



DEPARTMENT OF VETERANS AFFAIRS

Veterans Health Administration

ADMINISTRATIVE HISTORY PROJECT

**VHA SUMMARY OUTLINES, NARRATIVES, AND
SUPPORTING DOCUMENTS INDICES**

October 27, 2000

ADMINISTRATIVE HISTORY PROJECT VHA RESPONSE (SUMMARY OUTLINES, NARRATIVES, AND INDICES OF SUPPORTING DOCUMENTS)

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INTRODUCTION

During the Clinton Administration, the Veterans Health Administration (VHA) underwent the most dramatic metamorphosis of its history. The sweeping transformation was so outstanding that it was and continues to be chronicled in the annals of business and management, as a model of improved performance for organizations, private and public.

Back in 1993, VHA's very survival appeared in jeopardy, as it had waxed out of sync with prevailing trends in healthcare delivery. The organization's structure was convoluted and fragmented. Its emphases on medical specialization and inpatient care ran contrary to concurrent trends that were heading in the opposite direction, toward primary care and outpatient-based services. Most of VHA's services were centered around "brick-and-mortar" units - the traditional VA Medical Centers (VAMCs) - many of which were large, technologically intensive and often underutilized. Moreover, VHA had only a scant infrastructure for providing services in the community. In addition, there were serious prospects of budgetary cuts and competition for VHA's patients from private sector healthcare organizations. This was confounded by a highly centralized decision making hierarchy, and a seeming inability to adapt to external challenges. *The picture was bleak!*

By contrast, VHA in 2000 is a vibrant, living and breathing organism. The transformation entailed a 180-degree turnaround from a monolithic, military-style top-down organization, into 22 Veterans Integrated Service Networks (VISNs). VISNs became VHA's primary operational decision making and budgeting units. VHA headquarters substantially reduced its staff, and focused on policy setting and providing support and counsel to VISN Directors, and fostering these new concepts, rather than hierarchical dominance. VISN design reflected patient referral patterns among VHA hospitals and other service organizations. Resource allocation became dependent on capitation, i.e. the number of veterans served rather than blindly following "historical" costs. This new system eliminated layers of bureaucracy, and emphasized collaboration and efficiency. Case management is applied, with the patient assigned to a dedicated physician or physician-led team of caregivers, responsible for providing a continuum of care.

VHA today, in addition to its model transformation (and perhaps *because of it*), leads the nation in the areas of patient safety, quality emphasis and dissemination of innovations and lessons learned. Substantial improvements were made on a number of important performance indicators. Outpatient-based care, including outpatient surgeries have dramatically increased, resulting in an increase of outpatient visits by 44 percent and a decrease of Acute Bed Days of Care by 68 percent during 1994 -1999. Over 650 new community-based outpatient clinics have been established. Telephone-linked care was implemented at all hospitals. From 1997 -1999 unique patient costs were reduced by 16 percent in constant dollars, while the number of treated patients increased by 24 percent.

VHA's transformation, nonetheless, is still a work in progress, reflecting the challenges inherent in large-scale organizational change, as well as the reality that the entire health care industry is in transition. However, VHA is steadfastly set on a course towards becoming a fully integrated health care provider, competitive with and in fact providing leadership to other healthcare systems and agencies.

BACKGROUND

VHA, the largest US health care delivery systems, has four congressionally mandated missions: Patient Care, Research, Training, and Medical Emergency Backup for the Department of Defense. VHA is the largest integrated health-care system with 172 hospitals, 132 nursing homes, 40 domiciliaries, and over 650 community based outpatient clinics and a medical care budget of more than \$19 billion. Today, 3.9 million veterans are enrolled in VA health care.

VHA's extensive research programs in biomedical sciences, rehabilitation medicine, and health services delivery systems have produced a plethora of medical innovations in multiple fields. VHA's training mission is accomplished through academic affiliations with over 2,000 educational institutions. Each year, approximately 100,000 students receive clinical training in VA facilities. More recently, the agency has augmented its employee education programs by establishing the VA Learning University (VALU) and emphasizing a "One VA" approach to organizational learning.

In providing medical contingency backup for the Department of Defense, VHA provides wartime support to the DOD's medical system, and assists the Public Health Service and the National Disaster Medical System in providing emergency care to victims of natural and other disasters.

ABOUT THIS DOCUMENT...

This report contains highlights of VHA's history from January 1993 to the present. The "Background" section provides an overall review of VHA's missions. This is followed by reports from various VHA offices and elements on their respective histories during that period. A summary outline is followed by a narrative with a supporting document index. For questions concerning this report, please contact Laura Warfield or Dr. Victor Wahby at VHA's Office of Special Projects 202-745-2200.

CHIEF NETWORK OFFICE
Summary Outline

<u>Project or Accomplishment</u>	<u>Date Completed</u>	<u>Description</u>
Move from Outpatient to Inpatient focused care	Ongoing	To meet changing healthcare needs of veterans
Opened Community Based Outpatient Clinics	Ongoing	To improve access to care for veterans
Initiated VA/Labor Partnerships through local VHA partnerships and the National Partnership Council	Ongoing	Enhance cooperation between labor and management to improve patient care
Established and implemented 22 Veterans Integrated Service Networks (VISNS)	1996	Decentralized VA facility operational control to field based leadership from Headquarters
Established the Chief Network policy Office	1996	Provided Central Office guidance, leadership access, and support for VISNs
Safety in Workplace Initiative	Ongoing	Partnered with OSHA to improve safety for employees and veterans
Increased Partnership with other Federal Agencies for delivery of healthcare through Medical Sharing Agreements	Ongoing	Eliminate duplication, improve access, reduce costs
Patient Safety Initiatives	Ongoing	Designed and implemented patient incident registry to increase patient safety and reduce medical mistakes
Implemented electronic patient record system	Ongoing	Reduce paperwork, improve efficiency, provide more comprehensive and reliable system for monitoring health and tracking treatment for veterans

Homeless Initiatives	Ongoing	Improved access to care for homeless veterans through expansion of grants and executive accountability
Electronic media initiatives (established Web page, equipped all Field facilities with e-mail, implemented teleconferencing)	Ongoing	Broaden information access, improve efficiency and reduce communication costs
CARES	Ongoing	Review of capital asset infrastructure and market demands to enhance delivery of services through improved alignment
Management Improvement Checklist		Management tool outlining best practices for enhancing efficiency, reducing costs, and improving health care delivery through organization adjustments, integrations, and staffing guidelines
High Performance Development Model		Initiated and implemented an executive accountability plan based on performance measures and achievement
Facility Integration	Ongoing	Consolidated management of facilities in close geographic areas, establishing Centers of Excellence, reducing service duplication, cutting costs, and improving efficiency
Hepatitis C Initiative	Ongoing	Increased screening and aggressive treatment of Veterans
Bar Code Medication Administration	Ongoing	Increase efficiency and safety of medication administration
Waiting Time Initiative	Ongoing	Monitoring system and policy initiative to reduce waiting times for primary care medical appointments

CHIEF NETWORK OFFICE

Narrative

Move from Inpatient to Outpatient Focused Care -- To better meet the changing healthcare needs of veterans, the Veterans Health Administration has initiated a number of programs to encourage field facilities and leaders to shift the focus in health care delivery to ambulatory care. This change in focus has resulted in increased numbers of veterans served by VA as well as reduced costs associated with early medical treatment and intervention. Additionally, the change in operational doctrine has brought the Veterans Health Administration in compliance with the best industry practices of the private health care delivery industry.

Community Based Outpatient Initiative -- In an effort to provide maximum flexibility for improving the quality of patient care and to increase the efficiency of operations, Veterans Integrated Service Networks (VISN) have been authorized to establish Community Based Outpatient Clinics (CBOCs). The Chief Network Office established procedures for the justification and establishment of these new points of access. VHA Directive 97-036 became effective July 16, 1997 and expires July 16, 2002.

Veterans Integrated Service Networks (VISN) -- One of the most tangible signs of the changes in the veterans healthcare system is the implementation of the Veterans Integrated Service Network (VISN) management structure. This new management structure, composed of 22 geographically based entities, emphasizes decentralizing day-to-day operations, pooling and aligning resources with local needs, and improving customer service.

Chief Network Office -- The Veterans Health Administration (VHA) established the Chief Network Office to coordinate and manage interaction with field operating entities and the Office of the Undersecretary for Health. The Chief Network Office is composed of an executive leadership team, program teams, and a team of health systems specialists that interact with the field leadership to ensure consistency of operations and effective communication.

Facility Integration -- VHA utilized the term "integration" to describe the pooling of assets and operations of facilities that are part of the same healthcare system and that serve a well-defined and relatively stable population. The essential aspect of facility integration is that two or more facilities, and generally their various clinical and support operations are combined under single management. The overriding strategic intent of a facility integration is to create better ways of serving veterans with VHA's limited resources. In April 1998, VHA published A Guidebook for VHA Medical Facility Integration that outlines the background, goals and procedures for the facility integration program.

Homeless Initiatives -- VHA is the single largest direct care provider for homeless persons in the country -- a critically important element in the Nation's public safety net. Throughout the 22 VISNS, VA provides direct services such as outreach, case management, residential treatment, therapeutic work opportunities and assistance with permanent housing for homeless veterans and those at risk for homelessness. VHA has expanded the range of services available to homeless veterans through partnerships

with other federal agencies, veteran's service organizations, state and local governments and non-profit organizations.

Electronic Patient Record System -- Access to patient information is a crucial element in VHA health care delivery. Cross referral of patients within and among VISNs is becoming a standard method of providing care. The Electronic Patient Record System was designed to provide up-to-date clinical and demographic data automatically to facilities. This system provides the ability to identify and track all locations where patients are receiving care and implements a VHA Master Patient Index to enable consistent updates of patient demographic data.

Bar Code Medication Administration -- The Bar Code Medication Administration (BCMA) is a VHA initiative to increase efficiency in medication administration, improve medication administration accuracy, and provide online patient medication records. The Heartland Veterans Health Network (VISN) developed a software system that was modified to meet the general needs of all VA medical centers. The nationally released BCMA software enables users to electronically document medications at the bedside or other points of care. VA maintains a BCMA web page to provide access to information.

Patient Safety Initiative -- VHA is uniquely positioned to serve as a national laboratory for finding and implementing ways to prevent health care errors and improve patient safety. VHA is in the vanguard of the efforts to improve patient safety, ensuring safe, high-quality care. In an effort to understand the issues and to act for patient safety, VHA has joined a public-private consortium of organizations with a shared interest and commitment to patient safety improvement through the National Patient Safety Partnership (NPSP) that was formed in 1997. One of the primary initiatives is to investigate not only accidents, but also close calls. The analysis of close calls provides the best opportunity to learn and institute preventive strategies, as they will unmask most system weaknesses without having to experience a tragedy. This has led to the development of new safety strategies and processes to improve patient safety and prevent future health care errors.

Hepatitis C Initiative -- Hepatitis C Virus (HCV) has a particular importance for VHA because the prevalence in the VA's service population is substantially higher than in the general population. To address needs of HCV-positive patients, VA designated medical centers in Miami, FL and San Francisco, CA as Centers of Excellence to serve as research and education lynchpins of a VA 5-point strategic initiative to respond to HCV. The five-point strategic initiative includes: patient education; health care provider education; epidemiologic assessment; treatment and research. Additionally VHA conducted a nationwide surveillance activity and tested over 26,000 veterans from across the country for HCV in a single day. The data collected from this sample will be utilized to assess risk factors, prevalence rates, and serve as a basis for VA's ongoing HCV planning.

CARES -- The Capital Asset Realignment for Enhanced Services program was initiated by VHA to improve the delivery of health care to veterans. This program establishes a process for review of capital asset infrastructure and market demands to enhance delivery of services through improved alignment.

Management Improvement Checklist -- VHA developed a management tool outlining best practices for enhancing efficiency, reducing costs, and improving health care. The

checklist offers a tool for implementing organization adjustments, integrations, and staffing guidelines.

Performance Measures and High Performance Development Model – The VHA CNO initiated and implemented an executive accountability plan. This plan allows for review of VISN accomplishments based on objective performance measures and achievement.

Waiting Time Initiative -- VHA is committed to providing both quality and timely care to the veterans enrolled in our health care system. In an effort to improve efficiency and measurement of quality of care, VHA has developed a monitoring system and policy initiative to reduce waiting times for primary care medical appointments.

Federal Agency Partnerships -- To eliminate duplication, improve access to care for veterans and reduce the cost associated with health care delivery, VHA has increased partnership with other federal agencies for delivery of health care through medical sharing agreements. Additionally, VHA participates in a number of forums with other federal agencies and the private sector to address broad-based health care dilemmas.

Workplace Safety Initiative -- Safety of veterans and employees is a primary concern for VHA leadership. To improve safety for both veterans and employees, VHA has partnered with OSHA to develop workplace guidelines and monitors.

VA/Labor Partnerships -- VHA has initiated local partnerships to enhance cooperation between labor and management to improve patient care for veterans. Additionally, by working with representatives of labor as participants in the National Partnership Council, VHA has improved processes for identifying serious issues and improved relations through enhanced negotiating procedures.

CHIEF NETWORK OFFICE
Supporting Documents Index

Patient Safety Initiative

Information Letter 10-97-040

December 8, 1997

VHA Patient Safety Improvement Awards Program

The VHA is committed to improving healthcare quality in VHA treatment facilities and in the healthcare industry overall. One important element of the VA's healthcare quality improvement effort is its Patient Safety Improvement Initiative. This initiative includes: 1.) promulgation of the Patient Safety Improvement Directive (formerly entitled the Risk Management Directive, VHA Directive 1051); 2.) establishment of the Forensic Medicine Strategic Healthcare Group; 3.) inclusion of patient safety-related measures in the Fiscal Year (FY) 1998 Veterans Integrated Service network (VISN) Directors performance agreements; 4.) creation of the National Patient Safety Partnership; 5.) provision of funding and other support for industry-wide conferences and expert working groups on patient safety; 6.) establishment of a new health system management fellowship aimed at developing clinical leaders in healthcare quality improvement; and 7.) the funding of new quality of care clinical research projects. The VHA Patient Safety improvement Awards Program will provide a financial reward ranging from \$500 to \$5,000, along with other recognition, to individual caregivers or teams of caregivers. The exact amount of the award will depend upon the extent to which the improved process can be adopted in, or adapted to, other patient care settings and the severity of the potential hazard it reduces or eliminates.

VHA Directive 98-050

November 6, 1998

Request for Proposals for Patient Safety Center of Inquiry

This VHA Directive announces the opportunity for various entities of VHA to compete to become a VHA Patient Safety Center of Inquiry. A successful center is expected to provide leadership and develop and encourage duplication of successful innovations to enhance development of a VA culture of safety and related quality improvement activities in VHA.

Information Letter 10-98-015

July 9, 1998

VHA Patient Safety Improvement Awards Program

The VHA is committed to improving healthcare quality in VHA treatment facilities and in the healthcare industry overall. The VHA Patient Safety Improvement Awards Program provides a financial reward ranging from \$500 to \$25,000, along with other recognition, to recipients. Larger rewards shall be targeted for improvements that reduce or eliminate life-threatening risks and have system-wide application.

Information Letter 10-99-010

June 29, 1999

National Center for Patient Safety

Untoward outcomes for patients consequent to their medical care is a worldwide problem that has been identified and discussed in the literature and elsewhere for decades. In order to address this problem, the VHA has formed the National Center for Patient Safety (NCPS -- pronounced N-sies).

VHA Directive 99-038

August 6, 1999

Quality Management of Defibrillators

This VHA Directive establishes minimum standards for quality management of defibrillators at VA medical centers.

VHA Directive 99-042

September 21, 1999

Standardization of Glycohemoglobin Testing

This Veterans Health Administration (VHA) Directive establishes the standards for glycohemoglobin testing and reporting at the Department of Veterans Affairs (VA) medical centers.

VHA Directive 1050.2

Transmittal Sheet

June 12, 2000

Patient Advocacy Program

This VHA Directive provides expectations and requirements for the Patient Advocacy Program in all VHA facilities, and helps promote a meaningful understanding and utilization of the program.

Move from Inpatient to Outpatient Focused Care

VHA Directive 96-045

July 12, 1996

Continuum of Home Health Care within the Veterans Health Administration

The purpose of this VHA Directive is to: (a) Emphasize the need for a comprehensive array of home care services for eligible VA beneficiaries, (b) Define, describe, and differentiate the various home health services available from VHA and the private sector, and (c) Outline a policy for appropriate use of VHA and community home care resources including responsibility for coordination of care, medical management of home care patient, and monitoring the quality of care delivered.

VHA Directive 97-058

November 24, 1997

Veterans Health Administration Policy for Assigning Station Number Suffix Identifiers for Outpatient Clinics (OPCs)

This VHA Directive provides guidance for the assignment of station number suffix identifiers for outpatient clinic facilities. It replaces VHA Directive 10-94-023, Revised Station Numbers for Outpatient Clinics dated March 21, 1994.

VHA Directive 98-008

February 2, 1998

**Authority to Transfer Veterans Receiving Outpatient Care to Non-department
Nursing Homes**

This VHA Directive provides nationwide policy for implementing section 402(c) of Public Law (Public. Law) 105-114, the "Veterans' Benefits Act of 1997."

VHA Directive 98-022

April 1, 1998

National Home and Community-Based Care Strategy

This VHA Directive articulates national VHA policy and establishes a national VHA strategy that will provide the context for expanding and developing home and community-based care within each Veterans Integrated Service Network (VISN) to respond to healthcare needs of enrolled veterans.

VHA Directive 98-023

April 17, 1998

Guidelines for Implementation of Primary Care

This VHA Directive establishes guidelines and provides direction for the implementation of primary care at all VA medical facilities and at off-site locations.

VHA Directive 99-012

March 26, 1999

Outpatient Prescription Processing Time

This VHA Directive establishes policy regarding an outpatient prescription processing time standard across the VA health care system.

Information Letter 10-2000-006

July 25, 2000

Vocational Rehabilitation Veterans Outpatient Dental Procedures

This information letter is to remind all VHA facilities of the following information regarding services provided by the VA Vocational Rehabilitation and Employment (VR&E) Program. The VR&E Program provides all services and assistance necessary to enable veterans with service-connected disabilities to achieve maximum independence in daily living, and to the maximum extent feasible, to become employable, obtaining and maintaining suitable employment (see Title 38 United States Code (U.S.C.) 3100). VHA policy states that Class V, as well as all Classes I-VI, dental outpatients have a high priority to receive such care from VA and resources should be provided for their care.

Community Based Outpatient Initiative

VHA Directive 96-049

August 7, 1996

**Veterans Health Administration Policy for Planning and Activating Community
Based Outpatient Clinics**

The purpose of this VHA Directive is to establish a policy for planning and activating new VA Community Based Outpatient Clinics (CBOCs). It replaces VHA Directive 10-95-017, VHA Interim Policy for Planning and Activating VA Access Points. The intent of establishing a new presence of outpatient care is primarily to enroll current users of our health care system who find it difficult to access because of geographic location or

medical condition to travel to a VA medical center, independent outpatient clinic, or satellite outpatient clinic.

VHA Directive 97-036, Change 1

October 28, 1997

Veterans Health Administration Policy for Planning and Activating Community Based Outpatient Clinics

This change to VHA Directive updates the policy for planning and activating new VA Community Based Outpatient Clinics (CBOCs).

Veterans Integrated Service Networks (VISN)

VHA Directive 10-95-111

November 7, 1995

Implementation of Veterans Integrated Service Network Formularies

The purpose of this VHA Directive is to implement Veterans Integrated Service Network (VISN) Drug Formularies.

VHA Directive 97-054

October 30, 1997

Network Resource Allocation Principles

The purpose of this VHA Directive is to provide the guiding principles for resource allocation from networks to facilities.

VHA Directive 97-054, Change 1

November 19, 1998

Network Resource Allocation Principles

The purpose of this change to VHA Directive 97-054 is to add statement to 2b.(5) as recommended by the General Accounting Office (GAO) in its Final Report, VA Health Care: More Veterans Are Being Served, But Better Oversight is Needed. VHA will add a criterion concerning the equity of resource allocation to facilities. This amendment will enable VHA's compliance with the GAO recommendation.

<http://www.va.gov/stations97/guide/map.asp?DIVISION=VHA>

October 25, 2000

Facilities Directory

This web page site provides information on the location of Veterans Health Administration facilities. The site includes a map of the United States that demonstrates the locations of the 22 Veterans Integrated Service Networks (VISN) and provides flexibility to view facilities by state.

Chief Network Office

VHA Directive 96-002

January 19, 1996

New Office Titles for VHA Headquarters

The purpose of this VHA Directive is to designate the new office titles/symbols that will be used to refer to VHA Headquarters offices associated with the VHA restructuring. The new VHA Headquarters office titles replace the old VHA Central Office titles.

VHA Directive 1000.1

Transmittal Sheet

April 30, 1998

Bed Control Management

This VHA Directive converts and updates that portion of the VA, VHA Manual M-1, "Operations," Part I, Chapter 1, which addresses VA Bed Control Management activities. This VHA Directive provides Department-wide policy governing bed control management activities. Changes in authorized bed capacities require the prior approval of the respective Network Director. Facility Directors will be made aware of any proposed changes within special programs that may affect other VA healthcare facilities within and outside of their network, i.e., Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), or other referral centers.

VHA Directive 99-048

October 22, 1999

Use of Prior-Year Funds for Non-Recurring Maintenance (NRM) Construction Projects

This VHA Directive provides guidance for the appropriate use of prior-year funds in an expired account in accordance with the Expired Funds Control Act of 1990, Title 31, United States Code (U.S.C.) 1551-1557. The Chief Network Office (10NB) is responsible for the contents of this directive.

Information Letter 10N-2000-002

April 27, 2000

Fire Safety Requirements for Community Homes Housing Veterans

The VA clinical programs for placing veterans in and referring veterans to community homes and other facilities have expanded over the years in number and diversity. Many of the programs have specific VA policy manuals and directives addressing the programs fire safety requirements, such as the application of National Fire Protection Association (NFPA) Life Safety Code (LSC). However, it is often difficult to determine which fire safety requirements apply since they can differ for each program. This Chief Network Officer Information Letter clarifies the differences between the programs.

Homeless Initiatives

Information Letter 11-95-002

April 13, 1995

Proposal Request for Pilot Programs for Homeless Veterans' Dental Care

The Office of Dentistry in conjunction with Domiciliary Care Programs solicited proposals for three pilot programs that would demonstrate innovative ways to provide dental care for homeless veterans. The Secretary of Veterans Affairs has indicated that meeting the needs of the homeless veterans is one of his highest priorities.

Information Letter 10-95-011

July 19, 1995

Community Homelessness Assessment - Public Law 102-405

The Veterans Health Care Amendments Act of 1992, Public Law (Pubic Law.) 102-405, requires VA medical center Directors and Regional Office Directors to conduct yearly assessments to determine the needs of homeless veterans, and to describe progress

made within each community to develop comprehensive and coordinated services for homeless veterans. The results of these activities are reported annually to Congress. The first annual report, dated December 1994, was provided to the appropriate committees of Congress.

Information Letter 10-96-016

September 17, 1996

Community Homelessness Assessment - Public Law 102-405

The Veterans Health Care Amendments Act of 1992, Public Law (Pubic Law) 102-405, requires VA medical center Directors and Regional Office Directors to conduct yearly assessments to determine the needs of homeless veterans, and to describe progress made within each community to develop comprehensive and coordinated services for homeless veterans. The results of these activities are reported annually to Congress. The first report, dated December 1994, was provided to the appropriate committees of Congress. As these legislative requirements for the third year are addressed, VHA's continued support of these efforts and VHA's leadership demonstrate VA's commitment to working with other Federal, state and local agencies, veterans service organizations, and other non-profit organizations, dedicated to helping homeless veterans.

Information Letter 10-97-017

March 28, 1997

Community Homelessness Assessment -- Public Law 102-405

The Veterans Health Care Amendments Act of 1992, Public Law (Pubic Law) 102-405, requires VA medical center Directors and Regional Office Directors to conduct yearly assessments to determine the needs of homeless veterans, and to describe progress made within each community to develop comprehensive and coordinated services for homeless veterans. The results of these activities are reported annually to Congress. The first report, dated December 1994, was provided to the appropriate committees of Congress. As these legislative requirements are addressed for the 4th year, VHA's continued support of these efforts and the leadership provided by VA medical staff demonstrate VA's commitment to working with other Federal agencies, State and local governments, veterans service organizations, and other non-profit organizations dedicated to helping homeless veterans.

VHA Directive 99-040

September 16, 1999

Cost Distribution Reports (CDR) Accounts and Treating Specialty Codes for Homeless Veterans

The purpose of this VHA Directive is to emphasize the use of: 1.) Existing Cost Distribution report (CDR) accounts, 2.) Treating Specialty Codes and Budget Object Codes (BOC) for various Health Care for Homeless Veterans (HCHV) Program components, 3.) A new CDR Account for the Domiciliary Care for Homeless Veterans (DCHV) program.

Electronic Patient Record System

Information Letter 10-97-002

January 15, 1997

Ambulatory Data Capture Initiative

The Ambulatory Data Capture initiative is a data collection project which has the goal of creating a national ambulatory care database consistent with current health care industry claims databases. The national mandate for implementing the collection of ambulatory care data on October 1, 1996, was met.

VHA Directive 96-057, Change No. 2

October 21, 1997

Ambulatory Care Data Capture

This change to VHA Directive 96-057, dated September 17, 1996, replaces Attachment A, and adds Attachments C, D, and E. Attachment A now contains Mental Health Decision Support System (DSS) Identifiers in the 500-599 range, and includes a list of DSS Identifiers which were inactivated April 1, 1997. Attachment C contains three tables with implementation guidance and detailed descriptions of the changes to Mental Health DSS Identifiers (formerly stop codes).

VHA Directive 96-057, Change No. 3

June 1, 1998

Ambulatory Care Data Capture

This change to VHA Directive 96-057, dated September 17, 1996, updates the list of Decision Support System (DSS) Identifiers (IDs), in the reporting of VHA outpatient healthcare data, and standardizes VA medical centers' use of DSS IDs between Health Administration service (HAS) and DSS. Outpatients using surgery operating rooms will be assigned to stop code 429 as the primary stop. Seven new Observation stop codes will be used for reporting Observation care. The HAS use of DSS Identifiers should come into concordance with site DSS stop code usage. This change replaces Attachment A dated October 21, 1997, and adds Attachments F and G.

Bar Code Medication Administration

VHA Directive 98-049

November 5, 1998

Bar Coding Patient Wristbands

This VHA Directive defines policy for bar coding a patient's full social security number on the patient identification band.

Hepatitis C Initiative

Information Letter 10-98-013

June 11, 1998

Hepatitis C: Standards for Provider Evaluation and Testing

Hepatitis C Virus (HCV) infection was first recognized in the 1970's, when the majority of transfusion-associated infections were found to be unrelated to hepatitis A and B, the two hepatitis viruses recognized at the time. This transmissible disease was then simply called "non-A, non-B" hepatitis. Sequencing the HCV genome was accomplished in

1989, and the term hepatitis C was subsequently applied to infection with this single strand ribonucleic acid (RNA) virus. The genome of HCV is highly heterogeneous and, thus, the virus has the capacity to escape the immune surveillance of the host; this circumstance leads to a high rate of chronic infection and lack of immunity to re-infection. Reliable and accurate (second generation) tests to detect antibody to HCV were not available until 1992, at which time an effective screening donated blood for HCV antibody was initiated. Hepatitis C has particular importance for the VA because of its prevalence in VA's service population. All patients will be evaluated with respect to risk factors for hepatitis C and this assessment will be documented in the patient's chart. Based upon those risk factors, antibody testing should be utilized as elaborated on in the algorithm found in Attachment A.

The Capital Asset Realignment for Enhanced Services (CARES)

VHA Memorandum 10-2000-03

May 9, 2000

Capital Asset Review Methodology

This Under Secretary for Health's Memorandum establishes a methodology for review of Capital Asset proposals in VHA Headquarters prior to submission to the VA Capital Investment Board (VACIB).

VHA Directive 2000-032

September 26, 2000

Capital Asset Realignment for Enhanced Services (CARES) Program

This VHA Directive describes the Capital Asset Realignment for Enhanced Services (CARES) process.

Management Improvement Checklist

Information Letter 12-96-003

October 8, 1996

Request for Applications: Managing Access to Improve Outcomes

This letter invites research proposals from VA medical centers for studies in an area targeted for special emphasis by the VA Health Services Research and Development Service (HSR&D) in collaboration with Veterans Integrated Service Networks (VISN) Directors. The projects to be funded under this solicitation represent an important opportunity to link VA research with the practical information needs of managers and service providers. This letter and this attachment include example of eligible research topics and information about application procedures.

High Performance Development Model

Information Letter 10-97-012

March 4, 1997

Under Secretary for Health's Award for Superior Customer Service

Nominations are now being accepted for the Under Secretary for Health's Award for Superior Customer Service. This new award program is established to support the customer service values as defined in the "Prescription for Change." That definition is

"....To accomplish this mission VHA needs to be a comprehensive, integrated healthcare system that provides excellence in service as defined by its customers..." "Customers define excellence according to the degree to which services received match their expectations." This award program will recognize individuals and activities that have delivered superior customer service in response to customer expectations. Awards will be given annually, and nominees are invited from the following categories: individual, team, facility, Veterans Integrated Services Network (VISN), and VHA Headquarters. Recipients will receive a plaque signed by the Under Secretary for Health.

VHA Memorandum 10-2000-01

March 15, 2000

Performance Management Workgroup

This VHA Memorandum establishes the Performance Management Workgroup (PMWG) whose purpose is to develop a measurement system that reflects VHA priorities, evaluates VHA performance and meets the domains of health care value.

Federal Agency Partnerships

VHA Directive 2000-025

September 1, 2000

Brooke Army Medical Center (BAMC) Burn Unit

This VHA Directive provides policy for burn care provided at Brooke Army Medical Center (BAMC) Burn Unit.

Workplace Safety Initiative

VHA Directive 2000-011

March 22, 2000

Boiler Plant Operations

This VHA Directive revises VHA policy on the operation of boiler plants. It is VHA policy that boiler plants must operate in a safe and economical manner recognizing their importance and potential for explosion.

VA/Labor Partnerships

VA National Partnership Council

April 2000

Labor-Management Partnership Annual Progress Report

This document includes the transmission from the Secretary of VA to the Director of the Office of Management and Budget regarding the VA Labor-Management Partnership Annual Progress Report as directed by the President's Executive Memorandum on Reaffirming Executive Order 12871. This report reflects the Department's results and accomplishments of labor-management partnership within VA.

VA National Partnership Council

May 2000

Implementation Steering Committee

In September 1999, the VA National Partnership Council (NPC) charged the Implementation Steering Committee to put into practice the recommendations of an earlier group, the Improving Partnership Subcommittee. The original recommendations were geared to improving Labor-Management Partnership Councils. The Improving Partnership Subcommittee, a One-VA effort, reviewed the history of Labor Management partnerships in VA and found great variability in the success of the partnership concept throughout the Department. The Implementation Steering Committee's plan to energize the function of Partnership Councils involved a number of recommended necessary actions included in the document.

OFFICE OF POLICY & PLANNING
Summary Outline

- Passage and implementation of the Veterans Health Care Eligibility Reform Act of 1996.
- Monitoring capacity of special emphasis programs (requirement of Eligibility Reform Act)
- Passage and implementation of the Veterans Millennium Health Care and Benefits Act of 2000
- Reorganization of the veterans health care system: ***Vision for Change and Prescription for Change***
- Strategic Planning for VA's health care system, including national planning guidance and VISN strategic plans
- VHA Annual Report: ***Journey of Change I – III***
- VA Performance Plan, Targets and Accountability Report, focusing on 10 for 2002 and including 30-20-10
- VA Strategic Plan, Strategies and Targets (6 for 2006)
- Creation of Data Consortium to bring together data offices for purpose of improving data quality and application of data in supporting health care system decision making
- Development of Geographical Access analyses and station tracking system
- Development and application of planning models for inpatient, outpatient and long-term care

OFFICE OF POLICY & PLANNING

Narrative

I. Implementation of the Veterans Health Care Eligibility Reform Act of 1996

The Veterans Health Care Eligibility Reform Act of 1996, P.L. 104-262, realigned access to VA health care by basing care delivery on patient need and by expanding the spectrum of care available to eligible veterans. Prior to the enactment of this law, the Department of Veterans Affairs (VA) was required by law to have different rules for who could receive outpatient care and who could receive inpatient care. The rules favored inpatient settings and often restricted treatment to limited health problems for certain veterans. Whereas hospital care could be provided widely, outpatient care had historically been tied to inpatient admission for other than service-connected (SC) care. This was not conducive to providing care in the most cost-effective settings and was not consistent with generally accepted patterns of practice in the private sector, which had begun to focus on primary and preventive care and the ability to utilize new specialized technologies in outpatient settings. P.L. 104-262 eliminated the distinctions between eligibility for hospital care and eligibility for outpatient care. It also required most veterans to enroll in the VA system in order to receive care.

Under P.L. 104-262, the VA

- can provide health care in the most appropriate setting – inpatient, outpatient, or in the home or community;
- can provide preventive and primary care services;
- has expanded authority to provide prosthetics;
- has enhanced ability to provide care through expanded contracts and sharing authorities, thus improving access to VA care in communities closer to where veterans live; and
- must enroll veterans under the new enrollment priorities.

Under P.L. 104-262, VA furnishes hospital care and medical services "which the Secretary of Veterans Affairs determines to be needed." VA has defined "need" as any treatment, procedure, supply, or service that is considered medically necessary when, in the judgment of the patient's clinical care provider and in accord with generally accepted standards of clinical practice, it will

1) Promote health by:

- enhancing quality of life or daily functional level
- identifying a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment
- preventing development of future disease.

2) Preserve health by:

- maintaining current quality of life or daily functional level
- preventing progression of disease
- curing disease
- extending life span

- 3) Restore health by restoring quality of life or daily functional level that has been lost due to illness or injury.

To ensure that all veterans enrolled in the VA system had access to the same array of services regardless of their place of residence, VA developed a uniform benefits package. These benefits are available within each of VA's 22 geographic service areas (Veterans Integrated Service Networks - VISN) through in-house services, sharing agreements, contracts, and other arrangements. The package helps ensure that all veterans cared for by VA will receive a consistent level and quality of care and services regardless of the VISN providing the care. It enhances VA's ability to project the resources required and the number of veterans for whom care can be provided.

Each VISN must make the benefits package available to all enrolled veterans but has the flexibility, within certain limits, to decide where and how the care will be provided. VISNs may make arrangements to provide care directly or by contract, at only one or a limited number of sites, or, when necessary, in another VISN. Certain highly specialized programs, such as transplants, are provided at only a few sites nationwide.

The Law established two basic groups of veterans who are eligible to enroll for VA hospital care and medical services:

- those for whom VA "shall" provide such care and services (38 U.S.C. §§ 1710(a)(1)-(2) [mandatory]
- those for whom VA "may" provide such care and services (38 U.S.C. § 1710(a)(3) [discretionary]

With these two groups combined, the law also established seven enrollment priorities (38 U.S.C. § 1705(a), which are tools to help VA manage demand for care within its limited resources. The enrollment priorities are:

1. Veterans with SC disabilities rated 50 percent or greater.
2. Veterans with SC disabilities rated 30 percent or 40 percent.
3. Veterans who are former POWs. Veterans with SC disabilities rated 10 percent or 20 percent. Veterans whose discharge or release from active military, naval, or air service was for a disability that was incurred or aggravated in the line of duty. Veterans who received a Purple Heart Veterans who are in receipt of, or who, but for a suspension pursuant to 38 U.S.C. § 1151 (or both a suspension and receipt of retired pay), would be entitled to disability compensation, but only to the extent that such veteran's continuing eligibility for such care is provided for in the judgment or settlement provided for in such section.

4. Veterans who are in receipt of increased pension based on a need for regular aid and attendance or by reason of being permanently housebound and other veterans who are catastrophically disabled.

5. Veterans who are not in Priorities 1-4 and who are unable to defray the expenses of necessary care.

6. All other veterans who are not in Priorities 1-5, but who are listed at 38 U.S.C. § 1710(a)(2): veterans with compensable SC disabilities rated at 0 percent; veterans of the Mexican Border Period or WWI; and veterans exposed to a toxic substance, radiation, or environmental hazard.

7. Veterans not described above, e.g., discretionary veterans, including uncompensated SC 0 percent for their NSC conditions, if they agree to pay the applicable co-payment.

By September 1999, the VA had enrolled about seventeen percent of the total veteran population. About twenty-two percent of those enrolled were new enrollees (veterans who had not received care between October 1, 1995 and September 30, 1998).

In the last several years, VA has faced the challenges involved in implementing primary care and the care management it implies, while moving from a hospital-based system to one that is primarily focused on providing services on an outpatient basis. Thus far, however, VA has maintained the ability to provide acute inpatient, outpatient, and in-home care to all veterans, as medically indicated, and has been able to meet the health care needs of all enrolled veterans. Eligibility Reform has brought about some of the most significant changes since the creation of the veterans health care system. These changes have helped VA provide the right care, at the right time, in the right place.

Basic source document for this section is: The Veterans Health Care Eligibility Reform Act of 1996, P.L. 104-262

II. Monitoring Capacity of Special Emphasis Programs (Requirement of Eligibility Reform Act)

Public Law 104-262, Section 104, requires VA to maintain its capacity in meeting the specialized treatment and rehabilitation needs of disabled veterans. Providing specialized services to meet the special needs of veterans is an integral component of VA healthcare. Due to the prevalence of certain chronic and disabling conditions among veterans, VA has developed strong expertise in certain specialized services that are not uniformly available in the private sector. Included among these areas of expertise are Spinal Cord Injury and Disorders (SCI&D), Blindness, Traumatic Brain Injury (TBI), Amputation, Serious Mental Illness (SMI), and Post Traumatic Stress Disorder.

VHA is committed to keeping the special disability programs viable and strong. Monitoring these programs is a continuous improvement process, and work on improving the accuracy and meaningfulness of measures is ongoing.

Inpatient care is generally being maintained at the national level as appropriate and needed for these special patients. The growth in the VA health care system's capacity to treat special patients is largely attributed to the growth in new, innovative outpatient programs. Existing performance monitors suggest that generally access has been maintained and patients are satisfied with their care. Work will continue on developing additional and better outcome performance monitors.

Basic source document for this section is: Report to the Committees on Veterans' Affairs of Senate and House Representatives (Public Law 104-262, Section 104).

III. Strategic Planning for VA's healthcare system, including VHA Performance Plan, National Planning Guidance and VISN Strategic Plans

As part of the transformation of the veterans health care system, a strategic management framework was designed that would clearly articulate the core values of the organization, its goals and missions and how well it performed. This initiative ensured that the medical centers, headquarters, clinical and administrative service line managers, clinical teams and all staff would be able to link their activities to the organization's mission and would align the organization to accomplish its goals.

Several tools were used in this effort, including establishing the strategic goals of 10 for 2002. This clearly-understood set of performance expectations (some of which were incorporated in performance agreements with the top field management) was instrumental in helping achieve a fundamental transformation of the veterans health care system. These goals, along with accompanying measures and strategies, formed an important part of the strategic planning network. They have recently been updated and are reflected in the 6 for 2006.

Every year national planning guidance is issued to the 22 Veterans Integrated Service Networks (VISNs) which serve as the basis for the strategic plans developed and submitted each year. These plans provide the basis for assessing how well the VISNs are performing as well as representing a road map of how health care will be provided to veterans in the future. The VISNs describe how they intend to provide care to their enrolled patients and spell out their strategic goals for medical care, research and education to reflect current and future priorities.

The planning process, which involves both the field and headquarters, provides a continuous feedback loop to annually refine, monitor and assess performance and operating strategies and processes.

Basic source documents for this segment are: VHA National Strategic Planning Guidance FY 2001 – FY 2006; Department of Veterans Affairs FY 2001 Budget Submission Medical Programs; Department of Veterans Affairs FY 1999 Annual Accountability Report.

IV. VHA Annual Report: *Journey of Change I-III*

VHA's journey to date has been described in three documents appropriately titled *Journey of Change I (1997)*, *Journey of Change II (1998)*, and *Journey of Change III (1999)* all of which outline an evolving strategic direction. *Journey of Change I* introduced the strategic targets, 10 for 2002, built around a strategic framework consisting of the Mission, Goals and Domains of Value articulated in the *Prescription for Change*. The 10 for 2002 strategic targets provide standards for assessing organizational performance. These targets were associated with performance measures, operational strategies, and actions.

Continuing refinements to the strategic direction outlined in *Journey of Change II* include: (1) a full integration with the VA Strategic Plan and (2) a focus on critical strategic initiatives including:

- Full consolidation of VHA programs
- A deepening focus on quality
- Full implementation and consolidation of strategic management programs
- Continued institutionalization of best practices including patient safety
- Integration of strategic planning and management processes

Journey of Change III continued the documentation of VHA's progress. Key features include the following:

- Reaffirm the strategic direction articulated in the *Vision and Prescription for Change*
- Present the 2000 VHA strategic Framework
- Highlight 1998 and 1999 accomplishments
- Integrate network strategic plans with related national goals and strategies

This document also introduced VHA's Core Values to complement the Domains of Value:

- Trust
- Respect
- Commitment
- Excellence
- Compassion

During these times of change, the implementation process has focused on reengineering VHA's health care system. VHA's future will be enhanced by forging relationships with others, by contributing a broad array of services and resources to the national health care system, and by assuming leadership positions in areas of special expertise.

Basic source documents for this segment: Journey of Change I; Journey of Change II, and Journey of Change III.

V. Creation of data consortium to bring together data offices for purpose of improving data quality and application of data in supporting health care system decision-making

At the request of the Deputy Under Secretary for Health and under the guidance of the Chief Policy and Planning Officer, several Veterans Health Administration (VHA) data developers formed the VHA Data Consortium in December 1998.

The Consortium developed a Charter that identifies members, consultants, structure, goals, and missions. The Charter members are the Allocation Resource Center (ARC), the Healthcare Analysis & Information Group (HAIG), the Management Science Group (MSG), the Planning Systems Support Group (PSSG)/Office of Policy & Forecasting (105D), and the VISN Support Service Center (VSSC). Consultants to the Consortium include the Office of Quality & Performance/National Performance Data Feedback Center (NPDFC), the Office of Finance including the Decision Support Systems, the Office of Information/Austin Automation Center (AAC), and VA Information Resource Center.

The organization is a consortium of equals with chair responsibilities rotated among the charter members. The Consortium meets quarterly and also conducts conference calls periodically for specific issues. The Data Consortium strives to improve information reliability and customer access for the purposes of quality measurement, planning, policy analysis, financial management, etc.

The mission of the Consortium is that the members will provide support for the following common data concerns:

- Properly identify and serve the information customer
- Standardize terminology and data definitions
- Eliminate unnecessary redundancy
- Produce consistent, timely output, and
- Identify system problems for focused resolution

Calendar Year 1999 was the Consortium's first year of operation. Accomplishments included: (1) the development of the Charter, (2) the design of a web site and its search engine, (3) creation of business rules with regards to accepted definitions, (4) implementation accepted definitions with regards to enrollment, (5) development of issue papers for system problems regarding loss of surgical data and primary provider coding, and (6) assistance with the data collection plan requested by the American Legion.

Source Documents: Data Consortium Charter, Year End Report

VII. Development of Geographical Access Analyses and Station Tracking System.

Using Geographic Information Server technology, veterans health care system data can be mapped, displayed and analyzed providing a valuable tool in policy and operational decisions. A VA Site Tracking System was implemented which finally defines and tracks

all VA health care delivery sites. This has become the official source for facility counts and locator information.

Source Documents: Geographical Access Report, VAST Report

VII. Development and Application of Planning Models for Inpatient, Outpatient and Long-term Care.

Long Term Care Model

In December 1995, the Under Secretary for Health issued a Long-Term Care Policy and Plan (IL 10-95-024) which included an action plan stating that "a long-term care planning model will be provided to VISNs for guidance in planning for volume of demand in the continuum of long-term care." A task force was established to develop a methodology for projecting the need for long-term care in a variety of settings, including VA medical centers or nursing homes, state or community facilities, or in-home care.

Previous long-term care models were based only on age-specific use rates for nursing homes. There were no workload projections for non-institutional, home health care. By the mid 1990's, VA had moved from a health care delivery system highly focused on inpatient care to a system more focused on outpatient care. Additionally, VA was utilizing other service delivery settings that more closely matched the intensity of services required. Therefore, the Long Term Care (LTC) Model that was developed to guide future planning decisions was based on identifying in the veteran population the characteristics that would drive future health care needs, as described below. Additionally, a non-institutional component was developed which projects home health care workload. This methodology was developed in consultation with subject matter experts from VHA, the Agency for Health Care Policy and Research, and the University of Michigan.

The primary characteristic that determines future use of long-term care is a veteran's ability to care for himself, his Activities of Daily Living (ADL) deficiencies; e.g. able to feed, bathe, dress, etc. without assistance. The greater the number of deficiencies, the greater the likelihood that long-term care will be required. The LTC Model, which is both ADL and age-specific, is used in conjunction with other planning models by the Veterans Integrated Service Networks as part of the strategic planning process. The model projects for any target year the average daily census for nursing homes and the annual patient load for home health care.

As part of the planning process, that workload is distributed to alternative care settings as dictated by veteran eligibility, needs, and by available resources. The VISNs then allocate portions of the total workload to individual VA Medical Centers (VAMCs). In turn, VAMCs look at the implications of making different assumptions about VA-provided versus contract care and institutional versus non-institutional care

VIII. Special Projects--Capital Asset Realignment for Enhanced Services Program (CARES).

A March 1999 General Accounting Office (GAO) report concluded that the Veterans Health Administration (VHA) could significantly reduce the amount of funds used to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets. In response to the GAO report and a subsequent hearing on July 22, 1999, VHA initiated development of the Capital Asset Realignment for Enhanced Services (CARES) program.

Historically, VA's capital infrastructure has been designed, for the most part, as a "hospital-based" delivery system with a focus on inpatient care. In many cases, this does not reflect VHA's current delivery of care, as VA health care delivery has evolved into an integrated delivery system with greatly expanded outpatient services. The costs to maintain and operate the existing VA capital infrastructure are substantial, diminishing the availability of resources that could be devoted to direct patient care services. Realignment of VA's capital infrastructure, including contracting for acute hospital care in locations where there is not sufficient workload and establishing new facilities for provision of outpatient care, will yield improved access and service to veterans.

The goal of CARES is to assess veteran health care needs in VHA VISNs, identify service delivery options to meet those needs for the future, and develop an associated capital asset realignment plan that assures the availability of high quality health care in the most accessible and cost effective manner, while minimizing impacts on staffing and communities and on other VA missions. Through the CARES process, VISNs will develop plans for capital asset restructuring that are based on practices in health care delivery, demographics, strategic plans, and assessments of the existing as well as future capacity of physical plants to deliver accessible, quality health care.

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Supporting Documents Index

Data Consortium Charter, 1999 Year End Report

Department of Veterans Affairs FY 2001 Budget Submission Medical Programs

Department of Veterans Affairs FY 1999 Annual Accountability Report.

Geographical Access Report

Journey of Change I

Journey of Change II

Journey of Change III

Report to the Committees on Veterans' Affairs of Senate and House Representatives
(Public Law 104-262, Section 104).

The Veterans Health Care Eligibility Reform Act of 1996, P.L. 104-262

VAST Report

VHA National Strategic Planning Guidance FY 2001 – FY 2006

NATIONAL CENTER FOR PATIENT SAFETY
Summary Outline

<u>Project or Accomplishment</u>	<u>Status</u>	<u>Description</u>
• NCPS Office Established	Completed 1998	Created to lead and integrate the patient safety effort for the entire VA.
• Advisory Panel Created	Completed 1998	VHA Expert Advisory Panel on Patient Safety System Design created.
• National Training Program	Started 2000	National training program and roll-out of comprehensive adverse event and close call analysis program begins.
• Congressional Testimony	Completed 2000	NCPS Director testifies before congressional panels on VA patient safety issues.
• PSRS Agreement	Completed 2000	VA and NASA signed agreement that has NASA operating the National Patient Safety Reporting System (PSRS), an external and voluntary de-identified reporting system.

NATIONAL CENTER FOR PATIENT SAFETY

Narrative

In 1998, VA created the National Center for Patient Safety (NCPS) ¹ to lead and integrate the patient safety efforts for VA. VA created this center as a commitment to patient safety as a corporate priority with a direct reporting relationship to the Under Secretary for Health. The NCPS employs human factors engineering and safety system approaches in its activities. The first task for the Center was to devise systems to capture, analyze and fix weaknesses in our systems that affect patient safety.

In 1998 VA formed the Expert Advisory Panel for Patient Safety System Design to obtain expert advice to enhance the design of VA's reporting systems. These experts in the safety field included Dr. Charles Billings, one of the founders of the Aviation Safety Reporting System, as well as other experts from NASA and the academic community. They advised us that an ideal reporting system: a) must be non-punitive, voluntary, confidential and de-identified; b) must make extensive use of narratives; c) have interdisciplinary review teams; and d) most importantly, focus on identifying vulnerabilities rather than be a counting exercise. VA has used these principles to design the patient safety reporting systems we have in use. Based on the expert advice and on lessons learned from our mandatory adverse event reporting pilot, the NCPS has developed and rolled out a comprehensive adverse event, close call analysis and corrective action program and computer assisted tool which includes an end-to-end handling of event reports. This system not only allows for the determination of the root causes, but also captures the corrective actions as well as the concurrence and support of local management for implementation. The system includes a number of innovations such as human factors decision support tools and computer aided report tools to determine the root cause of adverse events and close calls.

In November 1999 the new event and close call reporting system was first pilot tested in VA's Veterans Integrated Service Network (VISN) 8 (Florida, South Georgia and Puerto Rico). Extensive training and constant mentoring and feedback are provided to assure full understanding of the search for the root cause and redesign of the system. The quality managers, risk managers, and clinicians using the system believe that the new methods analysis of error will make a significant improvement in the care of veterans. Independently, VHA's Patient Safety Improvement Oversight Committee has stated that the reports and corrective actions that are the product of this new approach are superior in numerous ways to the ones from the previous system. By August of 2000, all VA hospitals will have received this training and be using this system. To date, there have been nearly 600 participants at these national training sessions. While the vast majority of these participants have been VA employees, we have been pleased to accommodate requests for training about our system from participants in both the public and private sector. Participants have included guests from AHA, Baylor University, DOD, FDA, the Government Accounting Office, Kaiser Permanente, the University of Michigan, the University of Texas, and other private and public health care systems or affiliates. Response from participants has been overwhelmingly positive.

During the year 2000, NCPS Director Dr. James Bagian testified before various congressional committees on patient safety issues. This included testimony before the Senate Subcommittee of the Committee on Appropriations, Committee on Veterans Affairs, hearing on medical errors on January 25, 2000 ²; House Committee on

Commerce, Subcommittee on Health and Environment and Subcommittee on Oversight and Investigations joint hearing on medical errors on February 9, 2000³; House Ways and Means Subcommittee on Health hearing on medical errors on February 10, 2000⁴; and the House Subcommittee on Oversight and Investigation hearing on patient safety in the VA on July 27, 2000⁵.

To complement NCPS's internal reporting system, an agreement to establish the Patient Safety Reporting System (PSRS)⁶, a complementary, de-identified voluntary reporting system was finalized in May of 2000 with NASA. The PSRS is patterned after the highly successful Aviation Safety Reporting System that NASA operates on behalf of the FAA. It is external to VA and allows all employees, patients, visitors, etc. to report unsafe occurrences without fear of administrative or other action being taken against them.

NATIONAL CENTER FOR PATIENT SAFETY
Supporting Documents Index

- ¹ Under Secretary For Health's Information Letter, IL 10-99-010, June 29, 1999.
- ² Senate Subcommittee of the Committee on Appropriations, Committee on Veterans Affairs Hearing on Medical Errors, January 25, 2000, Transcript of Dr. James P. Bagian.
- ³ House Committee on Commerce, Subcommittee on Health and Environment and Subcommittee on Oversight and Investigations Joint Hearing on Medical Errors, February 9, 2000, Transcript of Dr. James P. Bagian.
- ⁴ House Ways and Means Subcommittee on Health Hearing on Medical Errors, February 10, 2000, Transcript of Dr. James P. Bagian.
- ⁵ House Subcommittee on Oversight and Investigation Hearing on Patient Safety in the VA, July 27, 2000, Formal Testimony of Dr. James P. Bagian.
- ⁶ VA and NASA Sign Agreement for VA Patient Safety Reporting, Department of Veterans Affairs News Release, May 30, 2000.

QUALITY & PERFORMANCE OFFICE – Summary Outline

<u>Project (Office of Quality and Performance 10Q)</u>	<u>Approx. Dates Completed</u>	<u>Description</u>
<ul style="list-style-type: none"> • <u>National Customer Feedback Program Established</u> 	<p>1993</p> <p>(see attached OQP 1999 National Survey Report on Recently Discharged Inpatients)</p>	<p>The Patient Feedback initiatives were created to facilitate organizational movement at VA medical centers towards a patient-driven culture. Based on results of nationwide focus groups of veterans and their families to determine priorities for high quality care experiences, annual inpatient and outpatient patient satisfaction surveys were developed and implemented VA-wide. Patient service standards were developed as well, and specialty surveys, such as long term care, have been added over the years. The surveys, now produced by OQP's National Performance Data Feedback Center in Durham, N.C., allow for comparisons with the non-VA sector of healthcare.</p>
<ul style="list-style-type: none"> • <u>Development of National Clinical Practice Guidelines</u> 	<p>1995</p> <p>(see attached Clinical Practice Guideline for The Pharmacologic Management of Chronic Heart Failure)</p>	<p>It was recognized that the use of evidence based, clinical practice guidelines would have an appreciable impact on VA medical care. Implementation of guidelines was incorporated into senior management's performance agreements. Guidelines were established for many high volume, high risk diseases experienced by patients treated in VA facilities. An Advisory Council on Guidelines was established to select and approve system-wide guidelines. National conferences on guidelines have been held each year since its inception. A joint effort between VA and the Department of Defense has led to the development of more than a dozen clinical practice guidelines designed to assure quality and continuity of care.</p>
<ul style="list-style-type: none"> • <u>Performance Measurement System Established</u> 	<p>1996</p> <p>(see attached 1999 Network Performance Report)</p>	<p>The Performance Measurement System was initiated to meet challenges of improving healthcare quality, patient and stakeholder satisfaction, and economic efficiencies. The foundation of the Performance Measurement System is broad, statistically reliable, ongoing measurement of performance objectives. Senior managers are held accountable through annual performance agreements containing explicit goals. A Performance Measurement Workgroup was established to provide a team approach to</p>

<u>Project (10Q) (continued)</u>	<u>Approx. Dates Completed</u>	<u>Description</u>
<ul style="list-style-type: none"> <li data-bbox="73 304 487 367">• <u>Performance Measurement System Established (cont.)</u> <p data-bbox="73 808 487 913">The following references which support the above information are attached:</p> <ol style="list-style-type: none"> <li data-bbox="73 945 487 1113">1. RECENTLY DISCHARGED INPATIENTS, 1999 National Survey Report, Office of Quality and Performance (10Q) <li data-bbox="73 1123 487 1281">2. The Clinical Practice Guideline for The Pharmacologic Management of Chronic Heart Failure – April 2000 <li data-bbox="73 1291 487 1417">3. The 1999 Network Performance Report, Office of Quality and Performance (10Q) 	1996	<p data-bbox="787 304 1485 462">coordination of measures. The Performance Measurement System articulates Veterans Health Administration's six domains of value: clinical quality, access, satisfaction, cost effectiveness, functional status, and community health.</p> <p data-bbox="787 472 1485 703">Establishment of a consistent measurement system has allowed VA to demonstrate that it delivers high quality care in a compassionate and courteous manner; that VA care frequently surpasses governmental goals and sets national benchmarks; and VA care results in positive health outcomes for our patients.</p>

QUALITY AND PERFORMANCE OFFICE

Narrative

The National Customer Feedback Center was established in 1993. The Feedback Center was created to facilitate organizational movement at VA medical centers towards a patient-driven culture. Based on results of nationwide focus groups of veterans and their families to determine priorities for high quality care experiences, annual inpatient and outpatient patient satisfaction surveys were developed. Patient service standards were developed as well, and specialty surveys, such as long term care, have been added over the years. The surveys allow for comparisons with the non-VA sector of healthcare. (see attached OQP 1999 National Survey Report on Recently Discharged Inpatients)

Development of National Clinical Practice Guidelines was initiated 1995. It was recognized that the use of evidence based, clinical practice guidelines would have an appreciable impact on VA medical care. Implementation of guidelines was incorporated into senior management's performance agreements. Guidelines were established for many high volume, high risk diseases. An Advisory Council on Guidelines was established to select and approve system-wide guidelines. National conferences on guidelines have been held. A joint effort between VA and the Department of Defense has led to the development of more than a dozen clinical practice guidelines intended to assure quality and continuity of care. (see attached Clinical Practice Guidelines for The Pharmacologic Management of Chronic Heart Failure.

The Performance Measurement System was established in 1996. The Performance Measurement System was initiated to meet challenges of improving healthcare quality, patient and stakeholder satisfaction, and economic efficiencies. The foundation of the Performance Measurement System is broad, statistically reliable, ongoing measurement of performance objectives. Senior managers are held accountable through annual performance agreements containing explicit goals. A Performance Measurement Workgroup was established to provide a team approach to coordination of measures.

The Performance Measurement System articulates Veterans Health Administration's domains of value: clinical quality, access, satisfaction, cost effectiveness, functional status, and community health. Establishment of a consistent measurement system has allowed VA to demonstrate that it delivers high quality care in compassionate and courteous manner; that VA care frequently surpasses governmental goals and sets national benchmarks; and VA care results in positive outcomes for our patients. (see attached 1999 Network Performance Report)

OFFICE OF QUALITY AND PERFORMANCE
Supporting Documents Index

RECENTLY DISCHARGED INPATIENTS, 1999 National Survey Report, Office of Quality and Performance (10Q)

The Clinical Practice Guideline for The Pharmacologic Management of Chronic Heart Failure – April 2000

The 1999 Network Performance Report, Office of Quality and Performance (10Q)

OFFICE OF PATIENT CARE SERVICES
Summary Outline

- Creation of Strategic Healthcare Groups (SHGs), 1997, New concept in consultative management at Head Quarters level
- Creation of VA National Center for Health Promotion and Disease Prevention, 1994, Great expansion of VHA preventive health services
- Revised Nurse Qualification Standard, 1999, Established BSN as entry level for VA nurses
- Expansion of Prosthetic Services, 1996, Nearly 1 million patients receiving prosthetics
- VA National Formulary for Medications, 1997, Large savings in drug costs due to national contracts, more consistent care across the system
- Millennium Bill, PL 106-117, 1999, dramatic changes in long term care programs and eligibility for nursing home care
- Establishment of Mental Illness Research, Education, and Clinical Centers (MIRECCs), 1997, Generate new knowledge and improve care for patients with mental illness.

OFFICE OF PATIENT CARE SERVICES Narrative

The Office of Patient Care Services (PCS) houses the Veterans Health Administration's clinically-related headquarters programs that serve to support the actual delivery of patient care services in the field. It integrates professional knowledge and practice skills into policy, planning and system wide development of patient care guidelines, critical pathways, and practice parameters. This includes providing leadership for nine of twelve programs designated as "special emphasis programs" by the Under Secretary for Health (USH). Working with the Office of Policy, Planning and Performance, network and field representatives and appropriate external stakeholders, the office develops evaluation mechanisms and outcome measurements for these programs. Interdisciplinary leadership is available to the Office of the USH and the field for consultation and to provide clinical coordination and integration with research, education and emergency medical preparedness activities. The Office also provides national leadership on professional issues for the medical, technical and allied disciplines and serves as liaison to various professional organizations. The traditional "stovepipe" structure organized around discrete professions and disciplines is replaced with a structure organized around thirteen Strategic Healthcare Groups (SHGs) reporting to the Chief Patient Care Services Officer.

Many significant achievements include:

Patient Care Services

Shift in focus from inpatient to outpatient care
Developed Programs of Excellence

Primary and Ambulatory Care

Implemented primary care system-wide
Developed primary care performance measures
Implemented telephone triage and advice programs
Hoptel program guidance developed
Expansion of primary care to Community Based Outpatient Clinics, increasing access to care

Dental

The National Dental Homeless Coordinator position was established and now resides at the Dallas VAMC. This office is responsible for providing assistance nationally to any dental service that is interested in developing a program of care for homeless veterans. Assistance can consist of plans for treatment by VA clinicians or by community based funded program clinicians. It has been instrumental in numerous homeless veterans receiving oral/dental care which has contributed positively to their rehabilitation process.

As part of the VA reorganization, the Office of Dentistry has completed re-engineering the Central Dental Laboratories. The total number of labs has been reduced from four to two. Data from a two year pilot study evaluating private sector costs compared to the same work done in VA demonstrated that VA was 30 per cent more cost effective.

VA Dentistry continues to support the ongoing "Normative Aging/Dental Longitudinal Study". This HSR&D funded effort has resulted in numerous publications which have brought positive exposure to the VA. The study has offered improved treatment modalities for providing oral health care to the elderly resulting in an improved quality of life.

VA Dentistry is in the forefront in the development of electronic management of clinical and managerial data. Development of the Dental Record Manager software package is completed and implementation is underway. Part of the success in program management is due to having a comprehensive data base. Modeling concepts have been utilized for evaluation of some of the data and to forecast possibilities.

VHA treats a large number of patients at high risk for developing oral cancer. VHA Dentistry has entered into partnership with NIH on an Oral Biomarkers Study. The study brings together six VA Facilities and is coordinated through the Office of Dentistry. In the study, current VA patients that are in the high risk category are monitored closely for early detection and early intervention. The study is ongoing.

VA Dentistry is actively involved in Dental Implantology as a leader in the field. One of the largest implant studies in the nation addressing case selection and success and failure rates was published. This study is providing data and information that will offer alternative treatment for patients who have experienced unsuccessful conventional oral rehabilitative therapy and will enhance the health and quality of life of numerous people. The results of these data contribute to the entire profession and impact nationally.

VHA began its Preventive Medicine Program in 1985 with assignment of a preventive medicine coordinator at each VAMC and independent outpatient clinic. This has evolved with establishment of the National Center for Health Promotion and Disease Prevention and the integration of preventive health measures into VHA's performance standards.

Physical Medicine and Rehabilitation

The Traumatic Brain Injury (TBI) continuum of care plan was accepted in 1993. TBI centers were established.

Programs began receiving accreditation from The Commission on Accreditation of Rehabilitation Facilities

Geriatric and Extended Care

The number of Geriatric Evaluation and Management programs increased

Established hospice consultation teams at every VAMC; expanded number of hospice units

Pilot program begun in 1993 to provide contract adult day health care, homemaker and home health services

Palliative Care Index

Expanded Home Based Primary Care programs

Pain management

Millennium Bill expanded programs and eligibility

Training for caregivers of patients with Alzheimers

Mental Health

National Initiative for Seriously Mentally Ill Veterans was begun in 1993

Homeless veterans programs

Compensated Work Therapy Programs

Established Mental Illness Research, Education, and Clinical Centers (MIRECCs), 1997 to generate new knowledge and improve care for patients with mental illness

Developed standardized clinical baseline assessment for substance abuse patients

Developed Comprehensive Substance Abuse Treatments Guidelines and Algorithms

Recreation Therapy

Support several national events that enhance the physical, social, mental and emotional well-being of disabled veterans

Pharmacy

Consolidated Mail Outpatient Pharmacies established

Developed national formulary, 1997

Large savings in drug costs due to national contracts, more consistent care across the system

Bar coding medications

Telemedicine

Telemedicine capability developed

Now used in some CBOCs

Acute Care

Shift to same day surgery

Hepatitis C

Hypertension care improvement initiative

Prosthetics

Expansion of Prosthetic Services, 1996, Nearly 1 million patients receiving prosthetics

Nursing

Qualifications standards revised 1999. Established BSN as entry level for VA

Distance Learning Project

Innovations in Nursing-Identification of ways to further foster creativity in enhanced innovations

Spinal Cord

Telemedicine – Home Health Care for veterans with SCI

Teleconsultation for veterans with SCI

CARF accreditation

Developed independent study guide, "Medical Care of Persons with Spinal Cord Injury" for all VA clinicians

OFFICE OF PATIENT CARE SERVICES
Supporting Document Index

VA Directive 5102.1, November 10, 1999, Nurse Qualification Standard

VHA Directive 97-047, October 16, 1997VA National Formulary Policy

VHA Directive 98-023, April 17, 1998, Guidelines for Implementation of Primary Care

VHA Friday 11:15 AM Announcement, October 15, 1999, Selections for 1999 Under Secretary for Health Clinical Programs of Excellence

Spinal Cord Injury and Disorders CME Course Examination, April 1, 1998

READJUSTMENT COUNSELING SERVICE
Summary Outline

<u>Project or Accomplishment</u>	<u>Status</u>	<u>Description</u>
Vet Centers serve a unique veteran population	1996/ongoing	Over 50,000 veterans a year served only at Vet Centers
Vet Centers provide access to VA medical care	1995/ongoing	Vet Centers refer over 100,000 veterans a year to VA medical facilities
Vet Centers are cited for exemplary outreach	March 1997	Final report for The Presidential Advisory Committee On Gulf War Veterans' Illnesses
Vet Center staff report Highest job satisfaction and sense of mission in VHA	1997	VA's One VA Survey
Vet Center clients report highest satisfaction for services	1999	99% of veteran clients reported being satisfied with Vet Centers
Vet Centers initiate Tele-health project	1997/ongoing	Tele-health equipment installed in 20 Vet Centers. Extends VA primary care to high-risk Veterans close to their communities
Vet Centers extend Services on Native American Reservations	1993/ ongoing	Vet Center outstations located on Hopi, Navajo, Sioux and Cherokee land. Extend VA Care to under-served, minority veterans
Vet Centers implement Sexual trauma counseling	1993/ongoing	VHA uses community-based Vet Centers to implement sexual trauma services pursuant to P.L. 102-585

<u>Project or Accomplishment</u>	<u>Status</u>	<u>Description</u>
Congress appropriates resources for a new Vet Center in Raleigh, NC	1994/ongoing	Extends availability of VA readjustment counseling
Congress appropriates resources for new Vet Centers in Bellingham and Yakima, WA	1994/ongoing	Extends availability of VA readjustment counseling
Congress appropriates resources for a new Vet Center in Williamsport, PA	1996/ongoing	Extends availability of VA readjustment counseling
P.L. 104-262 extends Vet Center eligibility to all war veterans	1996/ongoing	Extends Vet Center war trauma counseling to all eras of exposed veterans
Secretary authorizes eligibility for Somalia veterans	1994/ongoing	Extends services to new veteran groups in recognition of unique military-related stresses of peace keeping missions
Secretary authorizes eligibility for Bosnia/Kosovo veterans	2000/ongoing	Same as for Somalia veterans
Vet Center mission and program effectiveness verified by GAO	1996	GAO found Vet Centers effectively performing unique mission
Vet Centers cited as most frequent VA referral source for homeless veterans	1997	VA national survey of county veterans service officers
Vet Centers found effective in reducing PTSD in Gulf War Veterans	1995	RCS and NC/PTSD prospective study of PTSD in Gulf War veterans

<u>Project or Accomplishment</u>	<u>Status</u>	<u>Description</u>
Vet Centers incorporated into VHA clinical programs of Excellence	1999/ongoing	Two Vet Centers awarded designation as VHA clinical programs of Excellence
VHA's Vision for Change ratifies organizational structure Of Readjustment Counseling Service	1995	Readjustment counseling identified as a special emphasis program and program structure maintained to ensure community-based service functions
Director, Readjustment Counseling Service established In VHA HQ as Chief Readjustment Counseling Officer	1998	Position functions include acting as principle advisor to USH as well as national directorship for major VHA program
Vet Centers record highest Volume of service to veterans	1999	Vet centers provided over 870,000 visits to veterans and family members in FY 99

In 1998, government officials and health care providers from Croatia visited several of our Vet Centers. Their purpose was to study RCS's community-based system for treating war traumatized veterans as a model for development of a similar system in their own country.

READJUSTMENT COUNSELING SERVICE

Narrative

Readjustment counseling in VA is provided through a national system of 206 community-based Vet Centers. The Vet Centers are located outside of the larger medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of the local veterans. The Vet Center program service mission features: 1.) a holistic mix of direct counseling and multiple community-access functions; 2.) psychological counseling for veterans exposed to war trauma to include post-traumatic stress disorder (PTSD), and/or who were sexually assaulted during military service; 3.) family counseling when needed for the veteran's readjustment; 4.) community outreach and education; and 5.) extensive case management and referral activities. The latter activities include a full range of supportive social services designed to assist veterans improve general levels of post-military social and economic functioning.

For its pioneering initiative to improve access to care for minority veterans in rural settings by locating Vet Center outstations on Native American reservation lands, RCS received a "Best Practices" award in VHA's Journey for Change II, July 1998. The Vet Center outstation established in 1993 in Keams Canyon, Arizona on the Hopi Reservation, was the first VA facility ever sited on reservation land and dedicated to serving the Native American veteran. Based upon the success of this effort, a second outstation was established in Chinle, Arizona on the Navajo Reservation. In 1998 RCS advanced this effort by opening its Vet Center outstation in Martin, SD serving the Pine Ridge and Rosebud Reservations. The Vet Center outstation dedicated to serving the Cherokee in Tahlequah, OK was authorized for implementation in 1999. These initiatives provide culturally sensitive services to high-risk minority veterans close to their homes.

In 1993, as part of VA's extension of services to women veterans under Public Law 102-585, RCS Vet Centers were identified by VHA for implementation of a sexual trauma-counseling program for women veterans experiencing the traumatic aftermath of sexual assault and/or harassment during their active military service. VHA's decision to implement the outpatient portion of its sexual trauma program through the Vet Centers was based on the Vet Center program's convenient, veteran friendly locations within the community and its non-medical service mission designed to treat the veteran as whole person within his/her community. Available resources were distributed nation-wide to staff approximately 60 Vet Centers with a qualified mental health professional with specialized training in sexual trauma counseling. Subsequent legislation passed in 1994 authorized VA to provide these services on a gender-neutral basis.

In March 1995, in its Vision for Change, VHA identified readjustment counseling as one of its 12 special emphasis programs having particular relevance for veterans' health care. More specifically, the Vet Center program was recognized as a unique and specialized non-medical service delivery system specific to the psychological readjustment needs of returning war veterans. VHA's Vision for Change also ratified the organizational structure of RCS preserving the Chief Readjustment Counseling Officer's direct line of authority for Vet Center program operations. These provisions reflected the Under Secretary for Health's determination that the Vet Centers are best managed as a VHA special emphasis program apart from primary care at the medical centers, and, rather, as a set of special, non-medical service functions of particular relevance to improving veterans' post-war quality of life. Consistent with the guiding principles and objectives codified in VHA's Prescription for Change, March 1996, Vet Centers provide all

care on an outpatient basis, with maximum access for veterans to include visits outside the Vet Center and evening and weekend hours for working veterans and family members.

In 1995 the Vet Centers underwent the second GAO audit in the program's then 15-year history. Similar to GAO's first audit reported in 1987, the July 1996 report concluded that the program has a unique mission, is dispatching its mission to veterans as intended by Congress, and that in relation to its mission, the organizational structure is appropriate. Resulting from a comprehensive analysis of Vet Center workload undertaken in its 1996 report, GAO found that approximately 50 percent of Vet Center unique veteran clients are not seen in any other VA facility. GAO concluded that these veterans constitute a core group of frequent users who access care specifically for psychological war trauma to include war-related PTSD. Based on these findings in the 1996 report GAO further concluded that Vet Centers and medical centers not only have different missions, but they serve different veteran clients. As reported in VHA's Journey for Change III, March 2000, Vet Centers continue to see a unique population of veterans each year. For both 1998 and 1999 over 50,000 veterans seen at Vet Centers were not seen in any other VHA facility.

Through passage of Public Law 104-262 in October 1996, Congress extended eligibility for Vet Center services to any veteran who served in the military in any war, or in an area during a period in which armed hostilities occurred. This law authorized Vet Centers to serve all war veterans, thereby adding World War II and Korean War veterans to the list of eligible veterans. VA had now been authorized to provide timely outreach and PTSD counseling through its Vet Centers to all eras of returning war veterans.

A number of reports released in 1997 provided various indicators of Vet Center program effectiveness. The VHA Communications Audit and Strategy conducted by Price Waterhouse LLP concluded that the Vet Centers are a model of information sharing and outreach to veterans, largely due to their small size and focused audience. In addition, the final report of The Presidential Advisory Committee On Gulf War Veterans' Illnesses, March 7, 1997, cited the Vet Centers as providing exemplary outreach services to contact and inform Gulf War veterans. The Committee recommended that other VHA services and programs adopt Vet Center strategies for outreach on behalf of improving services to Gulf War veterans. VA's One VA survey reported significantly higher job satisfaction and staff morale for Vet Centers when compared to other VA units. A survey of county veterans service officers nation-wide conducted by VA's Director of Homeless programs found that 70 percent of respondents used Vet Centers for assistance to homeless veterans as compared to less than 50 percent of respondents who referred to other VA programs.

As reported in VHA's Journey for Change III, March 2000, Vet Centers reported a record number of visits. For fiscal year 1999, the Vet Centers provided over 870,000 visits to veterans and family members. Also in fiscal year 1999, 99 % of veterans using Vet Centers reported being satisfied with services received by responding yes that they would recommend the Vet Center to other veterans. The latter data was reported in VA's Fiscal Year 2000 Performance Plan included in the VA Fiscal Year 2001 Budget Submission.

In 1998 and 1999 the Vet Center program implemented the Vet Center-Linked Primary Care project previously authorized by the Under Secretary for Health. These initiatives make use of tele-medicine technology in 20 Vet Centers to promote access to primary care for high-risk, under-served veterans closer to their respective communities. Of particular note in this regard is the 1999 opening of a collocated Vet Center and CBOC facility in inner city Cleveland to serve African American, Hispanic and other veterans. VHA's Employee Education Service in

conjunction with RCS has produced a video, "Tele-Health Veterans' Link to Services", that covers the details of this program.

In 1998 the Readjustment Counseling Service (RCS) initiated its "Vet Centers of Excellence" program to review criteria unique to the Vet Center mission that add value to veterans and promote esprit de corps among its teams. Five Vet Centers were selected nation-wide that best represent the readjustment counseling service mission. In 1999 the Vet Centers were incorporated into VHA's process for designating clinical programs of excellence via Under Secretary for Health's Information Letter Designating Clinical Programs of Excellence, IL 10-99-005, April 28, 1999. The Vet Centers in White River Junction, VT and Morgantown, WV were designated as VHA Clinical Programs of Excellence.

READJUSTMENT COUNSELING SERVICE
Supporting Document Index

Counseling and Treatment for Veterans Who Have Experienced Sexual Trauma, Report to Congress pursuant to the Veterans' Millennium Health Care and Benefits Act, public Law 106-117, Section 115.

Department of Veterans Affairs, FY 2001 Budget Submission, medical programs, Vol. 2 of 6.

Employee education System, Tele-Health Veterans' Vital Link to Services, December 1999 (video tape).

GAO/HEHS-96-113, Readjustment Counseling Service, July 1996.

Journey of Change II, Annual Report and Strategic Forecast, July 1998.

Journey of Change III, Corporate Report and Strategic Forecast, 1998/1999.

"One VA" Employee Survey Results, July 1997.

Prescription for Change, Healthcare Value Begins with VA, March, 1996.

Presidential Advisory committee on Gulf War Veterans' Illnesses, Final Report, March 7, 1997.

VHA Directive 97-002, January 9, 1997, Readjustment Counseling Service (RCS) Vet Centers: Extension of Eligibility

IL 10-99-005, April 28, 1999, Under Secretary for Health's Information Letter Designating Clinical Programs of Excellence.

Vision for Change, A Plan to Restructure the Veterans Health Administration, March 17, 1995.

The County Veterans Service Officers Survey of Homeless Veterans Services, 1998.

The Vet Center Story, Department of Veterans Affairs, Readjustment Counseling Service, 1998 (See Media Section).

VHA Communications audit and Strategy, Price Waterhouse LLP, 1997.

OFFICE OF PUBLIC HEALTH & ENVIRONMENTAL HAZARDS
Summary Outline

- I. Designated Special Programs
 - A. Gulf War Veterans
 - 1. Revision of the Gulf War Registry Protocol to gather more exposure and health data from veterans.
 - 2. Establishment of five Gulf War Clinical Health Demonstration Projects to explore new ways of treating Gulf War veterans and to improve veteran satisfaction with VA health care.
 - 3. National Survey of Gulf War Veterans, a means of evaluating the health and exposure of all Gulf War veterans.
 - 4. Outreach to Gulf War veterans includes a quarterly newsletter on Gulf War health and compensation issues; a corresponding Web Site, posters describing VA health care and compensation services; answers to frequently asked questions; Spanish language translations; and an 800-HotLine number for Gulf War veterans inquiries.
 - 5. Support of legislation covering compensation of Gulf War veterans with undiagnosed illnesses – a VA first.
 - 6. Initiation and support of a National Academy of Sciences Institute of Medicine (IOM) study on health effects of key Gulf War veteran environmental exposures.
 - 7. Initiation of an IOM report on effective treatments for difficult to diagnose Gulf War veterans' illnesses.
 - 8. Establishment of VA Gulf War Referral Centers to deal with Gulf War veterans with particularly difficult to diagnose illnesses
 - B. Women Veterans Health Program
 - 1. Clinical/Benefits
 - a. VHA established 8 comprehensive women veterans health centers
 - b. Established a new division within the National Center for PTSD to study the effect of military trauma on women
 - c. Funded 66 sexual trauma counselors in Vet Centers
 - d. Maternity benefits provided to women veterans and almost 200 babies were born in 1999.
 - e. 3 Centers of Excellence recognized in VA
 - f. First grants (10) for homeless women veterans awarded.
 - 2. Research – Study of Women Vietnam Veterans Reproductive Outcomes completed
 - 3. Administrative
 - a. Appointment of the first full-time Director of Women Veterans Health Service
 - b. Creation of the Deputy Field Directors
 - c. Evaluation of the WVC program
 - d. Tracking system for women veterans health developed
 - 4. Educational – 1994 – First Women's Health fellowships established in VA
- II. Other programs for special populations
 - A. Veterans exposed to Agent Orange

1. Initiation of a series of IOM reports on health effects from exposure to Agent Orange, to support VA compensation policy for Vietnam veterans.
 2. Initiation of an IOM supported study on dose reconstruction of Agent Orange exposure of Vietnam veterans.
 3. Outreach to Vietnam veterans through a regular newsletter publication on Agent Orange health and compensation issues, a corresponding web site, posters describing VA health care and compensation services for Vietnam veterans, Agent Orange Fact Sheets on illnesses associated with Agent Orange exposure, and Spanish language translations of relevant materials.
- B. Veterans exposed to Ionizing Radiation ("Atomic" veterans) - The Department of Veterans Affairs is co-sponsoring a project with the Department of Health and Human Services to update and expand radioepidemiological tables used in the adjudication of compensation claims. The new tables will be in the form of computer software designated as the Interactive Radioepidemiological Program (IREP) and are currently under review by an expert scientific panel.
- C. Veterans exposed to Cold Injury - The Veterans Health Administration and Veterans Benefits Administration have collaborated to issue a special Cold Injury Protocol Examination and Protocol Examination History for veterans who experienced freezing and non-freezing cold injuries in service including frostbite and trench foot. Continuing Medical Education programs entitled "Cold Injury: Diagnosis and Management of Long Term Sequelae" also were issued in 1998 and 1999.
- D. Veterans with AIDS - VA is recognized as the largest provider of HIV care in the United States (approx. 18,000 patients/year)
1. Developed and implemented (1992) the VA Immunology Case Registry, the largest clinical database on HIV infection in the world. As of FY2000 this database contains complete blinded (not linked to patient name) clinical and utilization information on nearly 50,000 patients with HIV infection.
 2. Continuously funded 4 research centers on HIV and AIDS Infection.
 3. Demonstrated that the comprehensive care and case management model of HIV care reduces inpatient utilization (1998).
 4. Established the VA AIDS Information Center to provide up-to-date information about HIV/AIDS for VA staff and patients.
 5. Conducted multiple HIV clinical update conferences to educate VA clinicians about treatment advances in this rapidly changing field.
 6. Established the Center for Quality Management in HIV Care (1999) to use the VA's Immunology Case Registry as a tool to continuously improve HIV care across all VA settings.
 7. Developed an HIV Prevention Strategic Plan (2000) and will hold the first National VA HIV Prevention Conference (10/2000) to provider training in HIV risk identification and interventions to front-line staff.
- III. Smoking Prevention - The Veterans Health Administration has established smoking cessation clinics for veterans in each of its medical centers. Clinical Practice guidelines were developed to monitor the effectiveness of each program. Several

initiatives were developed for implementation during the next Fiscal Year. These initiatives include:

- Coordinating Federal smoking litigation with Departments of Justice and Defense.
- Survey VA employees to determine the number of smokers while addressing the potential of including smoking cessation as part of a comprehensive insurance package.
- Evaluate employee smoking habits and loss of productivity as a result of smoking.

IV. Occupational Health and Safety

A. Creation of the OESHG giving occupational health and safety increased visibility

B. Specific accomplishments

1. Creation of a tracking system for occupational injuries and illnesses.
2. Latex Allergy Evaluation Program
3. Partnership agreement with OSHA in worksite evaluation
4. Co-sponsored IOM report, "Safe Work in the 21st Century", with NIOSH, OSHA, and NIEHS

V. Environmental Epidemiology Service - The Environmental Epidemiology Service has initiated and completed a number of health studies, either mandated to Secretary of VA by legislation or directed by the Department, for WWII veterans exposed to radiation or mustard gas, veterans who participated in atmospheric nuclear weapon tests (Atomic veterans), Vietnam veterans potentially exposed to Agent Orange, Women veterans who served in Vietnam, and Gulf War veterans. The studies completed and published in peer-reviewed scientific journals are as follow:

A. Radiation Studies (4 articles)

- Kang, H.K., Bullman, T.A., Mahan, C.M. (2000). A mortality follow-up study of WWII submariners who received nasopharyngeal radium irradiation treatment. *American Journal of Industrial Medicine*, in print.
- Dalager, N.A., Kang, H.K., Mahan, C.M. (2000). Cancer mortality among the highest exposed U.S. atmospheric nuclear test participants. *Journal of Occupational and Environmental Medicine*, in print.
- Kang, H.K. (1996) Feasibility of an epidemiologic study of submariners who received radium irradiation treatment. *Otolaryngology-Head and Neck Surgery* 115, 433-437.
- Watanabe, K.K., Kang, H.K., and Dalager, N.A. (1995). Cancer mortality risk among military participants of a 1958 atmospheric nuclear weapons test. *American Journal of Public Health* 85, 523-527.

B. Vietnam Veterans Studies (11 articles)

- Kang, H.K., Dalager, N.A., Needham, L.L., et.al. (2000) U.S. Army Chemical Corps Vietnam veterans health study: preliminary results. *Chemosphere*, accepted for publication.
- Mahan, C.M., Bullman, T.A., Kang, H.K., and Selvin, S. (1997). A case-control study of lung cancer among Vietnam veterans. *Journal of Occupational and Environmental Medicine* 39, 740-747.

- Dalager, N.D., and Kang, H.K. (1997). Mortality among Army Chemical Corps Vietnam Veterans. *American Journal of Industrial Medicine* 31, 719-726.
- Bullman, T.A., and Kang, H.K. (1997). Posttraumatic stress disorder and the risk of traumatic death among Vietnam veterans. (in) *Posttraumatic Stress Disorder, Acute and Long-Term Responses to Trauma and Disaster* (Eds) Carol Fullerton and Robert Ursano, American Psychiatric Press, Washington, DC, London, England.
- Bullman, T.A., and Kang, H.K. (1996). Risk of suicide among wounded Vietnam veterans. *American Journal of Public Health* 86, 662-667.
- Watanabe, K.K. and Kang, H.K. (1996). Mortality patterns among Vietnam veterans: 24 year retrospective analysis. *Journal of Occupational and Environmental Medicine*, 38, 272-278.
- Watanabe, K.K. and Kang, H.K. (1995). Military service in Vietnam and the risk of death from trauma and selected cancer. *Annals of Epidemiology* 5, 407-412.
- Dalager, N.A., Kang, H.K., Burt, V.L. and Weatherbee, L. (1995). Hodgkin's disease and Vietnam service. *Annals of Epidemiology* 5, 400-406.
- Bullman, T.A. and Kang, H.K. (1995). A study of suicide among Vietnam veterans. *Federal Practitioner* 12, 9-13.
- Bullman, T.A. and Kang, H.K. (1994). Posttraumatic stress disorder and the risk of traumatic deaths among Vietnam veterans. *Journal of Nervous and Mental Disorder* 182, 604-610.
- Bullman, T.A., Watanabe, K.K., and Kang, H.K. (1994). Risk of testicular cancer associated with surrogate measures of Agent Orange exposure among Vietnam veterans on the Agent Orange Registry. *Annals of Epidemiology* 4, 11-16.

C. Women Vietnam Veterans Reproduction Health Studies
(3 articles)

- Kang, H.K., Mahan, C.M., Lee, K.Y., et al. (2000) Prevalence of gynecological cancers among women Vietnam veterans. *Journal of Occupational and Environmental Medicine*, accepted for publication.
- Kang, H.K., Mahan, C.M., Lee, K.Y., et al (2000). Pregnancy outcomes among U.S. women Vietnam veterans. *American Journal of Industrial Medicine*, in print.
- Dalager, N.A., Kang, H.K., and Thomas, T.L. (1995). Cancer mortality patterns among women who served in the military: The Vietnam experience. *Journal of Occupational Medicine*, 37, 298-305.

D. Gulf War Veterans Health Studies (9 articles)

- Kang, H.K., Mahan, C.M., Lee, K.Y., et al. (2000). Illnesses among US veterans of Gulf War: A population-based survey of 30,000 veterans. *Journal of Occupational and Environmental Medicine*, 42, 491-501.
- Gray, G.C., Smith, T.C., Kang, H.K., et al. (2000). Are Gulf War veterans suffering war-related illnesses? Federal and civilian hospitalizations examined, June 1991 to December 1994. *American Journal of Epidemiology* 151, 63-71.
- Murphy, F.M., Kang, H.K., Dalager, N.A. et al. (1999). The health status of Gulf War veterans: lessons learned from the Department of Veterans Affairs health registry. *Military Medicine* 164, 327-331.
- Kipen H.M., Hallman W., Kang, H.K., et al. (1999) Prevalence of chronic fatigue and chemical sensitivities in Gulf Registry veterans. *Archives of Environmental Health*, 54, 313-318.
- Gray, G.C., Hawksworth, A.W., Smith, T.C., Kang, H.K., et al. (1998) Gulf War veterans' health registries. Who is most likely to seek evaluation? *American Journal of Epidemiology*, 148, 343-349.
- Kang, H.K. and Bullman, T.A. (1998) Counterpoint: Negligible "healthy-warrior effect" on Gulf War veterans' mortality. *American Journal of Epidemiology*, 148, 324-325.
- Gray, G.C., Coates, B.D., Anderson, C.M., Kang, H.K., et al (1996). The postwar hospitalization experience of U.S. veterans of the Persian Gulf War. *New England Journal of Medicine* 335, 1505-1513.
- Kang, H.K., and Bullman, T.A. (1996). Mortality among U.S. veterans of the Persian Gulf War. *New England Journal of Medicine* 335, 1498-1504.
- Blanck, R.R., Hiatt, J., Hyams, K.C., Kang, H.K. et al. (1995). Unexplained illnesses among Desert Storm Veterans: A search for causes, treatment, and cooperation. *Archives of Internal Medicine*, 155, 262-268.

E. Other Studies (4 articles)

- Bullman, T.A. Kang, H.K., (2000). A 50-year mortality follow-up of veterans exposed to low level chemical warfare agent, mustard gas. *Annals of Epidemiology*, in print.
- Page, W.F., Mahan, C.M., and Kang, H.K. (1996). Vital status ascertainment through the files of the Department of Veterans Affairs and the Social Security Administration. *Annals of Epidemiology* 6, 102-109.

- Bullman, T.A. and Kang, H.K. (1994). The effects of mustard gas, ionizing radiation, herbicides, trauma, and oil smoke on US military personnel: The results of veterans studies. *Annual Review of Public Health* 15, 69-90.
- Kang, H.K. (1993). Dioxin, Health effects, *Handbook of Hazardous Materials*. Academic Press.

OFFICE OF PUBLIC HEALTH & ENVIRONMENTAL HAZARDS

Narrative

The Veterans Health Administration (VHA) has designated certain clinically-related areas for "special program" status. Typically, special programs address illnesses or medical care specific to the service-connected veteran population or are areas of special VHA expertise. Two special programs include Gulf War Veterans and Women Veterans. Significant accomplishments were also achieved for other programs for special populations such as veterans exposed to Agent Orange, ionizing radiation, or cold injury; veterans with AIDS, smoking prevention; and occupational health and safety.

Gulf War Veterans

VA has initiated many programs to respond to the needs of the Gulf War veterans including scientific research, medical care, disability compensation, and outreach efforts. One of the initiatives included a revision of the Gulf War Registry Protocol to gather more exposure and health data from veterans. A National Survey of Gulf War Veterans was done as a means of evaluating the health and exposure of all Gulf War veterans. To explore new ways of treating Gulf War veterans and to improve veteran satisfaction with VA health care, five Gulf War Clinical Health Demonstration Projects were established. A National Academy of Sciences Institute of Medicine (IOM) study on the health effects of key Gulf War veteran environmental exposures was initiated and supported (1). An IOM report was also initiated on the effective treatments for difficult to diagnose Gulf War veterans' illnesses.

Outreach to Gulf War veterans includes a quarterly newsletter on Gulf War health and compensation issues (2); a corresponding Web Site, posters describing VA health care and compensation services (3); answers to frequently asked questions; Spanish language translations (4); and an 800-HotLine number for Gulf War veterans inquiries. VA Gulf War Referral Centers were established to deal with Gulf War veterans with particularly difficult to diagnose illnesses. VA has supported legislation covering compensation of Gulf War veterans with undiagnosed illnesses – a VA first.

Women Veterans Health Program

Significant accomplishments were also achieved in enhancing services in the area of health care for women veterans. VHA established 8 comprehensive women veterans health centers and designed 3 Centers of Excellence in Women's Health. A new division within the National Center for PTSD was established to study the effect of military trauma on women. VHA funded 66 sexual trauma counselors in Vet Centers. Maternity benefits were provided to women veterans and almost 200 babies were born in 1999. Ten grants for homeless women veterans were awarded.

A study of Women Vietnam Veterans Reproductive Outcomes was completed.

A new administrative structure was established. The first full-time Director of Women Veterans Health Service was appointed. Deputy Field Director positions were created. A tracking system for women veterans health was also developed.

In 1994, the first Women's Health fellowships were established in VA.

Veterans Exposed to Agent Orange

A series of IOM reports on health effects from exposure to Agent Orange were initiated to support VA compensation policy for Vietnam veterans (5). An IOM supported study on dose reconstruction of Agent Orange exposure of Vietnam veterans was also initiated. Outreach to Vietnam veterans was provided through a regular publications on Agent Orange health and compensation issues (6), a corresponding web site, and posters describing VA health care and compensation services for Vietnam veterans (7). Outreach also included Agent Orange Fact Sheets on illnesses associated with Agent Orange exposure, and Spanish language translations of relevant materials (8).

Veterans Exposed to Ionizing Radiation ("Atomic" Veterans)

The Department of Veterans Affairs is co-sponsoring a project with the Department of Health and Human Services to update and expand radioepidemiological tables used in the adjudication of compensation claims. The new tables will be in the form of computer software designated as the Interactive Radioepidemiological Program (IREP) and are currently under review by an expert scientific panel.

Veterans Exposed to Cold Injury

The Veterans Health Administration and Veterans Benefits Administration have collaborated to issue a special Cold Injury Protocol Examination and Protocol Examination History for veterans who experienced freezing and non-freezing cold injuries in service including frostbite and trench foot. Continuing Medical Education programs entitled "Cold Injury: Diagnosis and Management of Long Term Sequelae" also were issued in 1998 and 1999.

Veterans with AIDS

VA is recognized as the largest provider of HIV care in the United States (approximately 18,000 patients/year). In 1992, VA developed and implemented the VA Immunology Case Registry, the largest clinical database on HIV infection in the world. As of FY 2000, this database contained complete blinded (not linked to patient name) clinical and utilization information on nearly 50,000 patient with HIV infection. With the establishment of the Center for Quality Management in HIV Care in 1999, this Immunology Case Registry is being used as a tool to continuously improve HIV care across all VA settings.

Research was supported through continual funding four research centers on HIV and AIDS Infection. Research findings were applied to the clinical setting. In 1998, VA was able to demonstrate that the comprehensive care and case management model of HIV care reduces inpatient utilization. Education has been a major component of the program. A VA AIDS Information Center was established to provide up-to-date information about HIV/AIDS for VA staff and patients. In addition, VA conducted multiple HIV clinical update conferences to educate VA clinicians about treatment advances in this rapidly changing field. An HIV Prevention Strategic Plan (2000) has been developed. One of the goals in the plan included a National VA HIV Prevention Conference to provide training in HIV risk identification and interventions to front-line staff.

Smoking Prevention

VHA has established smoking cessation clinics for veterans in each of its medical centers. Clinical Practice guidelines were developed to monitor the effectiveness of each program (13). Several initiatives were developed for implementation during the next Fiscal Year. These initiatives include:

- Coordinating Federal smoking litigation with Departments of Justice and Defense

- Surveying VA employees to determine the number of smokers while addressing the potential of including smoking cessation as part of a comprehensive insurance package
- Evaluating employee smoking habits and loss of productivity as a result of smoking.

Occupational Health and Safety

Creation of the OESHG gave occupational health and safety increased visibility. Some of the specific accomplishments included the creation of a tracking system for occupational injuries and illnesses, Latex Allergy Evaluation Program, Partnership agreement with OSHA in work site evaluation, and Co-sponsorship with NIOSH, OSHA, and NIEHS on the IOM report, "Safe Work in the 21st Century".

Environmental Epidemiology

The Environmental Epidemiology Service has initiated and completed a number of health studies, either mandated to Secretary of VA by legislation or directed by the Department. The areas for study included WWII veterans exposed to radiation or mustard gas, veterans who participated in atmospheric nuclear weapon tests (Atomic veterans), Vietnam veterans potentially exposed to Agent Orange, Women veterans who served in Vietnam, and Gulf War veterans. Studies were completed and published in peer-reviewed scientific journals (9 - 39).

OFFICE OF PUBLIC HEALTH & ENVIRONMENTAL HAZARDS
Supporting Document Index

1. A National Academy of Sciences Institute of Medicine (IOM) study on the health effects of key Gulf War veteran environmental exposures
2. Quarterly newsletter on Gulf War health and compensation issues
3. Posters describing VA health care and compensation services
4. Answers to frequently asked questions - Spanish language translations
5. Most recent IOM report
6. Agent Orange Brief
7. Posters describing VA health care and compensation services for Vietnam veterans
8. Agent Orange Fact Sheets on illnesses associated with Agent Orange exposure and Spanish language translations
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OFFICE OF INFORMATION – Summary Outline

<u>Project or Accomplishment</u>	<u>Date Completed</u>	<u>Description</u>
Computerized Patient Record System (CPRS)	Fully implemented 1999	Comprehensive suite of clinical applications that creates an electronic medical record to assist health care providers in providing quality care.
Year 2000 Project	Completed March 31, 2000.	Ensure that all VHA information technology and medical care equipment is year 2000 compliant by January 1, 2000.
Decision Support System (DSS)	Technical implementation completed 1999. Still evolving.	Executive information system that helps manage resources by providing data on patterns of care, patient outcomes, resource consumption, and costs associated with the health care process
Intranet/Internet Support	VHA intranet site established 1994. Newly designed VA web site debuted Jan 2000. Sites continue to evolve.	Enables VA to reach internal and external customers through expanded use of web technologies.
Enrollment	Enrollment officially began 1998. System still evolving.	Annual national enrollment system that allows VA to best manage access to health care within its limited resources.
Imaging	In progress.	Captures clinical images, scanned documents, and other non-textual data and makes them part of the patient's electronic record. Will eventually enable VA to have electronic access to all veteran patient images.
Government Computer-Based Computerized Patient Record (GCPR) Framework Project	In progress.	Will enhance the quality of patient care by facilitating the exchange of patient medical information between various cooperating health care sites. E-Gov 2000 Pioneer Award Winner.
Bar Code Medication Administration (BCMA)	Completed national implementation in FY 2000.	BCMA improves medication administration accuracy and increases the efficiency of documentation by automating the manual process of administering medications to veteran inpatients. Hammer and Scissors Award, June 22, 2000.

GAO Review of Government Computer-Based Patient Record (GCPR)	August 1999 & November 2000 (in progress)	GAO originally set out to review GCPR as a project to investigate VA/DOD health related issues. It has now evolved into looking into joint ventures between government agencies.
IG Audit of Decision Support Standardization No 9R4-A19-075	March 31, 1999	Concluded that DSS staff must adhere to its basic structural model.
IG Review of Prescribing Practices for Elderly Outpatients No. 7R1-A28-008	November 22, 1996	Recommended VISN Directors forward OIG furnished information regarding prescribing practices of specific drugs to individual VHA medical facilities and encouraged directors to utilize ADP applications to optimize medication management for specific drugs and patient populations
IG Audit of VA's Year 2000 Implementation Effort	March 8, 1999	Assessed VA's efforts to address Y2K issues and become Y2K compliant. Identified areas where effort could be strengthened.
IG Evaluation Efforts to Integrate Commercially Developed Software to Hospital Information Systems No. 7R5-G07-112	May 1997	Recommended VHA arrive at a consensus for future use of Interface Engine Message Routing and Translation System (MRTS) to optimize use of technology.
GAO Follow-up VA's Information Technology Investment Program	May 2000	Follow-up on five GAO recommendations in July 1998 report. Focus on how information technology has improved service to the veteran.
GAO Review :VA Health Care: Better Data and Accountability Needed for Care of Disabled Veterans	February 2000	Investigated VA's compliance with capacity legislation and implementation of performance standards for employees who manage resources for veterans with special disabilities.
IG Review of VHA's Income Verification Match Program 9R1-G01-054	March 15, 2000	Identified opportunities to improve means testing and income verification procedures.
GAO Audits of VA's Year 2000 Efforts	Final hearing held March 2000.	Between August 1999 and March 2000, GAO reviewed and evaluated VA's efforts in obtaining Y2k compliance for Information Technology Equipment and Medical Care Equipment.

GAO Review: Controls for Consolidated Financial Statement Audit	September 1999 and July 2000	Reviewing information system controls in connection with VA's required annual consolidated financial statement audit for FY 1999.
GAO Review: VA Health Care	August 1998	Concluded that more veterans are being served, but better oversight is needed.

OFFICE OF INFORMATION Narrative

Introduction

During the period from 1992 to 2000, the Veterans Health Administration (VHA) Office of Information (OI) enhanced and improved information technology throughout the VA medical facilities by creating and incorporating many new innovations and technologies. The veterans benefited directly by improvements in the quality and timeliness of service throughout all VHA medical care facilities. Outreach to both veterans and employees were vastly improved through the use of updated and integrated automated systems and techniques. Important achievements made throughout this period are highlighted below in the order of initiation. The majority of the projects are ongoing.

Veterans Health Information Systems and Technology Architecture (VistA)-Formerly Decentralized Hospital Computer Program (DHCP) (1992-2000)

The delivery of quality health care services to eligible veterans is one of the primary missions of the Department of Veterans Affairs (VA). Within the Department, VHA operates the largest centrally directed health care system in the United States. In 172 VA facilities nationwide and at VA outpatient clinics, nursing homes and other sites of care, electronic information systems support delivery of health care to veterans.

In 1996, the Chief Information Office introduced **VistA**...Veterans Health Information Systems and Technology Architecture...a rich automated environment that supports day-to-day operations at local VA health care facilities. **VistA**, which includes both "in-house" developed and commercially purchased software, provides automation for major clinical, management and administrative functions throughout VHA.

VistA is built on a client-server architecture, which ties together personal computers with applications by utilizing graphical user interfaces at VHA facilities. **VistA** includes necessary links that allow commercial off-the-shelf software and products to be used with existing and future technologies. VHA established the following criteria for design, development, and integration of software applications:

- Standardized software can be exported to all VA medical facilities;
- Technical integration using a common database, programming standards and conventions, and data administration functions;
- Functional integration through utilities such as order entry/results reporting and flexible health care summaries;
- Standard data elements;
- Timely access to data;
- Equipment and software specifications that avoid dependence on a single vendor;
- A system that is easy to use for the information resources manager and the health care professional; and
- System integrity and protection of data against loss and unauthorized change, access, or disclosure.

Examples of significant improvements to DHCP/**VistA** are summarized below:

- **Occurrence Screen (1993)** - Identifies events requiring follow-up review. It generates worksheets used by clinical, peer, management, and committee-level reviewers and identifies practitioner, systems, and equipment-related problems and results. This program enables medical facilities to define site-specific screens and to track associated events.
- **Clinical Monitoring System (1993)** - Allows users to design monitors that capture patient data to support quality assurance and management efforts.
- **Event Capture (1993)** - Tracks and accounts for procedures and delivered services that are not handled in any other *VistA* package. These procedures and services are delivered by both VHA and non-VA providers.
- **Consolidated Mail Outpatient Pharmacy Package (1994)** - Provides a regional system resource to expedite the distribution of mail-out prescriptions to the patient. The package aides outpatient pharmacies in dispensing and handling 20,000 prescriptions in 8 hours.
- **Prosthetics Module (1996)** - Enhances patient care by expediting the determination of veteran eligibility, determining what prosthetics services and devices have been provided to the veteran in the past, and decreasing the time required to order, deliver, and/or repair new and existing prosthetic devices.
- **Women's Health Package (1998)** - Assists in the management and assessment of women's healthcare services by:
 1. Providing data to determine if there are differences in disease frequency between women veterans and the general population;
 2. Providing information for clinical guideline development and determining if preventive healthcare screening guidelines developed for the general population, are applicable or need modification in the women veteran population; and
 3. Providing workload, preventive screening, women veterans health profile, outcome measurement and provider profiling.
- **Automated Medical Information Exchange (AMIEII)(1998)** - The AMIE system was developed when a majority of VHA medical records were stored in paper form. Since its introduction, VHA has rapidly increased electronic storage of medical information. Now, the information linkage between Veterans Benefits Administration (VBA) and VHA must shift away from electronic requests for paper documents, to mutual accessibility of electronic records. AMIE II supports that process and is an initiative that:
 1. Upgrades and shares communication linkages;
 2. Capitalizes VHA's electronic storage of medical information;
 3. Allows VA medical facility staff full read access to the Benefits Delivery Network system for veteran eligibility inquiries; and

4. Allows VBA staffs access to medical data in VHA *VistA* system.

AMIE II was installed at all VHA medical centers and VBA regional offices in 1998. Mutual accessibility of electronic records significantly reduces redundant labor intensive process in both agencies. AMIE II enhances the way VA conducts business and how work is processed within VHA and VBA. Implementation of AMIE II is a significant step toward the "One VA" objective to increase ability to transfer records electronically and moving towards a "paperless process" supporting the overall goal to provide prompt delivery of services and benefits to the veterans.

- **Computerized Patient Record System (CPRS)(1998)** - A comprehensive suite of clinical applications that creates an electronic medical record to assist health care providers perform their clinical responsibilities by:
 - Presenting a patient's conditions, past treatment, problems, and diagnoses, diagnostic and therapeutic procedures and interventions together in one place;
 - Allowing physicians, nurses, pharmacists, social workers, quality assurance managers, discharge planners and clinical managers a more comprehensive view of the patient's record and input into the care process;
 - Allowing clinicians to create, edit, and view problems, progress notes and orders, as well as view results data simultaneously;
 - Making available alerts, notifications, cautions, warnings, advanced directives, future appointments, demographic data, medications, and orders; and
 - Allowing physicians to sign orders and clinical documents electronically, virtually eliminating the need for chart entry.
- **Bar Code Medication Administration (BCMA)(2000)**- Provides a consistent, real-time, point-of-care solution for validating the administration of medications. BCMA is designed to improve medication administration accuracy and increase the efficiency of documentation. As each patient wristband and medication are scanned by a bar code reader, the software immediately validates that the medication is ordered, timely, and in the correct dosage and electronically updates the medication administration history.

BCMA improves efficiency by capturing drug accountability data, increasing the information available to the nurse at the point of care, improving communication between Nursing and Pharmacy, recording missing doses, and sending an electronic missing dose request to the Pharmacy.

Troubleshooting options in BCMA provide system administrators and managers the ability to monitor the system, correct problems with the Medication Log, review the Medication Variance Log, and set site- and user-specific parameters.

Bar Code Medication was the recipient of the Hammer and Scissors Award, June 22, 2000.

- ***VistA* Imaging (2000)** Captures clinical images, scanned documents and other non-textual files and makes them part of the patient's electronic medical record. The VA *VistA* Imaging System provides a tool for communication and consultation among clinicians in the same department, in different services or at different facilities across

the country. Use of this system will enable VA to eventually operate in a "filmless" mode with electronic access to all veteran patient images (i.e. radiology, cardiology, dermatology, pathology, surgery, etc.) for diagnostics and education from virtually any location.

Decision Support System (1994)

The Decision Support System (DSS) is an executive information system that allows for improved resource management and patient care by providing data on patterns of care, patient outcomes, resource consumption, and costs associated with health care processes. DSS supports an enhanced data-driven management process at VA medical centers aimed at improving the policies and practices of VA facilities in an evolving competitive health care environment.

The primary data source for DSS is data extracted from the core-plus-eight **VistA** packages. Additional data can be brought into DSS via the Event Capture software. This extracted data is compiled into a file, residing at the Austin Automation Center. This allows interaction among the VAMCs' department and financial structures, and patient databases, making it a relational database that the medical centers can query in any manner imaginable. Since DSS integrates data already in existence in current **VistA** files, for the first time, users can analyze and compare workload and cost data in great detail. With DSS, medical centers are able to perform product line analyses, modeling, "what if" scenarios, clinical performance measurement, and clinical quality management.

DSS supports the VA's continuous quality improvement initiatives by providing information systems support for outcomes-based performance measures that document the effectiveness of health care delivery processes. The combination of observations relating patient care outcomes (quality) with information about resource utilization (costs) can facilitate understanding of the value of health care services provided by VA medical centers.

VHA Intranet (1994)

The VHA Intranet was first established in 1994. Primary objectives that were successfully completed included:

- Develop a plan for future VHA Intranet directions;
- Identify a standard set of Intranet policies, procedures, tools and technologies;
- Provide necessary training or guidance to authors and users in VHA headquarters, VISNs, and VAMC Director's offices in the use of the VHA Intranet; and
- Ensure on-going technical support and resources following implementation.

An upgraded Intranet web site was released that provided a customized browsing experience with a "look and feel" that follows current industry trends. The Intranet has a customizable home page that allows the user to select their own links for a standard list of major VHA links, add other favorite links to web sites, and an external search engine. A number of static web pages were converted to dynamic database driven pages and applications that provide current information to the VHA community and add functionality to the web site.

The VHA Intranet site has the potential to become a key tool for improving internal communications, saving operational costs, and improving productivity of employees across VHA.

Upgrading Veterans Health Administration Technology Infrastructure (1995)

VHA has enhanced the telecommunications infrastructure for its Veteran Integrated Service Networks (VISNs), health care facilities, and headquarters in order to improve the electronic means by which VHA employees communicate. The telecommunications infrastructure addresses sending and receiving of voice, data, video, and images at acceptable speeds over local area networks and wide area networks (WAN), and improving the communications foundation to promote effective management with the VISN structure. The infrastructure includes fiber optic backbones, local area network hubs/switches, and multimedia mail servers and software for all VA medical facilities, as well as upgrades of the WAN nation-wide that link VHA facilities together. The infrastructure is the foundation of VHA's enterprise information system interconnectivity, and is central to providing faster and more reliable communications necessary in today's health care environment. Support provided for this infrastructure includes upgrading cabling plants, local area networks and wide area networks nationwide.

Accomplishments

- Upgraded the Frame Relay Wide Area network national backbone.
- Implemented MS Exchange hardware/software for e-mail among all facilities.
- Surveyed 266 VHA facilities to document "as-is" condition of telecommunications infrastructure and to document proposed recommendations and estimated costs. These reports are being used by the VISNs to plan improvements to the infrastructure.
- Implemented a new WAN network with Sprint under the FTS2001 contract.

Telecommunications Infrastructure Project (TIP)

The Telecommunications Infrastructure Project is designed to provide an enhanced telecommunications structure with expanded processing capabilities for all VHA automated applications. These performance enhancements were needed to support processing of CD-ROM applications, the computerized patient record, **VistA** Imaging, DSS, drug utilization, electronic document imaging, desk-top video-conferencing, telemedicine, MS Exchange, office automation and access to the Internet and World Wide Web. This project improves patient health care by enhancing the electronic means by which VHA employees communicate with each other within a healthcare facility, as well as between medical facilities. The goal of this project was to make a more complete, timely, and accurate clinical and management information available to VHA health care providers and managers.

Veteran Identification Card (VIC) (1996)

The Veteran Identification Card (VIC), developed in 1996, replaced the embossed data card as a means of identifying veteran patients entitled to care and services at Veterans Affairs (VA) healthcare facilities. This card includes a bar code, magnetic strip, and a photo of the patient as well as traditional embossing. Name, date of birth and social security number (SSN) are also embossed on the card. One of the features of the VIC card is that it provides the ability to download data for current inpatients, clinic patients with future appointments, patients with scheduled admissions in batches, or download data for a single patient. Currently the VA, is working on the next generation of identification card, the Smart Card.

Year 2000 Project (1996)

Within its national network of health care facilities, VHA manages and maintains a diverse systems and equipment inventory. This includes hospital information systems and applications, corporate information systems and databases, commercial off-the-shelf (COTS) hardware and software, communications systems and networks, biomedical equipment, laboratory and

research systems, and other computer-controlled facility equipment. There are many data interfaces among the systems and equipment in this extensive inventory. One of VHA's top priorities was to ensure year 2000 date compliance for all its system products and their interfaces. Due to the efforts of the VHA Year 2000 (Y2K) team, VHA successfully transitioned into the Year 2000 without any significant incidents. VHA was considered a "leader" in the biomedical arena for their efforts to ensure that all biomedical equipment in the hospitals was Y2K compliant and working effectively on January 1, 2000. VA remained on a "Green" operational status throughout the date rollover period and we continue to operate on a "Green" status without any Year 2000 interruptions.

Enrollment (1996)

Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, required the Department of Veterans Affairs to establish and operate a system of annual national enrollment as the primary tool for VA to manage access to health care within its limited resources. Each year, the Secretary of the VA makes an enrollment decision based on available resources that will ensure the quality of care and access to care will not be compromised. Enrollment Activities include:

- Processing of new enrollments and re-enrollments;
- Providing information services to veterans through a toll-free national call center; and
- Providing management and congressional reporting of enrollment status.

Enrollment Highlights

- **Trial year for the VA enrollment process (October 1, 1997 through September 30, 1998)** - An automatic application for VA health care enrollment was created for all veterans who had received care from October 1, 1998 through January 1998. Any veteran who was not enrolled automatically could apply for enrollment at any VA medical facility
- **Enrollment officially began (October 1998)** - Effective October 1, 1998, the Secretary of Veterans Affairs could not provide hospital care or medical services to veterans without enrollment.
- **Call Center Support in Operation (June 1998)** - A national Health Benefits Call Center (1-877-222-VETS), that also integrates two enrollment reform web based sites (www.va.gov/health/elig and www.vhacom/elig) was opened. This center ensures that all veterans have a single point of access for requesting assistance and information on eligibility reform policies and enrollment.

The Government Computer Based Patient Record Framework Program (GCPR) (1997)

The Government Computer Based Patient Record Framework Program originated as a joint VA and Department of Defense (DoD) response to satisfy a 1997 presidential directive to create a comprehensive, life-long medical record for all service personnel. In February 1999, the VA, DoD, and the Indian Health Service signed a Memorandum of Agreement authorizing this collaborative effort. The goal was to achieve an easily accessible, yet secure life-long medical record for each of our Nation's veterans, military personnel, their dependents, and Native Americans.

THE GCPR Framework is designed to meet inter and intra-agency needs to exchange and manage healthcare information through the joint development and implementation of a standards-based, open architecture clinical information infrastructure. The GCPR Framework Project will enhance the quality of care clinicians provide to patients by facilitating the exchange of patient medical information between various cooperating sites while enabling each site to

continue to use its own business practices and heterogeneous legacy systems where health care is being delivered. This design also provides the potential to link private sector contract providers with the Framework to share clinical information between the private sector and the federal participants.

GCPR was the E-Gov 2000 Pioneer Award winner.

Microsoft Exchange (1998)

Microsoft Exchange is a system that allows all VHA facilities, VISNs and VA headquarters offices to be connected via e-mail. The project was later expanded under the Telecommunications Infrastructure Project to cover all medical centers and related facilities. ScanMail Virus Protection software for MS Exchange attachments has been installed on all Exchange servers within VHA in order to protect the VA electronic mail system from virus attacks, such as Melissa.

Master Patient Index/Patient Data (MPI/PD) (1999)

Access to patient information is a crucial element in VHA health care delivery. Cross referral of patients within and among VISNs is a standard method of providing care. MPI/PD is a system that provides up-to-date demographic data automatically to the facilities. It also provides the ability to identify and track all locations where patients are receiving care and enables consistent updates of patient demographic data.

THE MPI/PD will support primary care as an integrated component of the Computerized Patient Record System (CPRS) Clinician Desktop. MPI/PD consists of software/procedures needed for facilities to ensure accurate databases and implement MPI, which is used to uniquely identify patients and track in real time all locations where they have received care. Patient demographic data is synchronized among sites that are treating the patient including the key data: patient name, social security number, date of birth, address and marital status.

Improving Data Quality-- Data Quality Summit (1999)

VHA's Data Quality Journey project began in January 1999 following the December 1998 Data Quality Summit. As a result of the summit, five field-based workgroups were formed to address data quality at VHA.

Each group worked on the three or four high-priority action items identified at the summit and completed the task in September 1999. Workgroup accomplishments to date include, but are not limited to: 1.) developing a memorandum describing the structure, membership and responsibilities of a data quality advisory group, 2.) creating the Data Quality Council; 3.) establishing a working cooperative with the Data Consortium; 4.) developing a questionnaire to assess veterans' needs for access to their health information and general health information; 5.) surveying clinical managers at a VAMC on current health summaries and patient access methods in order to assess what is used by the field; and 6.) reviewing the VA Information Resource Center roadmap of VA data sources documentation.

In July 1999, workgroup progress reviews and discussions of future directions for data quality improvement efforts resulted in a major focus on ways to improve the quality of ambulatory care data. Recommendations included: improvement and standardization of workload information; improvement of outpatient documentation for coding; development of a standard validation program; and development of an implementation plan for policies and standards for compliance planning.

Smart Cards (2000)

The Smart Card is being developed in order to streamline and simplify services to the veteran. According to the vision of the VA Smart Card Work Group, the VA Smart Card will be a portable card that will contain registration and emergency medical data on the veteran. It will allow administrative and clinical personnel, with appropriate security clearance, access to the veteran's electronic files regardless of geographic location. The VA smart card will be used by veterans to access services in all 3 VA organizations (Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration). The VA Smart Card will enable interactive access to information through web-enabled systems, and access to information through kiosks at medical centers, regional offices, community-based clinics and other locations. One VA card will eventually identify links to other VA electronic information resources. In addition to passwords, security will be enhanced with Public Key Infrastructure and potentially biometrics security.

Veterans-Focused Internet Redesign Project (2000)

A newly redesigned veteran focused VA Web site made its debut on January 31, 2000. This web site was designed using feed back from all major stakeholders including veterans and family members, Veterans Service Organizations (VSOs), business partners and congressional staff members. In addition, an on-line Web page redesign survey was posted to the existing site to gather additional feedback. A great deal of emphasis was placed on accessibility issues to assure the web design adhered to the Rehabilitation Act of 1973, Section 508 standards.

VA'S EMERGENCY MANAGEMENT STRATEGIC HEALTHCARE GROUP (EMSHG)
formerly

**Emergency Medical Preparedness Office
(EMPO) 1995-1997
and
Office of Emergency Medical Preparedness
(OEMP) 1990-1995**

Summary Outline

- Manages, coordinates, and carries out responsibilities in emergency medical preparedness assigned to VA by federal laws and regulations.
- Provides technical guidance, support management and coordination to ensure continuation of healthcare for eligible veterans, military personnel, and the public during Department of Defense (DOD) contingencies, and natural, manmade, or technical emergencies.
- Operates from headquarters in Martinsburg, WV with a field staff of Area Emergency Managers and Management Assistants located at VA medical centers throughout the nation.
- VA/DOD Contingency Hospital System:
 - (1) VA serves as the principal healthcare backup to DOD in the event of war or national emergency.
 - (2) Plans are maintained and updated jointly by VA and DOD.
 - (3) Assessments are conducted annually of VA's capacity to care for the sick and wounded military personnel in time of war or national emergency.
 - (4) Results of these assessments are reported to Congress each year.
- National Disaster Medical System (NDMS):
 - (1) VA is a partner, along with the Department of Defense, the Federal Emergency Management Agency and the Public Health Service, in the National Disaster Medical System (NDMS).
 - (2) NDMS combines federal and non-federal medical resources into a unified response that is designed to meet peacetime disaster needs as well as combat casualties from a conventional armed conflict.
 - (3) VA and DOD manage 73 NDMS Federal Coordination Centers across the U.S., with VA having responsibility for the majority (49).
 - (4) Memoranda of Agreement with over 1,500 non-Federal hospitals are maintained by the VA-managed Federal Coordinating Centers.

(5) NDMS training and exercises are conducted by VA in those communities where it has coordinating responsibilities.

- Federal Response Plan (FRP):

(1) FRP establishes the basis for federal assistance to state and local governments impacted by catastrophic disasters.

(2) In the FRP, EMSHG carries out VA's assigned responsibilities in four areas: engineering services, mass care and sheltering, resource support, and health and medical services under specific taskings.

(3) Health and medical support includes healthcare personnel, equipment, medical supplies, and mobile health clinics to meet the immediate needs of the affected populations.

(4) The Disaster Emergency Medical Personnel System (DEMPS) uses a database whereby VHA personnel can volunteer for future deployment in emergency situations.

(5) EMSHG maintains intra-organizational responsibilities through established Memoranda of Understanding (MOU) and Memoranda of Agreement (MOA) to enhance operational effectiveness.

- Natural and Technological Hazards:

(1) Presidential Executive Order 12567 (Federal Preparedness at Commercial Nuclear Electric Generating Stations) specifically tasks the Department of Veterans Affairs to provide for the management of patients with radiation trauma resulting from accidents at nuclear power plants, nuclear weapons, or from the commercial uses of nuclear materials including transportation.

(2) VA is a signatory to the Federal Radiological Emergency Radiological Preparedness Plan (FRERP) and will, with the permission of the Secretary, and at the request of the Lead Federal Agency (LFA) or affected local governments, provide medical response to supplement other governmental efforts.

(3) Mission taskings may include: Assessing the impact on human health; providing medical advice on the treatment of people exposed to, or contaminated by, radioactive material; managing radiation trauma; providing crisis counseling; arranging for temporary shelter and housing; and coordinating the use of other non-governmental medical resources.

(4) VA is an ad-hoc member of the National Response Team (NRT) which is the response and recovery arm of The Superfund Amendments and Reauthorization Act of 1986 (SARA) Title III. VA may be asked to manage the medical aspects of a qualifying hazardous materials incident including long-term recovery.

- Continuity of Government:

- (1) EMSHG will execute assigned actions to support VA's continuity of government.

- (2) EMSHG has responsibilities related to maintenance of specific sites when there is a threat to continued functioning of the federal government and the Department of Veterans Affairs.

- VA Continuity:

- (1) EMSHG prepares for response to emergencies that may affect any VA medical facility.

- (2) EMSHG also provides planning, training, management, and exercise support to VA medical centers, including emergency plans to evacuate and relocate patients if a hospital cannot provide service.

- (3) EMSHG coordinates VA's role in preparing for Weapons of Mass Destruction events to include training of healthcare personnel.

- EMSHG Responses to National Natural and Man-made Disasters since 1993.

Below are listed the natural and man-made disasters in which EMSHG played a direct role, including regional casualty and healthcare coordination, medical supply support and transportation, VA volunteer personnel recruitment and support, as well as additional duties in support of the Federal Response Plan.

- (1) Mid-West Floods (1993)
- (2) Northridge Earthquake (1994)
- (3) Southeast Floods (1994)
- (4) Oklahoma City Bombing (1995)
- (5) Hurricane Felix (1995)
- (6) Hurricane Luis (1995)
- (7) Hurricane Marilyn (1995)
- (8) Hurricane Opal (1995)
- (9) Northwest Floods (1996)
- (10) Hurricane Bertha (1996)
- (11) Hurricane Hortense (1996)
- (12) Hurricane Fran (1996)
- (13) North Dakota/ Minnesota Floods (1997)
- (14) New York Ice Storm (1998)
- (15) Hurricanes Bonnie/Earl (1998)
- (16) Hurricane Georges (1998)
- (17) Oklahoma/ Kansas Tornadoes (1999)
- (18) Hurricane Bert (1999)
- (19) Hurricane Floyd (1999)
- (20) Egypt Airlines 990 Crash (1999)
- (21) Hurricane Lenny (1999)

- Increased Disaster Preparedness and Emergency Medical Training and Exercises with other Federal, State and Local Government Agencies (1993-2000).

EMSHG conducted seminar, table-top, and practical hands-on training with other agencies and departments dealing with medical emergency responses and planning. Exercises keyed to patient care/survivability, as well as patient distribution to appropriate governmental or local hospital care, were conducted in various cities including New York, NY; Cleveland, OH; and Orlando, FL. These exercises reflected the lessons learned during EMSHG's deployments in the disasters listed above.

- List of Major Policy Initiatives and Agreements Since 1993

These Memoranda of Understanding (MOU) and Memoranda of Agreement (MOA) contain inter and intra agency agreements which specify certain performance requirements from EMSHG which further the emergency medical preparedness mission of VA under the Federal Response Plan (for PUBLIC LAW 93-288, AS AMENDED), April 1992. Note: The Emergency Management Strategic Healthcare Group (EMSHG) was previously designated the Emergency Medical Preparedness Office (EMPO) and later as the Office of Emergency Medical Preparedness (OEMP).

(1) Memorandum of Agreement between Deputy Assistant Secretary for Security and Law Enforcement, Department of Veterans Affairs, and the Director of the Emergency Medical Preparedness Office, Veterans Health Administration, Responsibilities for Emergency Preparedness Programs, dated August 5, 1994.

(a) The Deputy Assistant Secretary (DAS) for Security and Law Enforcement delegates his responsibility for policy, planning, and coordination of VA responsibilities in the Federal Response Plan (FRP) to Emergency Medical Preparedness Office (EMPO) and designates the Director, EMPO, as the "Principal Alternate" member of the Catastrophic Disaster Response Group.

(b) Routine matters regarding National Security and Emergency Preparedness will be coordinated between DAS and the Director, EMPO, and the Deputy Director for Policy and Planning, EMPO.

(2) Interagency Agreement between Department of Health and Human Services and the Department of Veterans Affairs, dated April 24, 1997.

(a) The Office of Emergency Preparedness (OEP) HHS and Office of Emergency Medical Preparedness (OEMP) VA enter into an agreement for the procurement, storage, and maintenance of caches of specialized medical supplies to be used in a Weapons of Mass Destruction (WMD) situation.

(b) OEP will identify cache locations and pay VA \$1.7 million in FY 97; while VA will designate the actual facilities; procure, store, and maintain the stockpiles; and deliver them within two hours of notification.

(3) Department of Veterans Affairs, Intra-Agency Agreement between Office of Emergency Medical Preparedness and the Office of Acquisition and Materiel Management, dated September 30, 1997.

(a) This agreement acknowledges that funds appropriated for OEMP's use in the periodic procurement, storage, and distribution of medical supplies, which remain unobligated, and are deposited into the VA Revolving Supply Fund, will remain subject to appropriation without regard to any fiscal year.

(b) OEMP retains all program control responsibilities and is solely responsible to obligate the funds held under this agreement. The Office of Acquisition and Materiel Management (OA&MM) will, without delay, execute authorized obligations in a timely and efficient manner.

(4) Statement of Understanding between the American Red Cross and the Department of Veterans Affairs, dated March 18, 1998.

(a) This Statement of Understanding defines the relationship between the American Red Cross (ARC) and VA in preparing for disaster relief situations at all levels, including the responsibilities of both agencies under Emergency Support Function (ESF) #6 of the Federal Response Plan (FRP).

(b) Representatives of the ARC Disaster Services and VA will meet annually to evaluate progress and to revise or develop new plans or goals as appropriate.

(5) Memorandum of Agreement between the Office of Emergency Preparedness of the U. S. Department of Health and Human Services and the Department of Veterans Affairs, dated March 6, 2000.

(a) This agreement is for the purchase, storage, quality control, maintenance, exercise, and contingent deployment of pharmaceutical and other medical products in support of the National Disaster Medical System (NDMS) WMD cache program. This Agreement supersedes the Interagency Agreement between HHS and VA, dated April 24, 1997, and defines in specific details, the responsibilities of both parties, including additional details on the security, deployment, compliance with Food and Drug Administration, Drug Enforcement Agency and Government Accounting Office requirements, budget projections, auditing procedures, and billing codes.

(b) The Director of the Veterans Health Administration (VHA) Emergency Pharmacy Services and the Emergency Planner, NDMS, (HHS) are designated as points of contact for logistical support of the NDMS/WMD cache.

(6) Memorandum of Understanding between the Pharmacy Benefits Management Strategic Healthcare Group and the Emergency Management Strategic Healthcare Group for the Management of the NDMS/WMD Cache, dated April 19, 2000.

(a) This MOU references the MOU between OEP, HHS and VA, dated March 6, 2000, and further delineates the duties of EMSHG and the Pharmacy Benefits Management Strategic Healthcare Group (PBMSHG) to comply with that MOA.

(b) The Director, National Programs, EMSHG, and the Director of PBMSHG are designated as points of contact in this MOU for the logistical support and development of plans for the management and deployment of the NDMS/WMD cache.

- Additional VHA Directives and Handbooks Undertaken Since 1993

The below-listed VHA Directives and Handbooks contain extensive mandates and procedures for EMSHG.

(1) VHA Directive 10-95-007, dated 1/19/95 Department of Veterans Affairs/Department of Defense (VA/DOD) Contingency Planning in Support of Federal Response Plan (FRP)

(2) VHA Directive 10-95-079, dated 8/11/95 Department of Veterans Affairs (VA)/Department of Defense (DOD) Contingency Planning System (RCS 10-0859)

(3) VHA Directive 0320, dated 5/1/97 Emergency Medical Preparedness

(4) VHA Handbook 0320.1, dated 5/1/97 Department of Veterans Affairs and Department of Defense Contingency Hospital System Plan

(5) VHA Handbook 0320.2, dated 6/12/00 Veterans Health Administration Emergency Management Program Procedures

(6) VHA Handbook 0320.3, dated 7/21/00 Disaster Emergency Medical Personnel System (DEMPS)

- Inspector General VHA (1998-2000) This report examined the current organizational scheme and recommended more stringent fiscal and personnel practices.
- Affected changes to Emergency Management standards of Joint Commission on Accreditation of Healthcare Organizations (JCAHO). National Standards were generated by EMSHG and were accepted as a national standard for all-hospital compliance.
- Effective use of the Internet. EMSHG has begun to internally develop an emergency management Internet capability involving support to deployed disaster responders, hospital bed reporting, and programmatic control of funds and personnel.