not typically available in administrative data. Future studies that compared outcomes between VHA and non-VHA patients should collect data on disease severity, performance status, health behaviors, and socioeconomic status.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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REFERENCES

1. Asch SM, McGlynn EA, Hogan MM, et al: Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. Ann Intern Med 141:938-945, 2004
2. Jha AK, Perlin JB, Kizer KW, et al: Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. N Engl J Med 348:2218-2227, 2003
3. Trivedi AN, Matula S, Miake-Lye I, et al: Systematic review: Comparison of the quality of medical care in Veterans Affairs and non-Veterans Affairs settings. Med Care 49:76-88, 2011
4. Keating NL, Landrum MB, Lamont EB, et al: Quality of cancer care for older cancer patients in the Veterans Health Administration versus the private sector: A cohort study. Ann Intern Med 154: 727-736, 2011
5. Jackson GL, Melton LD, Abbott DH, et al: Quality of nonmetastatic colorectal cancer care in the Department of Veterans Affairs. J Clin Oncol 28:3176-3181, 2010
6. Landrum MB, Guadagnoli E, Zummo R, et al: Care following acute myocardial infarction in the Veterans Health Administration: A comparison with Medicare. Health Serv Res 39:1773-1792, 2004
7. Petersen LA, Normand SL, Daley J, et al: Outcome of myocardial infarction in Veterans Health Administration patients as compared with Medicare patients. N Engl J Med 343:1934-1941, 2000
8. Petersen LA, Normand SL; Leape LL, et al: Regionalization and the underuse of angiography in the Veterans Affairs Health Care System as compared with a fee-for-service system. N Engl J Med 348:2209-2217, 2003
9. Ashton CM, Souchek J, Petersen NJ, et al: Hospital use and survival among Veterans Affairs beneficiaries. N Engl J Med 349:1637-1646, 2003
10. Hynes DM, Koelling K, Stroupe K, et al: Veterans' access to and use of Medicare and Veterans Affairs health care. Med Care 45:214-223, 2007
11. Fleming C, Fisher ES, Chang CH, et al: Studying outcomes and hospital utilization in the elderly: The advantages of a merged data base for Medicare and Veterans Affairs hospitals. Med Care 30:377-391, 1992
12. Potosky AL, Riley GF, Lubitz JD, et al: Potential for cancer related health services research using a linked Medicare-tumor registry database. Med Care 31:732-748, 1993
13. Ries LA, Wingo PA, Miller DS, et al: The annual report to the nation on the status of cancer, 1973-1997, with a special section on colorectal cancer. Cancer 88:2398-2424, 2000
14. American Joint Committee on Cancer: Collaborative stage data collection system. http://www.cancerstaging.org/cstage/
15. National Comprehensive Cancer Network: Clinical Practice Guidelines in Oncology: Colon cancer. Version 1.2001, 2001
16. National Comprehensive Cancer Network: Clinical Practice Guidelines in Oncology: Rectal cancer. Version 1.2001, 2001
17. National Comprehensive Cancer Network: Clinical Practice Guidelines in Oncology: Lung cancer. Version 1.2001, 2001
18. National Comprehensive Cancer Network: Clinical Practice Guidelines in Oncology: Multiple myeloma cancer. Version 1.2001, 2001
19. Laurie SA, Logan D, Markman BR, et al: Practice guideline for the role of combination chemotherapy in the initial management of limited-stage small-cell lung cancer. Lung Cancer 43:223-240, 2004
20. Fisher RI, Gaynor ER, Dahlberg S, et al: Comparison of a standard regimen (CHOP) with three intensive chemotherapy regimens for advanced non-Hodgkin's lymphoma. N Engl J Med 328:1002-1006, 1993
21. Charlson ME, Pompei P, Ales KL, et al: A new method of classifying prognostic comorbidity in longitudinal studies: Development and validation. J Chronic Dis 40:373-383, 1987

22. Klabunde CN, Potosky AL, Legler JM, et al: Development of a comorbidity index using physician claims data. J Clin Epidemiol 53:1258-1267, 2000

23. D'Agostino RB Jr: Propensity score methods for bias reduction in the comparison of a treatment to a non-randomized control group. Stat Med 17: 2265-2281, 1998

24. Rosenbaum PR, Rubin DB: Reducing bias in observational studies using subclassification on the propensity score. J American Stat Assoc 79:516-524, 1984

25. Kurth T, Walker AM, Glynn RJ, et al: Results of multivariable logistic regression, propensity matching, propensity adjustment, and propensity-based weighting under conditions of nonuniform effect. Am J Epidemiol 163:262-270, 2006

26. Sato T, Matsuyama Y: Marginal structural models as a tool for standardization. Epidemiology 14:680-686, 2003

27. Lin DY, Psaty BM, Kronmal RA: Assessing the sensitivity of regression results to unmeasured confounders in observational studies. Biometrics 54: 948-963, 1998

28. Lamont EB, Hayreh D, Pickett KE, et al: Is patient travel distance associated with survival on phase II clinical trials in oncology? J Natl Cancer Inst 95:1370-1375, 2003

29. Piccirillo JF, Tierney RM, Costas I, et al: Prognostic importance of comorbidity in a hospital-based cancer registry. JAMA 291:2441-2447, 2004

30. Stavraky KM, Skillings JR, Stitt LW, et al: The effect of socioeconomic status on the long-term outcome of cancer. J Clin Epidemiol 49: 1155-1160, 1996

31. Jackson NA, Fuchs CS, Niedzwiecki D, et al: The impact of smoking on cancer recurrence and survival in patients with stage III colon cancer: Findings from intergroup trial CALGB 89803. J Clin Oncol 26:187s 2008 (suppl; abstr 4039)

32. Lamont EB, Landrum MB, Keating NL, et al: Differences in clinical trial patient attributes and outcomes according to enrollment setting. J Clin Oncol 28:215-221, 2010

33. Kahn KL, Adams JL, Weeks JC, et al: Adjuvant chemotherapy use and adverse events among older patients with stage III colon cancer. JAMA 303:1037-1045, 2010

34. Chrischilles EA, Pendergast JF, Kahn KL, et al: Adverse events among the elderly receiving chemotherapy for advanced non-small-cell lung cancer. J Clin Oncol 28:620-627, 2010

35. Klevens RM, Giovino GA, Peddicord JP, et al: The association between veteran status and cigarette-smoking behaviors. Am J Prev Med 11: 245-250, 1995

36. Rabeneck L, Davila JA, Thompson M, et al: Surgical volume and long-term survival following surgery for colorectal cancer in the Veterans Affairs Health-Care System. Am J Gastroenterol 99:668-675, 2004

37. National Lung Screening Trial Research Team, Aberle DR, Adams AM, et al: Reduced lung-cancer mortality with low-dose computed tomographic screening. N Engl J Med 365:395-409, 2011

38. Agha Z, Lofgren RP, VanRuiswyk JV, et al: Are patients at Veterans Affairs medical centers sicker? A comparative analysis of health status and medical resource use. Arch Intern Med 160:3252-3257, 2000

39. Kazis LE, Miller DR, Clark J, et al: Health-related quality of life in patients served by the Department of Veterans Affairs: Results from the Veterans Health Study. Arch Intern Med 158:626-632, 1998

40. Selim AJ, Berlowitz DR, Fincke G, et al: The health status of elderly veteran enrollees in the Veterans Health Administration. J Am Geriatr Soc 52:1271-1276, 2004

41. Ryoo JJ, Malin JL: Reconsidering the Veterans Health Administration: A model and a moment for publicly funded health care delivery. Ann Intern Med 154:772-773, 2011

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EDITORIALS

True Patriotism: A Generation of Commitment to Quality in the Veterans Health Administration

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Americans owe their freedom and prosperity to the millions of men and women who have served in our armed forces. We show our commitment and support for veterans in part by providing lifetime medical care. The system to provide this care, the Veterans Health Administration (VHA), is the largest integrated care delivery system in the United States. However, there has historically been concern that the system did not adequately address the needs of veterans and that the quality of care provided was compromised, leaving those who deserve the best with lower quality care than those they served.

Recognizing this concern, the VHA embarked on a transformation during the last 25 years from a hospital-based care system to a comprehensive integrated care delivery system committed to quality.[1,2] As early as the 1980s, the VHA developed a program to reduce surgical complications—the National Surgical Quality Improvement Program—that has now been adopted in the private sector with the potential for saving tens of thousands of lives each year.[3] These efforts evolved in 1998 into an ambitious program termed the Quality Enhancement Research Initiative (QUERI). QUERI combines quality research and active quality improvement with the aim to build continuous performance measurement and quality improvement into the VHA's management and care systems.[4] An increasing body of literature demonstrates improvement in care in the VHA.[5] Indeed, the VHA may now be ahead of the private sector in quality improvement.[6]

Although colorectal cancer has been one of the target conditions in QUERI, the program's primary focus has been on chronic conditions. Specifically, system improvements have led to higher rates of use of preventive and screening services that may be expected to impact downstream outcome. Identifying appropriate outcome measures is difficult and quality measurement in the VA and other systems has largely focused on concordance of care with key process measures.[6] In general, and specifically in cancer care, demonstration that quality leads to improvement in the primary outcome of survival has been an elusive target.

In the article that accompanies this editorial, Landrum et al[7] present an elegant study that demonstrates that survival from cancer for those treated in the VHA is the same or better than that for persons treated in the private sector. They conclude that this may be a consequence of quality improvement in the VHA. Landrum et al evaluated the survival of older patients with cancer treated in the VHA system. The study examined all-cause and cancer-specific survival for colorectal and lung cancer, lymphoma, and myeloma in men older than age 65 years treated in VHA hospitals from 2001 to 2004. This was compared with older men treated in fee-for-service Medicare by using the linked SEER-Medicare claims file. Overall, at a median follow-up of 3 years, the observed all-cause survival and cancer-specific survival for VHA patients was better for colon cancer and non–small-cell cancer (NSCLC), although not for rectal cancer, small-cell lung cancer, B-cell lymphoma, or myeloma. Those treated in the VHA presented with cancer at what was an earlier stage on average than those in the fee-for-service Medicare system. Adjustment for stage accounted for the survival advantage for NSCLC but not fully for colon cancer. A more significant effect on survival was seen when rates of survival were adjusted for estimated rates of unobserved variables. Most notable were projected higher rates of poor performance status and severe comorbidity in the VHA patients. With these adjustments, the results predict that survival would be better with odds ratios ranging as low as 0.76 for colon cancer with significant improvements with adjustment for at least one factor in colon cancer, rectal cancer, NSCLC, small-cell cancer, and myeloma.

The authors[7] conclude that the observed survivals may result from attention to the processes of care in the VHA related to cancer screening and prevention. They cite data that these efforts have led to higher screening rates than observed in many parts of the private sector. Unfortunately, despite the importance of their findings, the cause and effect they seek cannot be defined by these data. In addition, they examined the concordance of care with standard guidelines as defined by receipt of stage-appropriate treatment. Such assessment is currently the focus of process measures used for quality evaluation by using measures approved by the National Quality Forum.[8] Interestingly, there was essentially no relationship between survival and receipt of stage-appropriate therapy, further calling into question the use of these data in identifying the causal relationship between concordance with accepted processes of care and outcome.

Beyond the findings related to the high-quality outcomes for men treated in the VHA, this study highlights the difficulty and complexity of such comparative outcomes evaluation and provides key lessons to those of us looking to understand causal effects of cancer treatment in the field of outcomes and comparative effectiveness research. In this example, simply reporting raw survival data or stage-specific survival data, although attractive and potentially intuitive to the public, would have led to erroneous conclusions.[9] Other factors, most notably differences in the general health of the cohorts, may have profound effects on survival. In this case, the investigators faced the specific challenge of accounting for differences in the study

population—those who receive care at the VHA tend to be socioeconomically disadvantaged and in worse general health compared with the general population—in a setting in which they did not have a standardized data collection system to provide equivalent data on the VHA and SEER cohorts. Landrum et al[7] used a rigorous statistical methodology to adjust for these differences and to account for confounders that are not available on either cohort. The methodology is of sufficient complexity that I was convinced upon first reading that this study was another example of what my father said, "You can prove anything with statistics." However, the complexity of the questions required complex solutions, and on careful review, the methods are elegant and revealing. Briefly, the frequency and degree of confounders were estimated from unrelated published studies. For example, the frequency of severe comorbidity was estimated from chart abstraction for VHA patients and from published data from the Cancer Care Outcomes Research and Surveillance Consortium (CanCORS) study for Medicare patients. The reader is urged to examine these methods closely for themselves in assessing the significance of these findings.

The desire to speed advances in cancer and other health care, the relatively long time to identify and answer questions in clinical trials, and the concern that persons treated on clinical trials may not be representative, has led to a call to use real-world data to evaluate health care and outcomes. Such studies face many pitfalls in addressing differences between study populations, or between those who receive one treatment compared with another. The group led by Landrum[7] certainly fully understands these issues. The group is a top-notch multidisciplinary academic team that strived mightily to overcome these barriers. Yet, they still cannot fully answer the deceptively simple question of whether improved concordance with key processes of care leads to improved survival for those treated in the VHA compared with those in private sector Medicare. That such a group, using the rigorous data sets and methods available, still has such problems highlights the challenges that face those conducting and interpreting comparative effectiveness research.

Finally, despite these concerns, this study[7] documents the real progress made by the VHA in improving the care and outcomes for American veterans. The VHA has exhibited the key commitments needed to achieve these goals. The transformation has leadership and vision from the top of the organization. They have instilled this vision in collaboration with all those who work in the VHA. They have engaged leading health services, management, and behavioral researchers to identify and act on opportunities for improvement. They are in this for the long-term. Indeed, their example of quality improvement has provided key programs that have translated into successful programs in the private sector. Certainly there have been and, with the current budgetary situation, will continue to be bumps in the road. Patriotism is best measured by unbending service to our nation. Given the noble mission of serving our nation's finest, my hat is off to those true patriots throughout the VHA for their dedicated and now documented successful service to our veterans with cancer.

AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

REFERENCES

1. Fuessner JR, Kizer KW, Demakis JG: The Quality Enhancement Research Initiative (QUERI): From evidence to action. Med Care 38:I1–I6, 2000 (suppl 1)

2. Ashton CM, Souchek J, Petersen NJ, et al: Hospital use and survival among Veterans Affairs beneficiaries. N Engl J Med 349:1637-1646, 2003

3. Stremple JF: The historical evolution of the Department of Veteran Affairs National Surgical Quality Improvement Program. J Am Coll Surg 213:567-571, 2011

4. Kizer KW, Demakis JG, Feussner JR: Reinventing VA health care: Systemizing quality improvement and quality innovation. Med Care 38:I7-I16, 2000 (suppl 1)

5. Stetler CB, Mittman BS, Francis J: Overview of the VA Quality Enhancement Research Initiative (QUERI) and QUERI theme articles: QUERI series. Implement Sci 3:8, 2008

6. Asch SM, McGlynn EA, Hogan MM, et al: Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. Ann Intern Med 141:938-945, 2004

7. Landrum MB, Keating NL, Lamont EB, et al: Survival of older patients with cancer in the Veterans Health Administration versus fee-for-service Medicare. J Clin Oncol doi: 10.1200/JCO.2011.35.6758

8. Desch CE, McNiff KK, Schneider EC, et al: American Society of Clinical Oncology/National Comprehensive Cancer Network Quality Measures. J Clin Oncol 26:3631-3637, 2008

9. Berry D: Cancer centers publishing comparative survival data. The Cancer Letter 37:7-10, 2011

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Generic (Brand) Name	Withdrawal Date	Reason for Withdrawal	Ever on VANF?	Date Added to VANF	Date Removed from VANF
Aprotinin (Trasylol)	2007	Increased risk of complications or death	Y	Aug-2006	Aug-2008
Astemizole (Hismanal)	1999	Arrhythmias because of interactions with other drugs	N		
Bromfenac (Duract)	1998	Safety reasons	N		
Cerivastatin (Baycol, Lipobay)	2001	Risk of rhabdomyolysis	N		
Cisapride (Propulsid)	2000	Risk of cardiac arrhythmias	N		
Dexfenfluramine (Redux)	1997	Caused heart valve disorder	N		
Drotrecogin alfa (Xigris)	2011	Lack of efficacy	N		
Efalizumab (Raptiva)	2009	Increased risk of progressive multifocal leukoencephalopathy	N		
Etretinate (Tegison)	1999	Risk of birth defects	N		
Fanolesomab (Technetium)	2005	Safety reasons	N		
Fenfluramine (Fen-Phen)	1997	Caused heart valve disorder	N		
Gatifloxacin (Tequin)	2006	Safety reasons	Y	Feb-2004	Mar-2006
Gemtuzumab ozogamicin (Mylotarg)	2010	Increased risks of veno-occlusive disease and no benefit in acute myeloid leukemia (AML)	N		
Grepafloxacin (Raxar)	1999	Prolonged QT interval	N		
Hydromorphone ER (Palladone)	2005	High risk of accidental overdose when administered with alcohol	N		
Inhaled insulin (Exubera)	2007	Safety reasons	N		
Levamisole (Ergamisol)	1999	Agranulocytosis	N		
Levomethadyl acetate (Orlaam)	2003	Safety reasons	N		
Mibefradil (Posicor)	1998	Dangerous interactions with other drugs	N		
Pemoline (Cylert)	2005	Hepatotoxicity	N		
Pergolide (Permax)	2007	Risk of heart valve damage	N		
Propoxyphene (Darvocet/Darvon)	2010	Increased risk of heart attacks and stroke	N		
Rapacuronium (Raplon)	2001	Risk of fatal bronchospasm	N		
Rofecoxib (Vioxx)	2004	Risk of myocardial infarction	N		
Sertindole (Serelect)	1998	Safety reasons	N		
Sibutramine (Reductil/Meridia)	2010	Increased cardiovascular risk	N		
Tegaserod (Zelnorm)	2007	Imbalance of cardiovascular ischemic events, including heart attack and stroke	N		
Terfenadine (Seldane, Triludan)	1998	Risk of cardiac arrhythmias; superseded by fexofenadine	N		
Troglitazone (Rezulin)	2000	Risk of hepatotoxicity	N		
Trovafloxacin (Trovan)	2002	Risk of liver failure	N		
Valdecoxib (Bextra)	2005	Concerns about heart attack and stroke.	N		

Questions for the Record
House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Oversight Hearing
"VA and Human Tissue: Improvements Needed for Veterans Safety"

April 2, 2014

Questions for the Record from Subcommittee Chairman Mike Coffman

Question 1: According to GAO, VA plans to fund further development of the Veterans Implant Tracking and Alert System (VITAS) in FY2014. Why then did VA not specifically ask for funding in its budget for FY 2014, FY 2015, or its advanced appropriations from FY 2016?

VA Response: VA determines which information technology (IT) projects will receive funding using a process where administrations and staff offices prioritize IT needs. During this prioritization process for Fiscal Year (FY) 2014 and FY 2015, the Veterans Implant Tracking and Alert System (VITAS) was prioritized below other funding requests, which prevented it from receiving funding through the initial budget process. However, VA allocates funding to unfunded projects as funds become available throughout the fiscal year.

Because the effort to build VITAS is an IT development project, it would be funded out of the Office of Information and Technology account, and it would not have been part of VA's FY 2016 advanced appropriations for the medical care account.

Question 2: What further development does VA have planned to utilize VITAS, and what funding will be requested to implement it, aside from the initial $750,000 requested in the 2013 budget?

VA Response: Should additional enhancements be required, VA will again consider VITAS funding with other competing priorities.

Question 3: According to GAO's testimony, VAMCs rely on product vendors to provide information on what facilities have received recalled biologics. Why does VHA not make an independent assessment?

VA Response: In nearly all cases of a recalled biologic product, the vendor for the product initiates the recall as a voluntary action with the knowledge of the Food and Drug Administration (FDA). When a vendor initiates a voluntary recall, they are required to complete a recall form and report to FDA if the product was sold to a Government agency, including VA. Therefore, the vendor of a biologic is the primary and early source for data linking a recall to a VA facility that potentially purchased a specific recalled product.

The vendor initiates a voluntary recall action by directing a letter to their affected customers, including affected VA facilities, to notify them of a recall. The vendor provides instructions on how to remove the product from use, issues a refund or replacement of the product, and requests acknowledgement of removal from inventory stock by the facility.

The Veterans Health Administration centralized the management of the recall process for all VA facilities in 2008 through the creation of the Product Recall Office (PRO), located within the VA National Center for Patient Safety (NCPS). The PRO posts recall notices with follow-up actions required by VA facilities for products known or likely to be available throughout VA's 150 medical centers and affiliates to remove the product from use. The PRO requires acknowledgement of actions taken and monitors compliance and completion of all follow-up actions related to the recall.

The PRO also independently assesses all recalls that potentially affect VA facilities. This is done through direct contact with the vendor and review of early notification of the recall provided by the Defense Logistics Agency or FDA. The PRO also reviews any information available about a recall from the FDA, vendor, or the facility. This independent review is completed by the PRO for VHA to determine if VA facilities are affected by a recall, and if so, how many and which ones require follow-up action.

If the PRO is able to determine which VA facilities are potentially affected, a recall notice is posted to target these facilities for required actions. If the PRO is unable to adequately determine impact and scope to VA, the PRO posts a recall to all VA facilities for required actions. If the impact of a recall requires clinical review, the PRO triages this for clinical investigation by subject matter experts. There are also instances in which the PRO assesses the recall and takes actions beyond those recommended by the manufacturer or FDA.

Question 4: According to GAO, VA does not conduct any oversight of whether VAMCs are checking for implanted tissue that has been recalled. How does VA plan to address this problem?

VA Response: VA is developing a national implant registry to provide a searchable database that links acquisition item details for a biologic to the patient's clinical record, ensuring traceability to the source of the biologic or biologic implant. The national implant registry will provide VHA with a standardized process to effectively track and manage recalled biologic implants across all VA facilities.

While the registry will standardize and potentially expedite the process of identifying patients, the process used to determine what clinical actions are needed will remain similar to the current process. Subject matter experts will be engaged to determine what clinical care is required for potentially-affected patients with an implant. If needed, a patient safety alert or advisory will be issued, and all alerts and advisories will be tracked according to the current process to ensure the facility closes out the required actions.

Question 5: If a biological implant, such as a skin graft, is recalled how does VA know that VAMCs have checked if this product has been used either in the surgery or outpatient setting?

VA Response: The data to track a recalled biologic implant to a patient currently exist and are available to VA facilities today, although not in an easily accessible format. The national implant registry will contain historical records, as well as new records to ensure VA facilities have a standardized method to check if a recalled product has been used in the care of a patient at VA.

Question 6: What is the time frame VA has established to address the concerns regarding the accurate accounting for and identification of all biologics in VAMC inventories to ensure no contaminated, expired, or recalled items remain? Also, please explain what steps will be taken at each point throughout that time.

VA Response: Patient safety recalls are all acted upon promptly when a patient safety alert is triggered. Each VA medical center is required to review its inventory to determine if any of the recalled items are stocked, and, if so, those items are subsequently pulled from inventory. Timelines for facility actions and reporting milestones are set for the specific recall action. VA has identified 13 product recalls in biologics and human tissue and 3 of these items were identified in VA inventories. The attached table provides details.

Copy of Final
Biologics Spreadsheet

Question 7: When does VA plan to have the results of its workgroup examining the feasibility of using scanning and tracking technology to automatically upload tissue product information into electronic medical records? Also, when the results are compiled, please provide a digital copy to the Subcommittee.

VA Response: VHA plans to have the results of its workgroup to review in the third quarter of FY 2014. Once results are reviewed and finalized, VA will share them with the Subcommittee.

Question 8: In his testimony, Mr. Matkovsky stated that twenty-two waivers were issued to purchase biologics on the open market in 2013. Please provide the Subcommittee with a digital copy of each of those waivers.

VA Response: Examples of Federal Supply Schedule (FSS) waiver documents are attached. These are images of manual copies. Also, a table listing tracked waivers from FY 2012 and

FY 2013 is attached, which identifies more than 21 waivers that include other product categories.


FSS_Endoscopic_Scopes_2014.pdf


FSS Waiver V2-528-14-001 Saline


Copy of Approved FSS Waiver.xlsx

Question 9: In his testimony, Mr. Matkovsky stated that a waiver is not obtained every time an implant is purchased on the open market. However, according to his May 23, 2012, memorandum, "an Open Market Waiver Request must be submitted through the Chief of Procurement and Logistics Officer to the National Acquisition Center for approval." This memorandum makes submitting a request for a waiver a requirement, so why is a waiver not submitted for every such purchase?

VA Response: VA requires waivers be submitted for purchases that do not utilize national or FSS contracts. Prior to September 30, 2013, these purchases were made by staff members who were not warranted contracting officers. The process for identifying FSS schedule holders is not a simple, straightforward task and involves frontline staff to navigate a complex Web site to perform individual, manual product searches across multiple sets of files. As the purchase authority for items above $3,000 has now transitioned to procurement, quality and consistency reviews will focus on VA's compliance with waiver processes.

Question 10: In his testimony, Mr. Matkovsky stated that a simple verification of whether biological implant vendors were registered with the FDA was important for patient safety. Why then does VA not conduct this simple verification?

VA Response: VA established an Integrated Product Team to develop requirements for a national contract for biological implants and tissue products. VA agrees FDA registration should be part of procurement activities. Please note that regional and/or local contracts are typically either entered into with firms that are certified by the American Association of Tissue Banks (AATB) and/or in possession of an FSS or other Governmentwide contract vehicle. There are certain challenges to using prosthetics purchasing data, which is a reporting database, to draw definitive conclusions about sourcing practices because reporting databases do not always accurately reflect information as to which firms are in possession of a Governmentwide contract vehicle.

For example, the attached table provides a comparison of the top 10 overall biologics firms VHA purchased biological implants from in FY 2012 and FY 2013. In FY 2013, there are data anomalies, but these anomalies point out some of the challenges relative to the conclusions regarding sourcing practices when using only the prosthetics database. The prosthetics database is not a procurement system. Therefore, data entry for a VA contract number is not a mandatory field and is not reliably provided even when the item acquired is on a VA contract. In FY 2013, the following firms and overall

purchase amounts showed up on the top 10 list of firms VA purchased biologics through a Federal contract, although the table does not reflect that these firms have FSS contracts:

796560394 - AVKARE INC	$7,184,067.00
006261481 - MEDTRONIC INC	$1,184,996.00
782796705 - ADVANCED BIOHEALING INC/SHIRE	$1,140,092.00

Taken together, these firms account for over $9.5 million of biological implant purchases that were classified as "open market" - that is, a firm that does not have a Federal contract - however, each of these firms does in fact have an FSS contract. VA provides this example to demonstrate that National Prosthetics Patient Database data are not a reliable source by which to determine findings in connection with a procurement spending audit..

The Committee previously expressed concern regarding the 8 percent of firms that did not have AATB certification (Note: AATB stated that it certifies roughly 92 percent of the market). The concern stated by the Committee is related to whether or not VA increased the likelihood of purchasing biologics from firms that were not AATB certified when it did not purchase off FSS contracts. In reviewing contract histories, VA has identified that open market orders that were not committed to FSS contracts were committed to AATB-certified vendors. It should be noted that firms with FSS contracts are not necessarily AATB-certified vendors. This pattern underscores the need to implement a national contract that contains quality, clinical requirements.

Attachment for
Question 10.pdf

Please provide data on each of these posts, including how VA learned of the recall, impetus for the recalls, date of the recall, recall class, the tissue product type, number of products affected within VA, number of VA medical facilities affected, and confirmations received (e.g., X items removed from inventory).

Attachment A Data search conducted from 7-1-10 through 9-30-13 using the search parameter of Biologic Implant.

Product	Reason for Recall	Source of Recall Information	Recall Type/Class at time of notification	Mfg. Recall Letter Date	Number of facilities with stock removed	Firm/Manufacturer	Facility Reported Product Implant Inventory Removal	Database Posting was Managed	Quantity of Product Included in the Source Document (FDA and/or Company Letter)
Puros Cancellous Particles and Puros Cortical Particles	The plastic tray containing the screw-capped vial of bone particles may not be adequately sealed to ensure sterility through the product's shelf life.	Manufacturer	Voluntary recall	7/21/2010	6	RTI Biologics	N/A	NCPS Recall Database	Company Letter Dated July 21, 2010 states: "All sizes" with no specific quantity of product.
XenMatrix Surgical Graft Rectangular	Testing cannot assure that all the units of the XenMatrix Surgical Graft are within FDA guidelines for endotoxin requirements.	DLA & ECRI	Voluntary recall	1/14/2011	2	Davol, Inc./C.R. Bard, Inc.	N/A	NCPS Recall Database	Company Letter Dated January 6, 2011 states: "Lots beginning with the follow 4 letters: HUFT, HUTJ, HUTJ, HUTK, HUTL, HUUA, HUUB, HUUG, HUUD, HUUE, HUUF, HUUG, HUUH, HUUI, and HUUJ." There is no specific quantity of product provided in the notice.
Strattice Reconstructive Tissue Matrix for Stoma Reinforcement 6x6, 8x8, and 6x10	The use of Strattice for stoma reinforcement at the time of stoma creation is not within the product's cleared indication for use in the US market.	Manufacturer	Voluntary recall	7/12/2011	0	LifeCell, a KCI Company	None.	NCPS Recall Database	Company Letter Dated July 12, 2011 states specific distribution dates and specific expiration dates for each of the product affected by the recall. There is no specific quantity of product provided in the notice.
Human Cornea recall initiated in 2007 was just announced as complete by the FDA on 2/22/2012. The Donor Network of Arizona states that the implanting surgeons were contacted, however, they will neither confirm or deny if any Department of Veterans Affairs facility or patient received this tissue. (Two Batches)	Human Corneas, recovered from a donor with risk factor for relevant communicable disease agents and diseases, were distributed.	FDA	FDA Class II	2/22/2012	0	Donor Network of Arizona	None.	NCPS Recall Database	FDA Enforcement Report Dated February 22, 2012 states: "Units: 070147OD, 070147OS; 2 Corneas." "Units: 070095OD, 070095OS; 2 Corneas."
Medtronic Grafton DBM Putty, Grafton DBM Gel, Grafton DBM Flex, Grafton DBM A FlexTM, Grafton DBM Crunch, Grafton DBM Matrix PLF, Grafton DBM Matrix Strips, Grafton DBM Orthoblend, Grafton Plus DBM Paste, Xpanse R, Expanse S	There is a possibility that sterility of the outer surface of the inner pouch may become comprised.	Manufacturer	Voluntary recall	4/20/2012	7	Medtronic/Medtronic Sofamor Danek	N/A	NCPS Recall Database	Company Letter Dated April 20, 2012 states: "...we are recalling multiple lots...." There is no specific quantity of product provided in the notice.
Colla Guide Collagen Membrane, 15mm X 20mm, a translucent, rectangular, resorbable, collagen membrane sheet derived from bovine tissue; - Colla Guide Collagen Membrane, 20mm X 30mm, a translucent, rectangular, resorbable, collagen membrane sheet derived from bovine tissue; - Colla Guide Collagen Membrane, 30mm X 40mm, a translucent, rectangular, resorbable, collagen membrane sheet derived from bovine tissue	Due to concerns regarding the sterility of the product.	DLA	Voluntary recall	5/16/2012	0	Kensey Nash	None.	NCPS Recall Database	DLA Notice Dated May 16, 2012 states: "6387 units distributed from 10/01/2009 to 01/31/2012."

Please provide data on each of these posts, including how VA learned of the recall, impetus for the recalls, date of the recall, recall class, the tissue product type, number of products affected within VA, number of VA medical facilities affected, and confirmations received (e.g., X items removed from inventory).

Attachment A Data search conducted from 7-1-10 through 9-30-13 using the search parameter of Biologic Implant.

Product	Reason for Recall	Source of Recall Information	Recall Type/Class at time of notification	Mfg. Recall Letter Date	Number of facilities with stock removed	Firm/Manufacturer	Facility Reported Product Implant Inventory Removal	Database Posting was Managed	Quantity of Product Included in the Source Document (FDA and/or Company Letter)
Fascia Lata (Med) Tissue	Initiated based on information that we discovered about the tissue donor while performing an additional review of the donor's records. We discovered that the donor lived in Europe for a cumulative total of 12 years from 1981 through 1998, which exceeds the allowable time frame (5 years) for tissue donors as defined in FDA's Eligibility Determination for Donors of HCT/Ps. This exclusion criterion is intended to reduce the potential risk of exposure to Bovine Spongiform Encephalopathy (BSE), and development of Creutzfeldt-Jakob Disease (CJD). Up to the time of death, the donor exhibited no signs or symptoms of CJD, and the extended time spent in Europe is the only known risk factor that the donor had.	Manufacturer	Voluntary recall	8/1/2012	0	LifeNet Health	None.	NCPS Recall Database	Company Letter Dated August 1, 2012 states: "... notifying you of a tissue recall." There is no specific quantity of product provided in the notice.
Bacterin International Inc. Biologics Division, Tendon Products, Bone Products and Fascia Product: For a detailed listing of Graft ID Numbers please review listing on the attachment. Recall Letters for each affected stations have been attached	Human allografts, recovered from a donor whose donor eligibility was initially determine with inaccurate and/or incomplete donor records, were distributed.	FDA	FDA Class II	8/8/2012	0	Bacterin International Inc. Biologics Division	None.	NCPS Recall Database	FDA Notice Dated August 9, 2012 states: "Tendon (product codes)... 100 units." "Bone (product codes)... 2063 units." "Fascia B10124252... 1 unit."
University of Miami Tissue Bank, RegenerOss® Allograft: View individual attachments for appropriate list of affected products.	Through an internal review, it has been determined that he assays used to test some UMBT tissue donors for Hepatitis B Surface Antigen and Hepatitis C Antibody were not FDA licensed for donor screening purposes.	Manufacturer	Voluntary recall	3/15/2013	1	University of Miami Tissue Bank	Milwaukee, WI reports: 1 box of 0085490136-11 1 box of 0085490138-11	NCPS Recall Database	Company Letter Dated March 7th, 2013 states: "The attached matrix includes donors / grafts distributed to your organization form the University of Miami Tissue Bank that were identified in our review." The company would then be responsible to provide letters specific to each affected site with the specific product information.
DuraGen Dural Graft Matrix, DuraGen Plus Dural Regeneration Matrix, DuraGen XS Dural Regeneration Matrix, and DuraGen Suturable Dural Regeneration Matrix.	The company has identified through internal QA review of processes that they may have deviated from a production process during the manufacture of specific lots of product.	Manufacturer	Voluntary recall	4/9/2013	8	Integra	Pittsburgh, PA reports: 1 box Duragen 1130417 Baltimore, MD reports: 1 package 1111277 Asheville, NC reports: 7 assembly 1104879 Hines, IL reports: 1 box DP-1045 lot 1130421 Oklahoma City, OK reports: 1 box DuraGen Plus 4x5in-lot 1125677 Salt Lake City, UT reports: 1 box ID-3305 / 1112109 San Diego, CA reports: 1 boxes DP-1022 lot# 1125526 Minneapolis, MN reports: 1 box 1125517	NCPS Recall Database	Company Letter Dated April 9, 2013 states: "... specific lots of product." There is no specific quantity of product provided in the notice.

Please provide data on each of these posts, including how VA learned of the recall, impetus for the recalls, date of the recall, recall class, the tissue product type, number of products affected within VA, number of VA medical facilities affected, and confirmations received (e.g., X items removed from inventory).

Attachment A **Data search conducted from 7-1-10 through 9-30-13 using the search parameter of Biologic Implant.**

Product	Reason for Recall	Source of Recall Information	Recall Type/Class at time of notification	Mfg. Recall Letter Date	Number of facilities with stock removed	Firm/Manufacturer	Facility Reported Product Implant Inventory Removal	Database Posting was Managed	Quantity of Product Included in the Source Document (FDA and/or Company Letter)
Helitene Absorbable Collagen Hemostatic Sponge	The company may have deviated from a production process during the manufacture of specific lots of product.	Manufacturer	Voluntary recall	4/9/2013	0	Integra	None.	NCPS Recall Database	Company Letter Dated April 9, 2013 states: "... specific lots of product." There is no specific quantity of product provided in the notice.
Helitape and HeliPlug Collagen Wound Dressing 10/BX	The company may have deviated from a production process.	Manufacturer	Voluntary recall	4/15/2013	0	Integra	None.	NCPS Recall Database	Distributor Letter Dated April 15, 2013 states: "The manufacturer of the above listed items (953-2720, 953-2723) has voluntarily issued this Medical Device Recall for the specified lot numbers mentioned above (1110250, 1110251, 1110252, 1111365, 1111878, 1104622, 1104962, 1110241, 1110242, 1110264, 1110786)...." There is no specific quantity of product provided in the notice.
Medtronic, Inc., Absorbable Collagen Sponge (ACS) which is a component of the INFUSE® Bone Graft Kit.: MEDTRONIC on behalf of Integra LifeSciences Corporation	Through internal Quality Assurance review of processes that we may have deviated from a production process during the manufacture of specific lots of product.	Manufacturer	Voluntary recall	5/29/2013	3	Medtronic, Inc./Integra LifeSciences Corp.	Syracuse, NY reports: 1 box M111052AAS Baltimore, MD reports: 1 box M111064AAT 1 box M111064AAX Minneapolis, MN reports: 1 package M111059AAB	NCPS Recall Database	Company Letter Dated Mary 29, 2013 states: "...we are recalling those specific lots...." There is no specific quantity of product provided in the notice.

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Attachment 1: JOINT REVIEW DOCUMENT FORM FOR J&As AND WAIVERS

Document Type Example: J&A or Waiver	TSS Waiver Endoscopic Scopes
Name of Reviewer	Doris Richardson
Document Number	TON-14-001
Date Received	12/9/13
Date of Review	12/11/13

	Yes	No
1. Do you have any concerns?	✓	
2. Do you have any recommendations? If so, please explain your response below:		

VHA is currently developing requirements for leasing Karl Storz & other scopes. No leasing agreements are currently existing at that company. Target Date Feb. 28/14

	Yes	No
3. Is this action something that should be a national contract? If so, please explain your answer below.	✓	

National Leasing agreements are being established with the GAC for endoscopes fitting the company's equipment specifications.
Recommend dis-approval. Temporary waiver thru 7/1/2014.

Doris Richardson
Signature of Reviewer

12/12/13
Date

Current contract Karl Storz ends Feb 2014.
Looking to direct the VAMC to seek an extension on current lease or enter into a temporary lease until national contract is released.
Spoke to Jim Gaudis, CLO, who will contact VAMC and get back to D. Richardson

Department of Veterans Affairs

FEDERAL SUPPLY SCHEDULE (FSS) REQUEST FOR WAIVER

(Federal Supply Class (FSC) 66 and Cost-Per-Test in FSC 66)

1. DATE OF REQUEST: 10/23/13

2. LOG NUMBER: 10N7-14-001

TO: 3. NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR

FROM: 4. VA MEDICAL CENTER / PROGRAM OFFICE: Atlanta VA Medical Center (508)

5A. FSS CONTRACT	5B. FSS PART NUMBER	5C. FSS VENDOR
V797D-30255	DCNS 07528	Karl Storz Endoscopy

6A. DESCRIPTION OF THE REQUIRED ITEM(S) (Descriptive literature such as, vendor information, cuts, illustrations, drawings, and brochures that explain the characteristics and or components; include the corresponding schedule part number or NSN for comparison.)

Endoscopic scopes are used during surgical intervention for diagnosis and treating patients during surgery. More and more procedures are performed by the aid of endoscopic scopes.

6B. PRIOR LOG NUMBER:

6C. PRICE OF REQUESTED ITEM: $383,521.01

6D. PRICE OF SCHEDULE ITEM: $383,521.01

6E. INADEQUACIES OF THE SCHEDULE ITEM TO PERFORM

We are seeking a waiver to lease Karl Storz scopes instead of leasing Olympus scopes. Karl Storz does not have a national lease agreement yet, Olympus does but Karl Storz is the preferred vendor.

6F. TECHNICAL, ECONOMIC, OR OTHER ADVANTAGES OF THE ITEM REQUESTED

1) The Karl Storz scopes allow for second attachments to be added to the scope so that attending physicians can teach residents - no other company offers this. (surgical code)
2) Karl Storz is the only company that offers an upgrade path. No additional purchase is required when new technology takes place.
3) Only Karl Storz scopes zoom in and out without losing resolution of the surgical display. (parfocal zoom).

6G. QUANTITY REQUIRED: 107

6H. ESTIMATED ANNUAL USAGE: 250 times per year

7A. NAME OF REQUESTER	7B. SIGNATURE OF REQUESTER	7C. DATE
Rocco LaBella, MD Surgery, Atlanta VA		11/13/13

8A. ACTION	8B. NAME OF FACILITY LOGISTICS MANAGER	8C. SIGNATURE OF FACILITY LOGISTICS MANAGER OR DESIGNEE	8D. DATE
☒ CONCUR ☐ DO NOT CONCUR	Theodora Hamilton	Theodora Hamilton	11/13/13

8E. RECOMMENDATIONS AND/OR REMARKS FROM FACILITY LOGISTICS MANAGER

I concur with the statements listed in 6F. In addition to this, leased scopes are exchanged with replacement scopes quickly. Purchased scopes must be sent out to vendors who fix the scope and often takes 3-4 weeks. These scopes are delicate and often break. Therefore, many scopes could be out for repair at the same time. By leasing the scopes the vendors exchange the scopes within 24 hours.

9A. NAME OF CHIEF OF STAFF	9B. SIGNATURE OF CHIEF OF STAFF OR DESIGNEE	9C. DATE
David Bower, MD	David Bower	11/13/13

9D. RECOMMENDATIONS AND/OR REMARKS FROM CHIEF OF STAFF

I support this request. Leasing Karl Storz scopes will ensure that the best patient care will be provided, as the technology will be upgraded automatically with a lease agreement. Purchasing the scopes limits the upgrades and we would be left with scopes that become obsolete before their expiration date.

10A. NAME OF VISN CHIEF MEDICAL OFFICER	10B. SIGNATURE OF VISN CHIEF MEDICAL OFFICER OR DESIGNEE	10C. DATE
Stephen R. Kest	Stephen R. Kest	11/18/13

10D. RECOMMENDATIONS AND/OR REMARKS FROM VISN CHIEF MEDICAL OFFICER

VA FORM 0753a AUG 2013

FEDERAL SUPPLY SCHEDULE (FSS) REQUEST FORM WAIVER *(Continued)*

2. LOG NUMBER: 10N7-14-001

11A. NAME OF VISN CHIEF LOGISTICS OFFICER	11B. SIGNATURE OF VISN CHIEF LOGISTICS OFFICER OR DESIGNEE	11C. DATE
James Gaudio		12/6/2013

11D. RECOMMENDATIONS AND/OR REMARKS FROM VISN CHIEF LOGISTICS OFFICER

The facility highlights the technical advantage provided by the ability to provide secondary attachments. Karl Storz does have an existing FSS award, the request is to deviate from the current national standardized endoscope lease awards to allow the facility to pursue a lease option rather than a purchase of endoscopes currently available for FSS purchase.

12A. NAME OF VHA CHIEF PROCUREMENT AND LOGISTICS OFFICER (10NA2)	12B. SIGNATURE OF VHA CHIEF PROCUREMENT AND LOGISTICS OFFICER (10NA2) OR DESIGNEE	12C. DATE
Norbert Doyle		1/10/14

12D. RECOMMENDATIONS AND/OR REMARKS FROM VHA CHIEF PROCUREMENT AND LOGISTICS OFFICER (10NA2)

☒ WAIVER APPROVED ☐ WAIVER DISAPPROVED

13A. NAME OF NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR	13B. SIGNATURE OF NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR	13C. DATE

13D. RECOMMENDATIONS AND/OR REMARKS FROM NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR

☐ WAIVER APPROVED ☐ WAIVER DISAPPROVED

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Attachment 1: JOINT REVIEW DOCUMENT FORM FOR J&As AND WAIVERS

Document Type Example: J&A or Waiver	FSS Waiver Saline Tissue & Vessel Sealer
Name of Reviewer	Doris Richardson
Document Number	528-14-001
Date Received	11-25-2013
Date of Review	11/26/2013

	Yes	No
1. Do you have any concerns?		✓
2. Do you have any recommendations? If so, please explain your response below:	✓	

Recommend approval. This technology is less traumatic to tissue and thus results in less scarring & possible reduction of collateral tissue damage

	Yes	No
3. Is this action something that should be a national contract? If so, please explain your answer below.		✓

S/A

Doris Richardson, RN
Signature of Reviewer

11/26/13
Date

Department of Veterans Affairs

FEDERAL SUPPLY SCHEDULE (FSS) REQUEST FOR WAIVER

(Federal Supply Class (FSC) 65 and Cost-Per-Test in FSC 66)

1. DATE OF REQUEST: 11/13/13

2. LOG NUMBER: V2-528-14-001

TO: 3. NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR
P.O. BOX 79, BLDG 37
1ST AVE, NORTH OF CERMAK RD
HINES, IL 60141

FROM: 4. VA MEDICAL CENTER - PROGRAM OFFICE
WNY VETERAN MEDICAL CENTER
3495 BAILEY AVENUE
BUFFALO, NY 14215

5A. FSS CONTRACT	5B. FSS PART NUMBER	5C. FSS VENDOR
V797P-4117B	97.000.36	Princeton Medical Group, Inc

6A. DESCRIPTION OF THE REQUIRED ITEM(S) *(Descriptive literature such as, vendor information, data, illustrations, drawings, and brochures that explains the characteristics and/or construction; include the corresponding schedule part number or NSN for comparison.)*

The VAWNY Healthcare System is requesting a Biopolar/Monopolar Saline Tissue and Vessel Sealer. This device is used in Thoracic and other surgical procedures in order to provide lower temperature hemostatic sealing of soft tissue and bone in both monopolax and bipolar modes cont'd on attached sheet

6B. PQDR LOG NUMBER: N/A

6C. PRICE OF REQUESTED ITEM: $32,150.42

6D. PRICE OF SCHEDULE ITEM: $25,360.00

6E. INADEQUACIES OF THE SCHEDULE ITEM TO PERFORM

This item is on schedule is not Bipolar/Monopolar Saline Tissue and Vessel Sealer. Instead the device is an Argon Enhanced Electrosurgical Unit. This device used Argon as the medium to deliver high energy for coagulation. The unit coagulates wounds - cont'd on attached sheet

6F. TECHNICAL, ECONOMIC, OR OTHER ADVANTAGES OF THE ITEM REQUESTED

The Aquamantys System from Medtronic is a Biopolar/Monopolar Saline Tissue and Vessel Sealing through the use of saline. The device does not cause a charring effect on tissue being operated - cont'd on attached sheet

6G. QUANTITY REQUIRED: 1

6H. ESTIMATED ANNUAL USAGE: 80

7A. NAME OF REQUESTER	7B. SIGNATURE OF REQUESTER	7C. DATE
DORTHY L. JOHNSON	Dorothy L Johnson	11-26-13

8A. ACTION	8B. NAME OF FACILITY LOGISTICS MANAGER	8C. SIGNATURE OF FACILITY LOGISTICS MANAGER OR DESIGNEE	8D. DATE
☒ CONCUR ☐ DO NOT CONCUR	STEVE RESETARITS		11/26/2013

8E. RECOMMENDATIONS AND/OR REMARKS FROM FACILITY LOGISTICS MANAGER

9A. NAME OF CHIEF OF STAFF	9B. SIGNATURE OF CHIEF OF STAFF OR DESIGNEE	9C. DATE
MIGUEL RAINSTEIN		11/26/13

9D. RECOMMENDATIONS AND/OR REMARKS FROM CHIEF OF STAFF

The facility had moved forward with acquiring this device however, there have been delays in the procurement process. For this reason, the request has become emergent as patient cases have been scheduled and the device is needed to complete these cases. The VAWNY has been leasing the Aquamantys device for a significant cost of $3000 per month. This is not a cost efficient approach as the lease price is about 12 percent of the purchase price each month. If this device is not procured and the lease is ended, patients requiring certain thoracic surgical procedures scheduled in - cont'd on attached sheet

10A. NAME OF VISN CHIEF MEDICAL OFFICER	10B. SIGNATURE OF VISN CHIEF MEDICAL OFFICER OR DESIGNEE	10C. DATE
LAWRENCE H. FLESH, MD		11/26/13

10D. RECOMMENDATIONS AND/OR REMARKS FROM VISN CHIEF MEDICAL OFFICER

FEDERAL SUPPLY SCHEDULE (FSS)
REQUEST FORM WAIVER *(Continued)*

2. LOG NUMBER: V2-528-14-001

11A. NAME OF VISN CHIEF LOGISTICS OFFICER	11B. SIGNATURE OF VISN CHIEF LOGISTICS OFFICER OR DESIGNEE	11C. DATE
DAVID J. EVANGELISTA		11-26

11D. RECOMMENDATIONS AND/OR REMARKS FROM VISN CHIEF LOGISTICS OFFICER
Urgent need within WNY VAMC verified. Patient care would be negatively effected.

PLEASE SIGN & DATE

12A. NAME OF VHA CHIEF PROCUREMENT AND LOGISTICS OFFICER (10NA2)	12B. SIGNATURE OF VHA CHIEF PROCUREMENT AND LOGISTICS OFFICER (10NA2) OR DESIGNEE	12C. DATE
NORBERT DOYLE		11/26/13

12D. RECOMMENDATIONS AND/OR REMARKS FROM VHA CHIEF PROCUREMENT AND LOGISTICS OFFICER (10NA2)

☒ WAIVER APPROVED ☐ WAIVER DISAPPROVED

13A. NAME OF NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR	13B. SIGNATURE OF NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR	13C. DATE

13D. RECOMMENDATIONS AND/OR REMARKS FROM NATIONAL ACQUISITION CENTER EXECUTIVE DIRECTOR

☐ WAIVER APPROVED ☐ WAIVER DISAPPROVED

Cont'd from block 5:

The device functions by focusing a spray of saline in conjunction with Radio Frequency energy to provide hemostatic sealing energy at a reduced and controlled temperature of approximately 100 degrees Celsius. The use of this technology effectively eliminates tissue charring caused by high temperature coagulation. This technology has been used at the VAWNY for over 8 years.

Cont'd from block 6C:

at a much higher temperature range than the device being requested (~200 degrees Celsius higher). This leads to a charring effect on tissues being operated on. Also, Argon Enhanced Electrosurgical Units cannot be used with saline solution to cool surrounding tissues. Thus, charring is inevitable with this technology. Due to the nature of the procedures being performed, charring is unacceptable and cannot occur on the tissue being operated on. Thus, the Argon Enhanced Electrosurgical Unit does not meet the clinical needs of this facility for these procedures.

Cont'd from block 6D:

on and may be used for certain procedures where charring would have a negative effect on the patient. The device also controls intra-operative blood loss and decreases blood loss per level of tissue fused during a procedure. All of the reasons mentioned provide clinical benefits to the patient and improve the quality of care offered to our veterans.

Cont'd from block 9D:

local hospitals. This can cause a delay in care as these patients may have to wait some time before they can be seen in the community. As some of these patients are extremely sick, a delay in care could be detrimental to their health. Thus, it is imperative the Aquamantys unit can be procured in order to ensure care can be delivered in a timely fashion to our veterans. This would also be the most cost effective method for the VHAWNY.

Status	Network	Loa Number	Description	Vendor	PMO Office	Date Received	Additional Comments	Date Approved CPLO	Date Approved NAC	Item Type	Path
Approved	8	V8-573-14-001	Propel Steroid Sinus Implant	Propel	Surgical	12/26/2013	Sent to PM 1/2/14///Sent to CPLO 1/10//Sent to NAC 1/10	1/10/2014	1/22/2014	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	8	V8-548-14-002	Planmeca Promax Panoramic X-Ray Replacement Parts	Planmeca Promax	Medical	12/26/2013	Sent to PM 1/2 CPLO signed and approved Sent to NAC for further review	1/7/2014	1/22/2014	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	8	V8-548-14-004	Tetar Cable & Rad Servis Detector for DeRadum AMX 700	GE Healthcare	Medical	12/26/2013	Sent to PM 1/2 CPLO signed Sent to NAC for further review	1/7/2014	1/22/2014	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	8	V8-548-14-005	GE OEC 9800 Parts	GE Healthcare	Medical	12/26/2013	Sent to PM 1/2 CPLO signed Sent to NAC for further review	1/7/2014	1/22/2014	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	CMOP	N/A	MINIMED INFUSION SETS XZ835, XZ925, XZ673, XZ670, XZ834, XZ871 & XZ110	MEDTRONIC	Clinical	12/12/2013	Sent to CPLO 1/2//Sent to NAC 1/8///2/4 Sent to CMOP	1/6/2014	2/4/2014	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	10	V10-487-14-0001	Apligraf	Shire Regenerative Medicine, Inc	Surgical	12/9/2013		12/19/2013	1/9/2014	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	7	10M7-14-001	Endoscopic Scopes - Facility wants to use Karl Storz Scopes	Olympus	Clinical	12/9/2013	Sent to PM 12/11//Sent to CPLO 12/20//Sent TO NAC 1/10///1/31 PBLO Followup NAC Stated Wai	1/10/2014		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	8	V8-548-14-001	Hologic ThinPrep 2000	Hologic ThinPrep 2000	Clinical	12/6/2013	Sent to NAC 12/9	12/9/2013	12/12/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	2	V2-528-14-001	Seline Tissue and Vessel Sealer	Medtronic	Surgical	11/26/2013		11/26/2013	12/12/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	CMOP	Not Listed	XC068 Catheter Plastic 14FR	Rusch	Surgical	11/4/2013	Sent to PM 5 Nov 13//Sent to CPLO 13 Nov//Sent to NAC 19 Nov 13	11/18/2013	12/4/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	CMOP	Not Listed	XX869 Cat Set Intern 14FR	MMG	Surgical	11/4/2013	Sent ot PM 5 Nov 13//Sent to CPLO 11/22//Sent to NAC 11/26	11/22/2013	12/12/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-14-001	Portable Site-Rite Vision Ultrasound Sys w/ ECG Tip Confirmation Sys	Site-Rite	Clinical	11/1/2013	Sent ot PM 11/16//Sent to CPLO 11/20//Sent to NAC 11/22	11/21/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-14-002	EP 5000 Press Furnance w/ Touch Screen Controls	Ivoclar	Clinical	11/1/2013	Sent to PM 11/16//Sent to CPLO 11/19//Sent to NAC 11/21	11/21/2013	12/4/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-14-003	S3 Partiot Beds	Stryker	Medical	11/1/2013	Sent to PM 11/16//PM notified follow up questions required, requestor will resubmit 11/21///Sent	12/6/2013	12/12/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	H11-13-30 FSS	8SS100 Pneumotach Research Spirometry System	Korr	Advance Medical Systems	10/30/2013	Sen to HCA 6 Nov//Sent to NAC 8 Nov	11/7/2013	11/21/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	Not Listed	Enteral Access System	Cortrak	Medical	10/28/2013	Sent to NAC 10/30	10/30/2013	11/20/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	CMOP	Not Listed	Test Drum (Glucose)	Accu-Chek	Clinical	10/28/2013	Sent to PM 10/29////Sent to CPLO 10/29//Sent ot NAC 10/30// Approved for 1yr see doc for specific	10/30/2013	11/21/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	4	V4-540-14-001	Endovenous Laser Treatment System	VenaCure	Surgical	10/28/2013	Awaiting Network to Submit Current Form 10/29 Network Notified/// Sent to PM for Review 10/29/	11/19/2013	12/4/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	V20-504-13-002	Software Upgrade	Space Labs	Clinical	9/28/2013	Sent to NAC 9/30	9/27/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	20	13-001	Blood Pressure Monitor Sys	Space Labs	Clinical	9/26/2013		9/27/2013	10/8/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	Not Listed	3D Mapping System	Ensite Velocity	Clinical	9/24/2013	Sent to HCA 9/26 /// Sent to NAC 9/26	9/26/2013	10/8/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	7	V7-509-13-012	Surgical instruments	Synthes	Surgical	9/25/2013		9/24/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	9	V9-764-13-001	Reservoir MiniMed MMT 326A	n/a	Clinical	9/23/2013	Sent to PM 9/24	9/25/2013	11/8/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	9	V9-764-13-002	Infusion Minimed MMT 397	n/a	Clinical	9/23/2013	Sent to PM 9/24	9/25/2013	11/8/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	9	V9-764-13-003	GLUCOSE SENSOR GUARDIAN MMT7002	N/A	Clinical	9/23/2013	SENT TO PM 9/24	9/25/2013	10/8/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	756-0001	Vision Equipment	Humphrey	Medical	9/17/2013		9/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	648-13-3-301-0020	Patient Transport Stretcher	Unassigned	Medical	9/17/2013	Sent to HCA 9/18/// Sent to NAC 9/24	9/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	13	V15-13-4-016	Ascht Injector	Covidien-Mallinckrodt	Medical	9/16/2013	Sent to HCA 9/18// Sent to NAC 9/24	9/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	578-13-0001	Perm Marker		Clinical	8/18/2013	NAC determine FSS Waiver was not needed	8/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-11	Dental Microscope	Zeiss	Clinical	8/16/2013	8/28 PM state awaiting feedback from field///Sent to NAC 9/5/13 /// 9/9/13 NAC Approved	9/4/2013	9/9/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-012	Opthalmic Surgery Microscope	Zeiss	Clinical	8/16/2013	Under review by Clinical PMO awaiting response from field///Sent to CPLO 8/28/13 /// 9/9/13 NAC A	8/27/2013	9/9/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	20	653-13-002	Audioscan Verifit VF-1 Real Ear & Hearing Aid Analyzer	Verifit	Clinical	8/16/2013	Clinical PMO reccomended approval 8/16/13	8/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-014	Bone Cement w/ Tobramycin	Stryker	Clinical	8/12/2013	NAC determine FSS Waiver not required 8/26/13	8/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-015	Bone Cement	Zimmer Palacos R+G	Clinical	8/12/2013	NAC determine FSS Waiver not required 8/26/13	8/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	2	Not Listed	Berchtold Lights	Not Listed (Open Market)	Surgical	8/5/2013	Surgical PMO recommended approval 8/15 Resent to CPLO 8/26 fo signature /// Emailed to NAC 8/28	8/27/2013	9/5/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	15	Not Listed	Glucose Test Strips	Bayer	Clinical	7/31/2013	NAC approved waiver on 8/21/13	8/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	4	5400-13-3-072-0105	Electric Dermatome Complete Kit	Zimmer	Clinical	7/29/2013		8/19/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	20	653-13-04	Insulin Pump	Medtronic	Clinical	7/28/2013	NAC Approved 9/9/13	8/19/2013	9/9/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	20	Not Listed	ScriptPro Compact Robotic Prescription Dispensing Sys	ScriptPro	Clinical	7/28/2013	NAC Approved 9/9/13	8/19/2013	9/9/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	2	Not Listed	Molecular Testing System	Reagent	Clinical	7/21/2013		7/22/2013	10/21/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	536-13-FSS-100	Stryker Motorized Stretcher	Stryker	Medical	6/25/2013	PMO medical reccommended approval 6-25-13	7/5/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	15	Not Listed	XV145 & XT 185 Catheter	OTP	Surgical	6/19/2013		7/5/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	Not Listed	Airway Mobilescope & Instrument Trays	Olympus America Inc	Surgical	6/11/2013		7/5/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	618-001-2013	Fluid Warming System	Medical Solutions, Inc	Medical	6/10/2013		6/12/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	15	Not Listed	Insulin Pump Parts	MMT Medtronics	Clinical	6/4/2013	PM recommended approval 6-4-13	6/10/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-009	Cirrus HD-OCT	Zeiss	Surgical	5/29/2013	surgical PMO recommended approval 07/18/13	7/22/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	699-13-008	Medical Portable Suction Unit	Armstrong Medical	Surgical	5/23/2013	Surgical PMO recommended aproval 07/18/13 /// NAC Approved 7/31/2013	7/22/2013	7/31/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V15-13-014	Vasu - Guard Peripheral Vascular Patch	Baxter - Synovis Surgical	Surgical	5/9/2013	Joint Review Document Recommendation 5-9-13	5/14/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-689-13-014	Local Dental Laboratory		Surgical	5/8/2013	Recommended approval Surgical PM 5/8/13 ... CPLO approved 5-24-13	5/24/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	V12-695-13-005	Stryker Motorized Stretcher	Stryker	Medical	5/9/2013	Medical team PM recommended Approval 5/10/13	5/14/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18		IO-Flex Ioal Probe 90 Device Kit (Bone Shaver)	Baxano	Surgical	5/9/2013	Joint Review Document Recommendation 5-9-13	5/14/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	Not Listed	DaVinci Surgical Supplies	SAVAHCS	Surgical	5/9/2013		5/14/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	9	Not Listed	Lancet	Lifescan Inc	Clinical	5/7/2013	Awaiting Facility - Return to Facility for additional information - Jody Goldsmith on 5-7-13 ... PM reco	7/3/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	9	Not Listed	Glucose Test Stips	Lifescan Inc.	Clinical	5/7/2013	Awaiting Facility - Return to Facility for additional information - Jody Goldsmith on 5-7-13..... PM reco	6/10/2013	9/3/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	9	Not Listed	Glucose Test Strips	Prodigy	Clinical	5/7/2013	Awaiting Facility - Return to Facility for additional information - Jody Goldsmith on 5-7-13..... PM reco	6/10/2013	9/3/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	15	V15-13-014	Balloon Kyphoplast Kit 5-9-13	Kyphon	Surgical	5/8/2013	PM recommended approval 5-9-13 CPLO approved 5-21-13	5/21/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	22	11-505-10-001-505-HT1001	Stryker Motorized Bed	Stryker	Medical	4/15/2013	PMO reccommended approval 4-15-13 sent to contracting	5/8/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-402-13-016	Human Dermal Collagen Mesh - Crosslinked	Not Listed	Surgical	4/3/2013		4/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-650-13-013	Human Tissue	Apligraf	Surgical	4/3/2013		4/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-650-13-012	Human Tissue	Apligraf	Surgical	4/3/2013		4/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	10	Not Listed	Apligraf	Dermagraft	Surgical	3/13/2013	Sent to CPLO 8/28//9/6 Rejected by HCA for 30-day lapse in processing			Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	Not Listed	Stryker Motorized Stretcher	Stryker	Medical	2/28/2013		3/4/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	15	V15-13-2-011	Mobile Drainage Device	Atrium Medical	Surgical	2/8/2013	Pending HCA Signature	2/11/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-650-13-010	Left Foot Apligraf	Apligraf	Surgical	2/7/2013		2/11/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-405-13-009	Voice Injectable Implant	Radiesse	Surgical	2/7/2013		2/11/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-003	Stryker Stretcher	Stryker	Medical	2/7/2013		2/11/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	No Number Assigned	Catheter	Not Listed	Surgical	2/7/2013		2/11/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	No Number Assigned	Cathether/Snare Devices	Covidien	Surgical	2/7/2013		2/11/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	Not Listed	Surgical System	Evesi	Surgical	2/6/2013		2/7/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	Not Assigned	Surgical System	Evesi	Surgical	2/6/2013		2/7/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	9	Not Listed	Urine Bag	Medline	Medical	2/5/2013		2/6/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	20	65313001	Insulin Pump	Medtronic	Medical	1/23/2013		1/31/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	Not Listed	Wild M660 Surgical Scope	Leica	Surgical	1/23/2013		1/31/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-650-13-004	Left Ankle	Apligraf	Surgical	1/13/2013		1/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-650-13-001	Left Foot	Apligraf	Surgical	1/15/2013		1/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1		Right Foot	Apligraft	Surgical	1/15/2013		1/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-650-13-006	Right Ulcer	Apligraft	Surgical	1/15/2013		1/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-650-12-001	Cornea	Northeast Pennsylvania Lions Eye Bank	Surgical	1/15/2013		1/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	21	Not Listed	Video Processor & Light Source Boxes	Olympus	Surgical	1/5/2013		1/31/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	H11-13-FSS	Camera	IRIS	Surgical	11/30/2012		12/14/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V01-402-13-003	Sterile Human Tissue Allograft	Transgraft	Surgical	11/29/2012		1/18/2013		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	537-12-001	Overbed Table	Nemschoff Oasis	Medical	11/27/2012		12/12/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	W18-13-001	Surgical Care Line	SAVAHCS	Surgical	11/6/2012		11/8/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	17	Not Listed	Sys6 Ortho Drill	Stryker	Surgical	11/3/2012		11/19/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-001	Ultrasonic Cleaner	Ultra Clean System Inc.	Surgical	11/2/2012		11/8/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	V18-12-0001	Motorized Stretchers	Stryker	Medical	9/24/2012		9/27/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	V11-12-44	Infusion Pumps	Smiths-Medical	Clinical	9/18/2012		9/25/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	V11-12-52	OEV-261H Visera Elite System	Olympus	Surgical	9/14/2012		9/27/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	V11-12-47	IV Pump	Alaris	Medical	9/12/2012		9/25/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	15	V15-12-4-018	Stretcher Matresses	Stryker	Medical	9/10/2012		11/25/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	V11-12-44	IV Pump	CADD	Clinical	9/7/2012		9/25/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-12-015	FloControl Arthroscopy Pump	Stryker	Surgical	9/1/2012		9/4/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	438-12-0033	Disinfectant	Fenner Patient Care	Clinical	8/28/2012		9/25/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	V19-12-0011	Urology Tower	Olympus America Inc	Medical	8/27/2012		9/4/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	8	673-12-01	Motorized Stretchers	Saryker	Medical	8/16/2012		8/17/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	Not Listed	Home Respiratory Care	No vendor listed	Clinical	8/13/2012		8/17/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	18	V17-001	Modular Foot	Synthes	Surgical	8/8/2012		8/17/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	437-12-W0001	Erbe Breamer	ERBE	Medical	8/8/2012		8/17/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	489-12-003	Electronic Stretcher	Stryker	Medical	8/2/2012		8/17/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V1-001	Voice Injectable Implant	Raidiesse	Surgical	7/23/2012		7/26/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	V23-0003	EP Workmate Version 4 Recording System	St Jude Medical	Surgical	7/19/2012		7/26/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	V23-0002	Carto 3 System	Biosense Webster	Surgical	7/19/2012		7/28/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	V23-0004	Ultrasound System	Siemens	Clinical	7/19/2012		7/28/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	V23-008	Version 4 EP Recording System	St Jude Medical	Medical	7/19/2012		7/28/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	V23-0005	Stretcher	Stryker	Medical	7/8/2012		7/26/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-12-012	Synthes Implants	Smith & Nephew	Surgical	6/25/2012		9/27/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	V23-0001	Incubation Chamber	Not Listed	Clinical	6/2/2012		6/3/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	17	No loa number assigned	Suture, Staplers & Endoscopic	Johnson & Johnson	Surgical	3/28/2012		3/28/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	13	No loa number assigned	Hand Piece	Ethicon	Surgical	3/3/2012		3/13/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	13	No loa number assigned	Harmonic Scissors with ergonomic handle	Ethicon	Surgical	3/3/2012		3/13/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	11	578-12-0001	Laser	VersaPulse	Surgical	2/8/2012		2/16/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	23	No loa number assigned	Beds	Stryker	Medical	12/20/2011		1/27/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V1-689-001	Stapler	Ethicon	Surgical			4/13/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	1	V1-689-002	Chitwood	Scanlan International	Surgical			4/13/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	489-12-002	Clinical Lab Equipment	No vendor listed on waiver	Clinical			7/26/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	807-12-002	Sutures	Ethicon	Surgical			2/24/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	537-12-001	Integrated Power Console	Medtronic	Surgical			6/20/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-12-010	Hysteroscope	Stryker	Surgical			4/2/2012		Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers

Approved	12	607-31812	CDR Desktop System	Video Select	Clinical	4/3/2012	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	665-12-004	Craniofacial Mandible Set	Smith & Nephew	Surgical	3/22/2012	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	607-12-0011	Surgery Microscope	Leica	Surgical	3/22/2012	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	12	695-13-004	Instruments & Implants	Synthes	Surgical	1/31/2013	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers
Approved	16	No loss number assigned	Endoscopes	Kellers	Clinical	3/22/2012	Item	PCLO/MMStrategicPlan/PEO/Lists/Federal Supply Schedule FSS Waivers

Contracting Agency	Contract Name	Total Obligated Amount	Number of Offers	Signed Date	Completion Date	Number of Contractors	Number of Transactions
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA26113P1307)	$11,928	1	03/12/2013	05/30/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA26113P1245)	$8,520	1	03/05/2013	04/30/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA26113P1115)	$6,816	1	02/15/2013	04/30/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA24613P1675)	$5,112	1	03/14/2013	04/14/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA25613P0823)	$5,112	1	03/28/2013	04/28/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA26113P1336)	$5,112	1	03/15/2013	03/30/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA25613P0903)	$5,112	1	04/05/2013	05/06/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA24313P1034)	$3,408	1	03/22/2013	03/22/2013	1	1
Veterans Affairs, Department Of	Drugs And Biologicals (VA25913P1528)	$3,408	1	03/28/2013	04/25/2013	1	1
Veterans Affairs, Department Of	Medical And Surgical Instruments, Equipment, And Supplies (VA25613P0716)	$3,408	1	03/08/2013	04/08/2013	1	1

Questions for the Record
House Veterans Affairs Committee
U.S. House of Representative

"Trails in Transparency II: Is VA Responding to Congressional Request in a Timely Manner?"

April 3, 2014

Representative Kirkpatrick

1. **Unlike most federal agencies, the Department of Veterans Affairs touches each congressional district in a unique way- we all represent veteran communities. This means that VA garners a lot attention from not only this committee, but the entire Congress. Outside of the requests for information from this committee, how many other requests does VA receive and respond to from the entire congress?**

   The level of care and services VA provides to Veterans every day has an impact on every Member of Congress because every Member represents Veterans in their district. Most Members of Congress also represent districts that have VA facilities that provide and maintain health care, benefits, and cemeteries. For that reason, VA receives a large number of requests from Congress.

   In the first six months of this fiscal year (FY) 2014, VA has testified at 32 hearings, delivered 213 briefings, responded to 1,346 requests for information, responded to 213 pieces of executive correspondence, completed 143 requests for technical assistance on legislation, answered 723 questions for the record and responded to 9,748 constituent casework inquiries from the Central office level, additional primary POC on casework and notification at local VA offices.

2. **How does VA prioritize requests for information from Congress? Does the committee need to do a better job of prioritizing our request?**

   We take all requests from Congress seriously and try to follow-up with answers in a timely and expeditious manner. We prioritize requests from Chairmen and Ranking Members of committees of jurisdiction, Congressional leadership, followed by any other request in the order that they are received. VA endeavors to work with the committee in a positive and constructive manner, and we would welcome any additional guidance the Committee may have on how we can best prioritize the requests.

3. **Mr. Gibson, as a new addition to VA, what are you your impressions of the department? What do you think VA does well and here do you believe there is room for improvement?**

My most prominent and important first impression is of the people who work at VA. I see men and women, many Veterans themselves, that care deeply about VA's mission, that want to do the right thing, and work incredibly hard to get it done. I believe this is the motivating force that drives the people I have met at the VA.

I believe the single most important opportunity for improvement is the need to do a better job conveying to Veterans, to the American people, and to their elected representatives the vast body of great work that is done for Veterans day in and day out. While there are opportunities for us to improve—as there always are in any large organization—the fact is that VA delivers on its promise to hundreds of thousands of Veterans every single day. This simple fact must be the foundation of the trust vital to our relationship with those we serve and those who provide the resources essential to our mission.

Representative G.K. Butterfield

1. **When Department of Veterans Affairs is hosting an event in a state and participation from Members of Congress is desired, what procedures do VA regional personnel take to invite the proper elected officials to events?**

   The Department's protocol suggests inviting both U.S. Senators and the U.S. Representative of the facility's congressional district to speak, while inviting other Members of Congress and state officials to attend.

2. **Who ultimately has oversight of VA's regional personnel in their dealing with Members of Congress? Is the VA Office of Legislative Affairs the best office within the Department to have ultimate oversight over VA's regional offices in their interactions with Members of Congress?**

   The local VA staffs are responsible to their individual offices in the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA) or National Cemetery Administration (NCA). Given the volume and complexity involved in the management of the day-to-day local VA/congressional interactions, it is beneficial to utilize all available resources to include regional and local VA staff. The Office of Congressional and Legislative Affairs (OCLA) serves as the Department's primary point of contact for Members of Congress and their staffs on matters regarding policy, oversight, and Members' requests. The office maintains relationships and encourages the flow of information between VA and Members of Congress and congressional staff. OCLA should be the focal point for Department management and coordination of all matters involving Congress.

3. **How are invitations disseminated to Members of Congress and their offices? What are the procedures for following-up on these invitations?**

The Department's protocol includes recommendations on the development and distribution of invitations for special events. Local facilities are responsible for ensuring this guidance is incorporated into their local standard operating procedures.

The Department's protocol includes recommendations on the development and distribution of invitations for special events, including following-up on invitations. Local facilities are responsible for ensuring this guidance is incorporated into their local standard operating procedures.

4. **After initial invite, how do VA regional office personnel communicate with Members of Congress and their staff?**

   The Department's protocol includes recommendations for following-up on invitations, including requesting RSVPs. Local facilities are responsible for ensuring this guidance is incorporated into their local standard operating procedures.

5. **In dealing with Members of Congress, how do the regional VA offices communicate with your office in Washington, D.C. to update you on their interactions with Members and their staff? Who reports to whom and who is ultimately responsible for proper communication with Members and their offices?**

   Regional and local offices communicate with VA central office through their respective chains of command in each administration and program office. Constituent issues are generally handled at the local level and national policy issues are handled by OCLA. OCLA works with the administrations and staff offices to advance responsive and effective congressional communications.

   OCLA is the focal point for Department management and coordination of all matters involving the Congress. OCLA serves as the Department's primary point of contact for Members of Congress and their staffs on matters regarding policy, oversight, and Members' requests. The office maintains relationships and encourages the flow of information between VA and Members of Congress and congressional staff.

Questions for the Record
Committee on Veterans' Affairs
U.S. House of Representatives

"A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths"
April 9, 2014
Questions for the Record from the Honorable Jeff Miller, Chairman

1. **Please list and describe the efforts made by local Department of Veterans Affairs (VA) medical facility or Veterans Integrated Service Network (VISN) leaders in the areas where consult backlogs resulted in preventable veteran deaths and/or institutional disclosures, to utilize existing authorities- including but not limited to fee basis care, beneficiary travel benefits, and the Veterans Transportation Service -to ensure that veterans received needed care in a timely manner.**

   On Wednesday, May 21, former Secretary Shinseki directed the Veterans Health Administration (VHA) leadership to personally review their appointment scheduling processes to ensure the Department of Veterans Affairs (VA) is doing everything possible to schedule Veterans for their appointments.

   VA has redoubled its efforts to provide quality care to Veterans and has taken steps at national and local levels to ensure timely access to care. VHA has developed the Accelerating Care Initiative, a coordinated, system-wide initiative to accelerate care to Veterans, and promptly communicated this to leadership in the field on May 22, and launched implementation the morning of May 23.

   The purpose of the initiative is to strengthen access to care in the VA system, while also ensuring flexibility to use private sector care when needed in accordance with VA guidelines. Where VA cannot increase its own capacity, VA is increasing the use of care in the community through non-VA care. Each of VA's facilities is reaching out to Veterans to coordinate the acceleration of their care.

   Non-VA Medical Care: VA may authorize the use of Non-VA Medical Care for eligible Veterans when care is not readily available through VA or the VA facility is geographically remote from the Veteran's home, as well as in emergency situations.

   Beneficiary Travel (BT): BT promotes Veterans' access to care, but by law (38 U.S.C. §111 and 38 C.F.R. Part 70) is provided only to certain Veterans who have a VA-adjudicated service connected disability and/or low income. VA pays for special mode transportation for Veterans who are eligible for BT when they need to be transported in a vehicle specific to their limitations, if a VA clinician determines the

transportation is medically required, and if VA approves the transportation in advance except in emergencies. BT is available to eligible veterans for travel to VA facilities and VA authorized facilities.

Title 38 United States Code (U.S.C.) § 111, "Payments or allowances for beneficiary travel" as implemented in 38 Code of Federal Regulations CFR) §§ 70.1 – 70.50 authorizes mileage reimbursement (currently $0.415), special mode (ambulance, wheelchair van etc.) transport, and common carrier (plane, bus etc.) transport to certain eligible Veterans and other beneficiaries. VA may also provide or reimburse for the actual cost of bridge tolls, road and tunnel tolls, parking, and authorized luggage fees when supported by a receipt. The actual cost for meals, lodging, or both, not to exceed 50 percent of the local government employee rate, may also be provided in limited circumstances. The Beneficiary Travel Program (BT) is discretionary in nature with funding coming from the yearly VA health care Medical Services appropriation.

Veterans Transportation Service (VTS): Title 38 U.S.C., § 111A(a), "Transportation of individuals to and from Department facilities" authorizes VA to transport any person to or from a VA facility or other place for the purpose of examination, treatment, or care. The Veterans Transportation Service (VTS) provides Veterans with transportation regardless of BT eligibility, and can be used to assist Veterans when they lack the ability to get to their health care appointments. The program is intended to improve access to care by removing, where possible, travel as a barrier to care. VTS provides transport to VA care using VA vehicles and drivers through a combination of direct patient transport from residence, "bus route" pick-up and return, and transport between VA facilities (shuttles). VTS FY 13 expenditures were $19.25 million.

BT vs. VTS: BT authorizes VA to ***pay or reimburse for*** transportation provided to eligible beneficiaries while VTS allows VA to ***provide*** transportation to eligible beneficiaries, using VA vehicle and staff resources, regardless of their BT eligibility.

Volunteer Transportation Network: Additionally, under 38 U.S.C. § 111A(b), the Volunteer Transportation Network (VTN) provides needed transportation for Veterans seeking services from a VA facility or an authorized facility. VTN guidelines permit volunteer participation in providing transportation to Veterans using a volunteer's privately-owned conveyance or a government-owned vehicle, including donated vehicles, county vehicles, and DAV Department (State) or Chapter (local) vehicles.

2. **Please describe the anticipated effects of the National Consult Delay Review on the way consults are monitored locally, regionally, and nationally throughout the VA health care system.**

The National Consult Delay Review, which is scheduled to be complete mid-

summer, 2014, will do two things: 1) review and address open consults and 2) implement standard business rules. This will allow VHA's new consult oversight information system (called the consult switchboard) to separate clinical consults from other uses of the electronic consult package (for example, some facilities use the consult package to order tests such as an EKG). VHA officials will be able to use this system to see all VHA consults individually, which enables monitoring of the data locally, regionally and nationally. This system will allow VHA officials to monitor the number of open consults and consult timeliness.

3. **Please list the VA official(s) who will be responsible for monitoring and acting on information provided via the new consult "switchboard" at the local, regional, and national level.**

VHA created the new consult "switchboard" to assist VA facilities in day-to-day management of the consult process. Veterans Integrated Service Network (VISN) Directors are responsible for monitoring this information for their regions. Several national program offices, e.g., the Mental Health Operations program office, will be reviewing and monitoring the information at the national level. Each program office aggregates the data and uses it for a specific purpose (e.g., Mental Health Operations will monitor the mental health access information). In October 2013, VHA assigned responsibility for the overall aggregation and trending of this information into the Access and Clinic Administration Program (ACAP) organized within VHA operations.

4. **When will the Consult Management Committees be in place in all VA medical facilities? What will the composition of these Committees be and what authority will they have to take needed actions to address consult delays? How will the effectiveness of these Committees be measured?**

In an Under Secretary for Health memorandum dated May 23, 2013, regarding Consult Business Rule Implementation, it was recommended, but not required, that facilities either stand up a committee or assign an existing committee the task of overseeing and managing the business rules and outcomes. The memorandum did not specify a target date or certification requirement regarding such a committee. Training calls managed by VHA's Office of Access and Clinic Administration included discussion on the functions and benefits of having a committee and the need for facility oversight, group decision making, and review of the implementation process, and consult performance.

The Medical Center Director oversees the consult processes locally. The consult committees are a mechanism the director uses to assist in monitoring open consults, improving consult processes, and assisting in creating care coordination agreements. These agreements aim to improve the patient care related communication between Primary Care and Specialists. It is anticipated that the effectiveness of local consult management processes will be measured by consult

timeliness, the number of open consults over 90 days, and the number of consults that are written but subsequently sent back to the sender.

5. **According to information the Department provided, VA has issued 76 institutional disclosures to-date as a result of consult delays. Of those, 23 veteran patients are now deceased. Moving forward, how will VA monitor the health of the 53 surviving patients who received institutional disclosures? Please list what, if any, additional health benefits these veterans will be eligible to receive should they require care in connection with conditions they may have developed while waiting for VA care?**

   Patients for whom institutional disclosures are completed continue to be followed by their providers, who coordinate appropriate treatment and follow-up.
   Any Veteran enrolled in VA health care is eligible for care provided under the medical benefits package based on clinical need. VA providers are actively working with those Veterans who received institutional disclosures to ensure that they receive any needed services.

6. **How is the implementation of the Patient Centered Community Care Program (PC3) expected to impact the timely delivery of consults through the VA health care system?**

   Patient-Centered Community Care (PC3) is expected to improve the timely delivery of health care through the VA health care system and improve the patient experience when receiving care in the community. VA currently monitors and tracks expenditures through the PC3 contracts, in order to compare the use of PC3 to other non-VA care contract vehicles.

   Local VA facilities create authorizations (orders) for non-VA medical care when the required medical services are not readily available through VA or the VA facility is geographically remote from the Veteran's home. Authorizations for PC3 follow the Non-VA Care Coordination (NVCC) process which is a system of business processes that standardize and streamline front-end processes, and improve patient care coordination. Included in the NVCC process is the creation, routing, and issuance of authorizations, which are used for all non-VA medical care, including PC3.

   PC3 will help the patient-care coordination process through contractually-mandated timeliness requirements which cover the following areas:

Requirement Description	Standard
Time from receipt of authorization to appointment completion	• 30 days or less
Timeliness from completion of the authorized episode of care to the return of clinical documentation	• Medical documentation authorized outpatient care submitted within 14 calendar days after completion of initial appointment • Medical documentation for authorized episode of inpatient care submitted within 30 business days
Timeliness of critical and urgent findings reporting	• Urgent oral report transmitted to VA within 48 hours of finding • Documentation return critical findings on outpatient imaging or lab testing transmitted to VA by phone within 24 hours of completion of test/evaluation/treatment • Urgent written report transmitted to VA within 48 hours of finding • New diagnosis of cancer reported to VA within 48 hours • Notification within 24 hours if Veteran requires urgent follow-up or additional care during authorized episode of care
Network adequacy to enable access	• Regular care: o Urban within 60 minutes of commute time o Rural within 120 minutes of commute time o Highly rural within 240 minutes commute time • When a higher level of care is needed, which is specialized consultative health care, usually for inpatients and in a facility that has personnel and facilities for advanced medical investigation and treatment, such as tertiary referral hospital, e.g., cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for serve burns, advanced neonatology services, palliative, and other complex medical and surgical interventions: o Urban within 120 minutes of commute time o Rural within 240 minutes of commute time o Highly rural within community standard commute time

7. **Please list and describe the oversight mechanisms the Department has in place to monitor compliance with VA directives and policies at the local, regional, and national level.**

VA has a robust set of oversight mechanisms in place to monitor compliance with VA and VHA directives, handbooks, memorandums, and other policy documents. In light of recent events, we are aware of the need to do more, and so we are developing processes and tools to enhance oversight.

Responsibility for ensuring compliance with policy falls to every staff member in the Department, while oversight falls to the managers and leadership teams at each level of the organization. VA nurtures an environment that encourages staff to speak up when they believe there is a potential issue or violation of policy occurring. Staff are routinely trained on the ways in which they can speak up about issues that may be occurring at their facility. National Program Offices also provide program specific oversight across all VISNs and Facilities. Some specific mechanisms include, but are not limited to:

- One oversight mechanism utilized by the Department includes the analysis and reporting of data, as well as associated site visits. As one example, VHA Occupational Health monitors drug testing lab error reports, workers compensation claims and cost data, sexual assault training completion and facility violence risk assessment data as well as employee health clinic quality metrics. Occupational Health uses laboratory-generated error reports and random site visits to monitor compliance with VA policies and mandatory Department of Health and Human Services (HHS) guidelines on the Drug Free Workplace program. Results of site visits are used to improve performance via feedback to facility and VISN executives, and VHA leadership.

- As a second example of an oversight mechanism, VHA Central Office program offices also collect and utilize data from the field to monitor compliance. VHA Mental Health Services, in coordination with VHA Mental Health Operations, surveys the field quarterly to ascertain compliance with the Uniform Mental Health Services Handbook. This survey evaluates programs at the local, regional and national level. Additionally, Mental Health Services supports Mental Health Operations in conducting site visits which thoroughly evaluate all mental health programs at a local level.

- A third mechanism is the use of metrics to assess performance. The VHA Health Information Management (HIM) office co-produces and publishes

metrics related to facility compliance with clinical coding requirements. In addition, HIM collaborates with the VHA Chief Business Office on coding and billing audits and shares its findings with facility and VISN leadership. When negative trends are discovered, HIM prepares training for HIM professionals nationwide to ensure improved clinical coding practices. HIM also shares best practices that individual facilities have employed to improve their success in these areas. In a similar fashion, VHA Rehabilitation and Prosthetic Services utilizes dashboards for certain performance measures, with regular reporting to VHA Policy and Services and the Office of the Assistant Deputy Under Secretary for Health for Clinical Operations to enforce compliance. The program office uses the Procurement Acquisition Lead Time tool to monitor provision of prosthetic items to Veterans (and any delays). It also monitors corporate data (from the Decision Support Systems, and the VHA Support Service Center and Office of Productivity) and distributes analyses to the field to provide feedback, education and support.

- A fourth mechanism for oversight is ongoing communication and coordination with the field to monitor compliance. Data on Patient Aligned Care Teams (PACT) implementation including access, continuity, and care coordination are available online in the PACT Compass. This data is available at the provider, facility, VISN and national level, and is extracted in a PACT Dashboard that indicates each facility's level of achievement. The VHA Office of Primary Care Operations leads twice monthly calls with Primary Care VISN Leads, where primary care leaders representing each VISN are provided the opportunity to discuss issues and problems they are having implementing PACT functions and processes at the regional level, and Compass and Dashboard data are routinely reviewed. On a quarterly basis, these calls include facility leads as well.

8. **When a patient safety incident and/or preventable veteran death is identified does VA automatically review the incident to assess whether administrative action is warranted against the employees involved? Please explain.**

Any adverse event for a Veteran within our care is one too many. When an incident occurs in our system we aggressively identify, correct and work to prevent additional risks. We conduct a thorough review to understand what happened, prevent similar incidents in the future, and share lessons learned across the system.

VHA along with many other healthcare organizations pursues a "just culture", in which accountability principles are clearly stated but people are not punished for making inadvertent medical errors. Professor Lucian Leape of the Harvard School of Public Health has testified before Congress that the single greatest impediment to error prevention in the medical industry is that we punish people for making

mistakes.[1] Calling for punishment and termination of employees is not supported by the research describing Just Culture as a model for management of mistakes and errors. Ignoring what the science of safety tells us about the causes of human error encourages staff to cover up or not report such errors. Adverse events and close calls are a function of system level vulnerabilities rather than intentionally unsafe acts requiring administrative review or disciplinary action. Event reporting and speaking up by employees is openly encouraged by VHA leadership. The National Center for Patient Safety (NCPS) collects and analyzes adverse events and close call reports in order to share remedies and lessons learned. Reports and analyses collected by NCPS are not used for administrative or disciplinary action.

When a patient safety incident or preventable death occurs and it reasonably appears to be the result of, among other issues, an intentional or negligent unsafe act on the part of a provider, the case is given a preliminary review by clinical leadership at the facility. If facility leadership has concerns related to the adverse event, it may convene an administrative investigation.

In the case of adverse events in which clinical decision-making associated with care delivery is of concern, a peer review of the case can be initiated. A Peer Review program is in place in every VA facility to assist with this process and to improve the quality of care provided to Veterans. Peer review for quality management is an evaluation of the care provided by an individual provider to evaluate the performance of a peer professional. If a clinical event falls into one of the categories listed in the VHA policy on peer review for quality management, e.g., death appears to be related to a hospital-incurred incident or a complication of treatment, the case will be referred for peer review pursuant to policy. Any resulting recommended actions to improve performance are communicated back to the provider who was the subject of the peer review. However, if willful misconduct or gross negligence is identified during the initial case review or conduct of a peer review for quality management, the peer review will not be initiated, or will be discontinued. The case will then be referred back to facility leadership to determine the appropriate administrative course, e.g., an Administrative Investigation Board.

9. **The Department's written statement alleges that the root cause analysis (RCA) is used to, "...determine basic and contributing system causes of errors." Yet, the VA Inspector General (IG) found that implementation of the RCA action plans at the Memphis VA Medical Center were delayed, incomplete, and contained errors in fact. The IG also found that, "when issues were identified through the RCA process, actions to prevent a recurrence were not taken seriously." Please respond to the IG's findings. In addition, please provide the number of RCAs that were conducted at VA**

[1] Testimony, United States Congress, House Committee on Veterans' Affairs, Dr. Lucian L. Leape, MD, October 12, 1997.

medical facilities last year. Of those, how many concerned delays in care and treatment?

The October 23, 2013, OIG Report documents that the Memphis VA Medical Center completed actions related to the OIG recommendation that the facility director ensure root cause analysis action plans are documented, monitored, and completed promptly. The facility established a tracking tool for RCA actions in June 2013.

The National Center for Patient Safety (NCPS) SPOT (electronic Root Cause Analysis database), reflects 1,597 RCAs for the period from Jan 1, 2013 to Dec 31, 2013. Of those, 195 were related to delay in diagnosis, treatment, or combined category.

10. **During the hearing, the American Legion referenced waiting approximately five months for the Department to respond to a request for a report regarding the Jackson VA Medical Center. When will the Department provide that report to the American Legion?**

The report referenced is in final review at the Department. It will be provided to the Committee when review is complete.

Ranking Member Michaud

4. Continued investment in technology is a big component of VA's strategy to expand access to benefits and services, eliminate the claims backlog, and end veteran homelessness, the top three priorities of the VA. You have requested nearly an 11 percent increase.

a. Can you point to specific programs and initiatives that support your top three priorities that you will be able to undertake with this increase?

VA Response: VA's information technology (IT) development budget includes significant investments in meeting the agency's priority goals of expanding access to benefits and services, eliminating the claims backlog, and ending Veteran homelessness, including:

- $150 million to support elimination of the backlog (Veterans Benefits Management. System, Veterans Relationship Management, legacy systems)
- $250 million to support integrated Electronic Health Record development.
- Expanded healthcare, benefits and services for our Nation's Veterans.
  - New Models of Care and Healthcare Access = $36.2 million.
  - Veterans Relationship Management = $120.1 million.
  - Virtual Lifetime Electronic Record = $11.3 million.
  - Affordable Care Act = $3.4 million.
- Continued work on Virtual Lifetime Electronic Record.
- Finishing our work on the other Transformational Initiatives such as GI Bill automation enhancements.
- Improving efficiency and effectiveness of operations and maintenance of existing systems and infrastructure.
- International Statistical Classification of Diseases and Related Health Problems, revision 10 (ICD-10).

The increase in VA's IT budget also supports sustainment of ongoing efforts to meet its priority goals. Some of these IT sustainment costs include:

- Providing the IT equipment and solutions needed for new users given the full time equivalent (FTE) growth throughout the Department;
- As new applications supporting agency goals are added to the infrastructure, they must be supported and maintained;
- New facilities have been activated; once activated, those facilities require continued IT dollars to sustain the equipment suite;
- Telecom cost increases driven by telework, telehealth, telemedicine applications; and
- Increases in telecom use generally by the VA user community.

b. Please provide the Committee with any strategic plan that is in place that directly correlates your IT systems and software with your three stated priorities, including proposed lifespan of these systems and software and identified necessary investments in the next five fiscal years.

VA Response: As part of VA strategic planning process, VA is working on a revised strategic plan, which includes IT. VA will provide the completed plan to the committee upon publication.

5. A large component of your IT budget, $2.2 billion, is for "sustainment." This includes spending on legacy systems.

    a. Do you have a long-term strategy to reduce your expenditures on legacy systems? What are the short and medium term steps in this plan?

VA Response: VA is committed to ensuring that it gets the best possible return on its IT investment for Veterans and taxpayers. VA has aggressively addressed rising sustainment costs in order to ensure every IT dollar at VA is well spent.

VA has been working to develop and pursue approaches to reducing spending on IT systems, services, and processes that may be inefficient, redundant, or overpriced, specifically through its Ruthless Reduction Task Force. These efforts are focused on both new and legacy systems. VA is continuously soliciting ideas and recommendations, following up with research and analysis, and initiating reduction projects as warranted. Each approved project will be assigned a budget, a project manager or managers, target dates, and cost avoidance targets.

VA has identified many areas where potential savings may exist, including data consolidation (with no impact to patient care) and data reuse, retiring expensive legacy systems, and reducing duplicative system processes. Not only will these efforts allow VA to better spend critical IT dollars, they should introduce better business value by increasing system response times. Other sustainment divestment plans include consolidating data warehouses, controlling the number of mobile devices assigned, moving to multifunction printing devices instead of desktop printers, and eliminating dedicated fax lines.

    b. Is VA's spending on legacy systems in line with other Federal agencies and the private sector?

VA Response: The private sector and public sector are very different in terms of financial management, budgeting, and financial tracking. While the private sector is concerned with revenue and expenditures, public sector leaders focus on appropriations and obligations, making it difficult to match performance to expenditure. The lack of information technology cost data makes it difficult to compare legacy IT costs to the private sector.

However, this is why VA instituted the Project Management Accountability System (PMAS). PMAS allows VA to focus its resources in a way that can be accurately and objectively measured (time and functionality) versus those that cannot (cost and progress). Today, VA has 256 active development projects, tracked in real-time through

a dashboard. PMAS principles enforce fiscal discipline by limiting software deliveries to six months or less, detecting and stopping wasteful programs early in their lifecycle. Since PMAS was required for all IT projects in 2010, VA has delivered 83 percent of projects on time, and a total of 98 percent of all IT projects ultimately deliver on their requirements, compared to the industry rate of approximately 42 percent.

6. Your information technology budget for FY 2014 projects $252 million, or 51 percent of the development budget request of $495 million, to fund the Interagency Program Office (IPO), which will manage the integrated Electronic Health Record (iEHR) and the Virtual Lifetime Electronic Record (VLER). Given the problems with the management of the IPO that were examined in a recent hearing, what substantive changes have been made to the structure of the IPO that will improve its performance and what are the measurable outcomes you expect to achieve with this $252 million dollar expenditure?

VA Response: VA's $252 million request is for iEHR. VA is working with DoD and the IPO to implement the spending and project management approaches at the IPO that we have at the VA. This includes managing iEHR deliverables under the VA's Project Management Accountability System (PMAS), including the key PMAS principles of incremental delivery and "3 strikes" for projects. By using an incremental focus, VA delivers software and feature enhancements with direct value to the customer every six months or less. The 3 strikes rule mandates that any project missing three delivery dates will be stopped for review, after which the project will either be refactored with a new project team or canceled. Moreover, many projects are reviewed and restructured or canceled before reaching a third strike. At VA, these changes have allowed us to meet an on-time delivery rate of over 83 percent, and all projects ultimately meet their delivery requirements 98 percent of the time. We are working with the IPO to require incremental delivery for iEHR projects. VA hopes that instituting these changes at IPO will help better position IPO to meet its critical iEHR delivery dates.

Rep. Corrine Brown

1. In FY13, there was a line item for 508 compliance of $9.43 million. However, there is no line item in the FY14 budget for 508 compliance, specifically 508 compliance to IT systems. What staffing resources and line item funding will be available for FY14? Please explain.

VA Response: Previously, VA's Section 508 IT compliance efforts were divided between the "Section 508 Program Office" within the Office of Information and Technology (OIT), and the "Health 508 Office" in the Veterans Health Administration (VHA). In FY 2014, all 508 efforts will be centralized within OIT.

In FY 2014, the combined government IT staff for both offices will be 11 FTE. The FY 2014 President's Budget has $37.265 million identified for "Product Development Tools Management Competency." This line item includes funding for Product Development

IT's "Product Assessment Competency Division" of which $11,871,309 is for VA's 508 program."
Funding will cover:

- Contracted resources to support the development and execution of Section 508-related training for developers, testers and non-technical staff.
- Testing support services to: (1) bring new software into compliance with Section 508 requirements, and (2) audit existing Section 508-compliant software to ensure that it remains compliant.
- Maintenance of hardware and software that is used to test IT systems for Section 508 compliance.
- Development of an enterprise-wide approach to bring all VA SharePoint repositories into compliance with Section 508 requirements.