

VA'S EMERGENCY MANAGEMENT STRATEGIC HEALTHCARE GROUP (EMSHG)

Narrative

VA's Emergency Management Strategic Healthcare Group (EMSHG) formerly known as the Office of Emergency Medical Preparedness (OEMP), and the Emergency Medical Preparedness Office (EMPO), has several functional missions in accordance with federal laws and regulations.¹ EMSHG operates from its headquarters located at the VA Medical Center, Martinsburg, WV with a field staff of area emergency managers (AEM) and management assistants (MA) assigned to various VA medical centers throughout the nation.²

Under its functional missions, EMSHG manages, coordinates and carries out responsibilities in emergency medical preparedness assigned to VA by federal laws and regulations. The OEMP Missions and Authorities Summary contains the legislative authorities for the accomplishment of specific EMSHG emergency missions.³ EMSHG provides technical guidance, support management and coordination to ensure the continuation of health care for eligible veterans, military personnel, and the public during Department of Defense (DOD) contingencies and natural, manmade, or technological emergencies.⁴ In this context, VA serves as the principal health care backup to DOD in the event of war or national emergency. Plans are maintained and updated jointly by VA and DOD. Assessments are conducted annually of VA's capacity to care for the sick and wounded military personnel in time of war or national emergency. The results of these assessments are reported to Congress each year and provide a summary analysis of VA medical capabilities.⁵ Public Law 97-194, enacted on May 4, 1982, gave the Veterans Administration (now the Department of Veterans Affairs) the added mission to serve as principal health care backup to DOD in the event of war or national emergency. Plans were jointly developed to establish a VA/DOD Contingency Hospital System. In this regard, all Veterans Affairs medical centers assess 13 specific bed categories (that include highly specialized beds) required by DOD. Assessments take into account the impact on local operations of VA employees subject to mobilization, since long-standing VA policy is that no employee is unavailable for active military duty in a national emergency by reason of his/her VA position or assignment.

DOD policy requires Federal agencies to continually screen their ready reservists in peacetime to ensure immediate availability of these individuals during any mobilization. The DOD Authorization Acts of 1982 and 1983 elevated the mobilization priority of standby reservists and certain military retirees under age 60 in good physical health. VA's screening list now identifies approximately 16,351 employees who are subject to mobilization.⁶

The reported bed estimates are for staffed operating beds in the modified 13 DOD evacuation categories and take into account contingency planning considerations such as projected loss of personnel to mobilization, other staffing issues, beds out of service due to construction, planned program reductions or expansions, and other factors that may affect bed capability.

VA's objective is to provide DOD with maximum bed availability in the specific contingency bed categories within 72 hours of activation of the VA/DOD Contingency Hospital System. In order to accomplish this, the law permits the Secretary of VA to raise the priority for care of active duty personnel to second, immediately behind that of veterans being treated for service connected disabilities.

In coordination with DOD, VA designates its health care facilities as either Primary Receiving Centers (PRCs) or Secondary Support Centers (SSCs). Some of these facilities are also designated as Installation Support Centers (ISCs).

Primary Receiving Centers are those VA hospitals that would receive direct admission of military, active duty casualties, either as transfers from DOD health care facilities, or directly from the overseas combat theater. The SSCs would provide backup to the PRCs by accepting transfers of patients or providing resources (personnel, equipment and/or supplies). In contrast, the ISC role is to assist a neighboring DOD installation or medical facility in providing medical care and services for assigned active duty personnel, primarily during a military mobilization. Fifty-eight VAMCs (40PRCs and 18SSCs) and three outpatient clinics have been classified as ISCs.

In January 2000, VA medical centers completed their 17th annual capability assessment under the provisions of the VA/DOD contingency plan. The attached tables reflect information based on individual VAMC VA/DOD contingency data. Table 1 provides the estimated total number of staffed VA beds that could be made available to DOD under the plan. The staffed VA bed estimates in Table II reflect those beds that could be provided for active duty casualties at the PRCs. Table III shows bed availability of the Base/Installation Support and SSCs. Table IV identifies the number of Veterans Health Administration (VHA) employees who are active in the reserves, military retirees (by VHA network location), and total number of VAVHA employees subject to military mobilization.⁷ These statistics are important for VA to consider in making its estimate of the number of staffed beds that it can provide to DOD in a major military conflict involving a partial or full mobilization of National Guard and Reserve forces.

VA is also a partner, along with the Department of Defense, the Federal Emergency Management Agency (FEMA) and the U.S. Public Health Service (PHS) in the National Disaster Medical System (NDMS).⁸ NDMS combines federal and non-federal medical resources into a unified response that is designed to meet peacetime disaster needs as well as provide care to combat casualties resulting from a conventional armed conflict. The NDMS, formally created on June 14, 1984, is designed to fulfill three primary functions:

- Provide assistance in a domestic disaster by deploying medical assistance teams, supplies, and equipment to the disaster area.
- Transport patients who are unable to receive definitive care because the local health care system is overwhelmed.
- Provide hospitalization through a network of communities and private sector hospitals that have agreed to accept patients in the event of a major disaster or national emergency.

Today VA and DOD manage 73 NDMS Federal Coordination Centers (FCCs) across the United States with VA having responsibilities for the majority (49) of these. VA has signed Memoranda of Agreement with over 1,500 non-federal hospitals which are maintained by the VA-managed FCCs. VA regularly conducts NDMS training and exercises in the communities where personnel at its health care facilities have coordinating responsibilities. While FCCs coordinate the medical management of civilian patients brought to their area, Public Health Service Disaster Medical Assistance Teams (DMATs) are charged with providing medical support in disaster areas where they are deployed. The civilian members of the DMATs are federalized during their activation so they may receive health coverage and pay, and are covered by state licensures for their medical practice.⁹

During the Clinton Administration, January 1993 to the present, NDMS DMATS have deployed to numerous catastrophic events within the United States and overseas territories, usually following a disaster declaration by the President and the activation of the Federal Response Plan (FRP). Working with the Department of Health and Human Services (HHS), lead agent for NDMS, VA has facilitated DMAT deployment to many of these disasters through taskings under the FRP.

The FRP was initiated as a result of Public Law 93-288, as amended by Public Law 100-707 in 1988, and retitled as the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). The Stafford Act provides the authority for the Federal government to respond to disasters and emergencies in order to provide assistance to save lives and protect public health, safety and property. The FRP applies to natural disasters such as earthquakes, hurricanes, typhoons, tornadoes and volcanic eruptions; technical emergencies involving radiological or hazardous material releases; and other incidents requiring Federal assistance under the act.¹⁰ Under the FRP, VA is tasked to provide a variety of medical and other services as a support agency under the following Emergency Support Functions (ESFs):

- ESF-3 Engineering Services
- ESF-6 Mass Care And Sheltering
- ESF-7 Resource Support
- ESF-8 Health and Medical Services.

As the largest federal healthcare provider, VA has been tasked by HHS to assist in disaster relief. Resources were furnished when State and local resources were overwhelmed and medical and/or public health assistance was requested from the Federal Government. Resources were also made available through the NDMS.

Natural and man-made disasters in which EMSHG played a direct role during the time from 1993 to present are listed below. These missions included regional casualty and health care coordination, medical supply support and transportation, VA volunteer personnel recruitment, and additional duties in support of the FRP. The details of VA's commitment are contained in the EMSHG After-Action Reports for each catastrophic event:¹¹

- (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) Northeast 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)

The summary of medical support provided by VHA under the FRP in response to Presidentially declared disasters (1992-1998), or in support of Federal preparedness actions in the event of terrorist attack during high profile national events, is shown in the Index. This summary report reflects VA assets used in each event, i.e. location, facility, and type of support provided.¹²

In order to facilitate and expedite the availability of Veterans Health Administration (VHA) personnel for assistance within VA and deployment to disaster events, the Disaster Emergency Medical Personnel System (DEMPS) was developed. The Acting Under Secretary for Health authorized the DEMPS program through Handbook 0320.3 on July 21, 2000.¹³ This handbook contains the basic instructions for implementing and maintaining DEMPS whereby VHA personnel can volunteer in advance for possible future deployment in emergency situations. The DEMPS database will be used by VHA Headquarters and Veterans Integrated Service Network (VISN) Directors as a personnel resource listing to match personnel qualifications to emergency response requirements. VHA personnel desiring to volunteer for possible deployment in an emergency will be requested to complete a questionnaire which, when completed, is the source document for the entry of personnel information into the DEMPS database.¹⁴

In conjunction with the FRP, there has been an additional emphasis in recent years on preparing for terrorism.¹⁵ In June 1995, the White House issued Presidential Decision Directive 39 (PPD-39), "United States Policy on Counterterrorism." PPD-39 evoked a number of measures to reduce the Nation's vulnerability to terrorism, to deter and respond to terrorist acts, and to strengthen capabilities to prevent and manage the consequences of terrorist use of nuclear, biological, and chemical (NBC) weapons of mass destruction (WMD). As a result of this PDD and the subsequent development of four National Medical Response Teams (NMRTs) by HHS, VA has an agreement with the United States Public Health Service (USPHS) to maintain National NDMS/WMD caches, which are located at five strategic locations within the United States. Four of these cache components are for support of each NMRT, while the fifth component is designated for support of "special events."

With this National Security emphasis on counter-terrorism, VA has become a strong advocate for preparing for domestic incidents involving WMD. As part of VA's Comprehensive Emergency Management (CEM) approach to disaster preparedness, and in concert with the Clinton Administration's Policy on Critical Infrastructure Protection (PDD- 63), VA is preparing all of its health care facilities for all hazards, including WMD. Another Presidential Decision Directive (PDD-62: Combating Terrorism) provides for VA to work with HHS "to ensure adequate stockpiles of antidote and other necessary pharmaceuticals nationwide and the training of medical personnel in NDMS hospitals." Accordingly, VA has entered into an agreement with the Centers for Disease Control (CDC) for assistance in the development of caches of supplies and equipment that could be used by metropolitan areas that have been subjected to a WMD attack. Also under PDD-62, PHS has the authority to transfer up to one million dollars to VA for training of NDMS hospital personnel. VA is uniquely positioned to do this training since it represents a large portion of the Nation's medical capability and has facilities located throughout the country.¹⁶

Another area of VA support provided in response to threats emanating from a natural, accidental or terrorist event is the area of response to a radiological incident. The Federal Radiological Emergency Response Plan (FRERP) was developed by FEMA, the Department of Energy (DOE), and 15 other Federal agencies or departments in response to Executive Order (EO) 12241 and EO 12657.¹⁷ This plan provides procedures for Federal Agencies to discharge their responsibilities during a wide range of radiological emergencies. As a signatory to the FRERP, VA, with the permission of the Secretary, and at the request of the Lead Federal Agency (LFA) or affected local government, can provide medical response to supplement other governmental efforts. VA's 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.¹⁸

During the Clinton Administration, VA organized and trained a medical response team that can provide technical assistance, decontamination and direct medical support to a hospital or other health care facility located close to an area when a radiological disaster has occurred. Called the Medical Emergency Radiological Response Team (MERRT) it consists of 25 specialized VA physicians and health physicists who receive additional training and participate in various federal exercises on an annual basis. This team was specifically organized under a Concept of Operations that was approved by the Secretary of VA in response to E.O. 12657 (1988).

VA is also 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 assistance for patients exposed to a qualifying hazardous materials incident including their long-term recovery.

In accordance with Executive Order 12656, "Assignment of Emergency Preparedness Responsibilities" (November 18, 1988) and PDD-67, EMSHG's mission also includes support to VA's Continuity of Government (COG) and Continuity of Operations (COOP) plans during national emergencies. EMSHG maintains specific relocation sites when there is a threat to continued functioning of the federal government and the Department of Veterans Affairs. VA, along with other federal departments, has specific responsibilities regarding COG and COOP under various emergency conditions including attack on the United States.

While EMSHG has always had a role in providing support and assistance to VA health care facilities in the areas of emergency management and preparedness, in Calendar Year (CY) 2000 that role was enhanced by the publication of a new VHA Handbook (0320.2) on Emergency Preparedness Procedures. This document formally introduced and mandated the implementation of a Comprehensive Emergency Management (CEM) program "...to enhance VA medical centers' abilities to effectively respond and recover from contingency situations that could adversely affect the continuity of patient care or hospital operations. Such contingency situations include, but are not limited to, war, national emergencies, and natural, technological, or man-made disasters including terrorist events involving weapons of mass destruction (WMD)." Importantly, it assigned a consultative role to EMSHG with Area Emergency Managers (AEMs) as "...consultants and program experts on CEM...for support of Veterans Integrated Service Networks (VISNs) and VA health care facilities." This enhancement and redefinition of EMSHG's role was in concert with a CY 2000 reorganization that removed the AEMs from direct line supervision of the medical center to which they were assigned, and

centrally assigned, for administration, all EMSHG employees to the EMSHG Headquarters, placing them under the direct line authority of the Chief Consultant, EMSHG.

The support to be provided each of the 22 VISNs will be detailed in EMSHG/VISN Service Support Agreements (SSAs) that will be tailored to meet the individual comprehensive emergency needs of the VISN and its health care facilities. Under these SSAs, EMSHG will provide guidance and technical support through its AEMs to the respective VISNs and VA medical facilities. EMSHG AEMs will assist in planning, training, management, and exercise support to VA medical centers, including emergency plans to evacuate and relocate patients if a hospital cannot continue to provide service due to a situation that would adversely affect its supporting infrastructure.

In addition to the duties that will be in each specific SSA for internal VHA Comprehensive Emergency Management (CEM) programs, there are external support requirements that VHA, VISNs, and individual VAMCs must accomplish. This support will extend to national-level requirements as mandated under the various authorities that direct VA support, or provide the mechanism for a VA tasking in a disaster or national emergency. Complementing the CEM approach being used in the respective VISNs, the Incident Command System (ICS) has also been institutionalized for all VHA. Use of ICS as well as CEM is consistent with the revisions in the Environment of Care Standards undertaken by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).²⁰

In order to test VHA plans and provide readiness training for VHA personnel, throughout the eight years of the Clinton Administration, EMSHG has conducted numerous seminars, exercises, and practical hands-on training with other federal agencies and departments dealing with medical emergency preparedness. In concert with VA's federal partners, these events were keyed to patient care/survivability and patient evacuation through appropriate channels to receiving hospitals where definitive care could be provided. Annual and periodic medical exercises were conducted in key metropolitan areas where EMSHG AEMs had Federal Coordinating Center responsibilities. Two of the largest VA training events were Consequence Management '98 and Consequence Management '00 which were conducted at Fort Gordon, GA in April 1998 and May 2000. These exercises and training events were developed through a joint effort of VA, DOD and PHS. VISN 7, VHA, EMSHG and the Department of the Army, Regional Training Site-Medical (RTS-MED) provided primary sponsorship. These training events were designed primarily for federal emergency medical response team personnel who have specific and/or assigned duties during a WMD related emergency. The primary objectives of these joint exercises and training events were to provide specialized NBC training, offer an opportunity to perform emergency medical functions at a field location, and evaluate performance in responding to a WMD-based scenario.²¹

In summary, the administrative history of what has become the present day Emergency Management Strategic Healthcare Group (EMSHG) has paralleled almost exactly the eight years of the Clinton Administration. From a primary focus of providing back-up medical support to DOD in times of a major overseas conflict, following the Gulf War, the role of VA, VHA and EMSHG has expanded to embrace various roles associated with domestic preparedness and response, as well as a heightened focus on continuity of operations and infrastructure protection. As the new millennium dawns, to accommodate these enhanced missions, EMSHG has developed and is implementing a comprehensive emergency management program that promises to bring together all of the various activities and functions that contribute to a healthcare system that is not only prepared to respond to emergencies, but is also prepared to

survive disasters and ensure continuity of medical care to our Nation's veterans well into the next century.

Listed below are the major policy documents, agreements, and other authorities that have been published and executed, during the Clinton Administration, that affect the emergency management and preparedness roles of VA, VHA and EMSHG.

(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, 1994.²²

The agreement provides:

a. That 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. That 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, 1997.²³

This agreement provides that:

(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 provide necessary funds to VA to procure, store, maintain and deliver the stockpiles to designated areas for deployment.

(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, 1997.²⁴

(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, 1998.²⁵

(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, 2000.²⁶

(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. It defines, in specific detail, 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, 2000.²⁷

(a) This MOU references the MOA 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 for the logistical support and development of plans for the management and deployment of the NDMS/WMD cache.

(7) 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)²⁸

(8) VHA Directive 10-95-079, dated 8/11/95 Department of Veterans Affairs (VA)/Department of Defense (DOD) Contingency Planning System (RCS 10-0859)²⁹

(9) VHA Directive 0320, dated 5/1/97, Emergency Medical Preparedness³⁰

(10) VHA Handbook 0320.1, dated 5/1/97, Department of Veterans Affairs and Department of Defense Contingency Hospital System Plan³¹

(11) VHA Handbook 0320.2, dated 6/12/00, Veterans Health Administration Emergency Management Program Procedures³²

(12) VHA Handbook 0320.3, dated 7/21/00, Disaster Emergency Medical Personnel System (DEMPS)³³ (complements VHA Directive 97-046, dated October 7, 1997 DEMPS.

EMERGENCY MANAGEMENT STRATEGIC HEALTHCARE GROUP
(EMSHG)
Supporting Documents Index

1. Emergency Management Strategic Healthcare Group (EMSHG) Organizational Brochure, January 2000.
2. EMSHG Personnel Directory, April 4, 2000.
3. Office of Emergency Medical Preparedness (OEMP) Missions and Authorities Summary, 1992.
4. Public Law 97-174, May 4, 1982, Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.
5. Report to Congress on the Department of Veterans Affairs Bed Capacity in Support of the Department of Defense Contingency Planning, July 28, 2000.
6. Ibid.
7. Ibid.
8. National Disaster Medical System (NDMS), Emergency Medical Preparedness Board, National Security Council, under the "National Plan of Action for Emergency Preparedness Mobilization," July 11, 1984.
9. The VA's Role in Disasters: How the System Works in Times of Crisis, EMSHG Information Update, Vol. 7, No. 2, Fall-Winter 1999.
10. Federal Response Plan (for Public Law 93, as amended), published April 1992; updated and re-published April, 1999.
11. After-Action Report File, Operations Division, Emergency Management Strategic Healthcare Group, Building 500, VA Medical Center, Martinsburg, WV, 25401.
12. Support Provided in Response to Federal Disasters and National Events by the Veterans Health Administration (VHA), 1992-1993, updated October 23, 1998.
13. Terrorism Incident Annex to the Federal Response Plan (FRP), FEMA 229, Change 11, Subject: Terrorism, February 7, 1997.
14. Items 50 and 51, Responses to Questions for Dr. Thomas L. Garthwaite, Acting Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs from The Honorable Arlen Specter, Chairman, Committee on Veterans Affairs, United States Senate, June 2000.
15. VHA Handbook 0320.3, Disaster Emergency Medical Personnel System (DEMPS), July 21, 2000.

16. DEMPS Volunteer Data Sheets, Appendix A, VHA Handbook 0320.3, (interim guidance), July 21, 2000.
17. Federal Radiological Emergency Response Plan (FRERP), September 6, 1994 (Federal Register, Vol. 59, No. 171, pp. 46086-46107).
18. VA Mission Statement, Implementation of Presidential Executive Order 12657, October 16, 1992.
19. Radiation Disaster, EMSHG Information Update, Vol. 5, No. 1, Winter 1997, and RADEX NORTH, EMSHG Information Update, Vol. 5, No. 2, Spring 1997.
20. VA Memorandum, Subject: EMSHG Reorganization Input, July 27, 2000.
21. Consequence Management '98, Information Update, Vol. 6, No. 1 (Summer-Fall 1998), and Augusta VAMC Sets the Stage for CM2k, VAnguard, June/July 2000.
22. 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.
23. Interagency Agreement between Department of Health and Human Services and the Department of Veterans Affairs dated April 24, 1997.
24. 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.
25. Statement of Understanding between the American Red Cross and the Department of Veterans Affairs dated March 18, 1998.
26. 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.
27. 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.
28. VHA Directive 10-95-007 dated 01/19/95 - Department of Veterans Affairs/Department of Defense (VA/DoD) Contingency Planning in Support of the Federal Response Plan (FRP).
29. VHA Directive 10-95-079 dated 08/11/95 - Department of Veterans Affairs (VA)/Department of Defense (DoD) Contingency Planning System (RCS 10-0859).
30. VHA Directive 0320 dated 05/01/97 - Emergency Medical Preparedness.
31. VHA Handbook 0320.1 dated 05/01/97 - Department of Veterans Affairs and Department of Defense Contingency Hospital System Plan.

32. VHA Handbook 0320.2 dated 06/12/00 - Veterans Health Administration Emergency Management Program Procedures

33. VHA Handbook 0320.3 dated 07/21/00 - Disaster Emergency Medical Personnel System (DEMPS).

OFFICE OF FACILITIES MANAGEMENT
Summary Outline

- Change focus of VA major construction program from inpatient to outpatient care - ongoing
- Expand VA's Enhanced-Use program - ongoing
- Completed major construction and lease projects

OFFICE OF FACILITIES MANAGEMENT
Narrative

1) Change in Focus of VA Major Construction from Inpatient to Outpatient

Advances in health care technology have increased the number and percentage of health conditions that can be successfully treated on an ambulatory basis. These advances have reduced the need for inpatient beds and correspondingly increased the need for ambulatory care space throughout the health care industry. VA has responded by refocusing construction expenditures on ambulatory care. From FY 1993 through FY 2000, \$1,329,918,000 has been utilized for ambulatory care focused projects.

2) Expand VA's Enhanced-Use Program

Enhanced-Use lease authority has allowed VA to develop cost-effective alternatives to traditional means of acquiring and managing its facility and capital holdings. This authority enables VA to lease underutilized VA property, on a long-term basis, to non-VA users for uses compatible with VA programs in return for obtaining facilities, services and/or money for VA requirements that would otherwise be unavailable or unaffordable. Originally enacted as a "test" program for a 5-year duration and limited to 20 projects, the legislation was first extended on a year-by-year basis, then re-authorized through 2011, and the cap on the number of projects was eliminated. The maximum allowable out-lease term has been extended from 35 years to 75 years.

Since FY 1993, VA has used this program to significantly reduce costs and provide corresponding benefits to veterans, employees and local communities. To date, 18 Enhanced-Use leases have been awarded (2A) in the process, winning 5 Hammer awards from the National Partnership for Reinventing Government. In addition, over 150 potential projects have been studied. Sixty are currently in development. These projects address a broad array of initiatives including: mixed-use development projects, clinical and research facilities, skilled nursing homes, administrative offices, residential care and temporary lodging facilities, energy plants, elder care facilities, child development centers and parking facilities. This program has resulted in over \$200 million dollars of private investment into VA facilities with over \$2 billion anticipated in the next five years.

3)

A. Major Construction

Between FY 1993 and FY 2000, VA completed the following types of facility construction projects: 12 clinical improvements, 3 domiciliaries, 11 nursing homes, 22 ambulatory care/outpatient clinics, 10 parking garages, 4 research additions, 7 seismic corrections, 12 medical-center replacements, 17 general medical, 5 regional offices and 11 cemeteries major projects (3A1). Also, during this same time, VHA received \$1.9 billion in funding for 58 major construction projects (3A2).

B. Leases

VA opened 31 major leased facilities between FY 1993 and FY 2000. This initiative included leasing approximately 1.5 million square feet of space at a cost of \$23M annually. The space

is used to provide sufficient housing to meet growing patient workloads for clinical activities: ambulatory care, dental, laboratory, psychiatric, pharmacy, radiology, rehabilitation medicine; and other specialty clinics and programs as VA continues to shift from inpatient to outpatient care.

OFFICE OF FACILITIES MANAGEMENT
Supporting Document Index

1 Change in Focus

2A Enhanced-Use Program

3A1 Major Construction Completed

3A2 Major Construction Funded

3B Leases

VA LEARNING UNIVERSITY (VALU)
Summary Outline

<u>Project or Accomplishment</u>	<u>Date Completed</u>	<u>Description</u>
<ul style="list-style-type: none"> Office of Academic Affairs is separated into OAA (Office of Academic Affairs) and the Employee Education System (EES) 	1996	To enhance continuing education to VHA employees
<ul style="list-style-type: none"> EES reorganized to become a virtual organization organized by product line instead of geographic location 	1997	To further enhance continuing education to all Licensed health Professionals, administrative and support staff throughout VHA
<ul style="list-style-type: none"> Developed Learning Maps® 	Aug. 1998	An interactive Learning application to support the One VA initiative.
<ul style="list-style-type: none"> VA Learning University established 	1999	To become part of the overall Education and training efforts of VA.
<ul style="list-style-type: none"> One VA Conferences 	1999	Coordinated the Conferences in support of the One VA initiative.

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| <ul style="list-style-type: none"> ● Establishing 10 Employee Education Resource Centers | <p>In Progress</p> | <p>To better support the National Training Priority Areas established by the VHA Integration Advisory Council.</p> |
| <ul style="list-style-type: none"> ● Established VISN teams | <p>August 2000</p> | <p>To better coordinate with key VISN leaders and determine regional and facility-specific education and training.</p> |
| <ul style="list-style-type: none"> ● VA Online Learning University | <p>In progress</p> | <p>To provide VA employees access to online training from their desktop.</p> |
| <ul style="list-style-type: none"> ● VA Knowledge Network | <p>In progress</p> | <p>To provide training and communication to VA employees through VA's first digital satellite network which will be capable of operating four channels, 24 hours a day, seven days a week.</p> |

VA LEARNING UNIVERSITY (VALU)

Narrative

- Office of Academic Affairs was separated into OAA and the Employee Education System in 1996 in an effort to enhance continuing education to VHA employees. This change occurred as a result of a recommendation from the VHA Education and Training Task Force which was appointed by the Under Secretary of Health and chaired by Dr. Jule Moravec. The rationale underlying the change was that employee education functions would be more closely aligned with the Under Secretary for Health's office, thereby elevating its importance.
- In 1997, EES reorganized to become a virtual organization organized by product line instead of geographic location. This further enhanced continuing education to all licensed health professionals, administrative and support staff throughout VHA. This change essentially merged 22 separate continuing education field units previously known as Regional Medical Education Centers (RMECs) and Cooperative Health Manpower Education Centers (CHEPs). Education Service Representatives (ESRs) positions were also established at this time to provide better customer service to the 22 Veterans Integrated Service Networks (VISNs) (1,2).
- In August 1998, in response to major changes in the Department and to support the One VA initiative, EES produced a series of Learning Map® applications designed to help employees better understand the Department's basic strategic goals and objectives as well as the realities during organizational change. These maps engage knowledge sharing from all levels of employees in an organization. The Learning Maps® have revolutionized the way learning is presented to employees throughout the VA system. The first 10 Learning Maps® are so popular with VA employees, a Veterans Benefits Learning Map® with a target audience of both VA employees and veterans is due to be released early FY01 (3,4).
- The VA Learning University (VALU) was established in 1999 as the primary learning organization for VA. VALU addresses cross-cutting learning initiatives of VBA, VHA and NCA and provides ways for Department employees to have learning at their fingertips through the use of distance learning. VALU establishes products and services that integrate technology to make learning more affordable and accessible, and more tailored to the needs of Department workers. By overcoming barriers of space and time, technology enables educators and other VA professionals to reach larger audiences, not only expanding and enhancing communities of learning and practice, but saving scarce travel dollars and staff time. Technology improves both the responsiveness and timeliness of education, and improves the correlation between what an employee needs to learn right now and their access to learning opportunities.
- Beginning in 1999, VALU staff coordinated four regional One VA Conferences, and one national conference in support of the One VA initiative. These five conferences were held over the course of a year to enhance Department employees' understanding of ways to provide seamless services to our nation's veterans. These conferences increased awareness of VA's need to promote a department-wide, systematic approach to the education, training and development of VA employees in order to provide high-quality,

seamless service to veterans (5).

- EES is determined to be responsive to customers and clients. Currently staff has been positioned in VISNs across the country to support the National Training Priority Areas established by the VHA Integration Advisory Council. EES established 10 Employee Education Resource Centers to better partner with clients and customers. These centers allow EES staff to adapt best practices and leverage resources and expertise for best accessibility and affordability. These resource centers ensure communication is maximized, work is focused, cycle time is reduced, and products are delivered when and where needed. EES is committed to continually assessing and improving our performance to be the partner of choice for employee learning.
- Beginning in August 2000, EES established VISN teams to better coordinate with key VISN leaders and determine regional and facility-specific education and training. These teams are led by an Education Service Representative (ESR), and joined by an Education Specialist and an Education Technician. These teams obtain resources to meet VISN needs, and also evaluate their outcomes. The mission of the VISN team is to partner with clients to provide customer-focused educational and performance services which are accessible, timely, cost-effective and driven by organizational objectives and strategic initiatives (6).
- The VALU Online University is currently being developed to bring web-based learning to the fingertips of VA employees, improving employees' abilities to reach the required 40 hours of training each fiscal year. This partnership between VALU and one of the 22 VISNs is seeking a collaborative arrangement with business and academia to offer commercial off-the-shelf web-based training to approximately 9,000 employees on a pilot basis to VA employees. These courses shall be offered via the Internet and shall be accessible by and through personal computers, whether in the office, at home, or from any remote location. Course offerings include human resources, personal development, information technology programming to include certification programs, accounting/finance, preparatory courses for the GED, technical skills, and management as described in the eight core competencies of the VHA High Performance Development Model. These courses can be related to job specific skill development and general learning, and may be tailored to attain maximum efficiency for all employees in their duties.
- The VA Knowledge Network, VA's first digital satellite network, is being established by the Employee Education System cofunded with the Office of the Chief Information Officer (7). The VA Knowledge Network will enhance communication and provide training to employees, and will be capable of operating four channels, 24 hours a day, seven days a week. This network will offer employees unprecedented access to education and knowledge by improving transmission quality, minimizing operation requirements, and increasing the flexibility of programming. It will allow educators and communicators across the VA to:
 - Offer programming based on the best time of day to deliver content to each time zone, re-broadcasting to encompass different tours of duty;
 - Optimize program length for each target audience - what works best for the employee; and
 - Improve education opportunities - the network has the potential for interactive classroom training directly to employees' workstations.

VA LEARNING UNIVERSITY (VALU)
Supporting Documents Index

1. Power Point Presentation, "Employee Education System, Delivering the Future Today"
2. "Delivering the Future Today" brochure
3. "The Learning Map Process – Three New Applications" brochure
4. "The Learning Map – Putting Employees in the Picture" videotape
5. One VA Conference Handouts.
6. "VA Knowledge Network" brochure

OFFICE OF THE ACADEMIC AFFILIATIONS
Summary Outline

<u>Project or Accomplishment</u>	<u>Date Completed</u>	<u>Description</u>
National Medical Informatics Fellowship Program	1995	The program was initiated in 1995 provide a fellowship program in Medical Informatics. Informatics is the field that helps to define how computer, data bases, and other tools of the information science can best be used in health care.
Residency Realignment	1996	In 1996, the Residency Realignment Review Committee (RRRC), an advisory committee to the Under Secretary for Health, recommended replacing 1,000 specialist positions with 750 generalist positions over a three-year period and eliminating 250 specialist positions. OAA successfully implemented these recommendations.
Primary Specialist Program	1997	The result of the program was the definition of seven broad criteria for the residency training programs in VA that encompassed primary care of seriously ill patients by specialists.
VA Medical School Affiliation Reviews	1997	A review of all VA medical school partnerships was completed.
National Quality Scholars Fellowship Program	1998	This new program was initiated in in 1998 to provide a fellowship program in which physician-scholars learn to develop and apply new knowledge in quality improvement for the ongoing improvement of healthcare services for VA and the nation.

Project for Improved Care End of Life	1998	Through a generous grant of nearly the \$1 million from the Robert Wood Johnson Foundation, the Office of Academic Affiliations launched a two-year initiative to focus greater attention to training of resident physicians in end of life care.
Resident Orientation Pocket Card	1998	The Resident Orientation Pocket Card and web site were introduced in 1998. They have become part of the orientation of medical and allied health students and residents to VA medical facilities. The initiative reflects a commitment to making the veteran patient aware that unique experiences as a veteran are of concern to VA clinicians. The card suggests opportunities to invite the veteran to tell his or her own story while the website provides the student or resident with information that will offer greater insight into the veterans story.
Associated Health Education	1999	A revised methodology to allocate trainee positions was developed to include more emphasis on the quality of profession-specific and inter-professional clinical education at the facilities.

OFFICE OF THE ACADEMIC AFFILIATIONS

Narrative

The National Medical Informatics Fellowship Program was initiated in 1995 to provide a fellowship program in Medical Informatics. Informatics is the field that helps define how computer sciences and other tools of the information sciences can best be used in health care.
(Attachment #1)

In 1996, the Residency Realignment Review Committee, an advisory committee to the Under Secretary for Health, recommended replacing 1,000 specialist positions with 750 generalist positions over a three-year period and eliminating 250 specialist positions. The Office of Academic Affiliations successfully implemented these recommendations.
(Attachment #2)

The Primary Specialist Program defined seven broad criteria in 1997 for the residency training programs in VA that encompassed primary care of seriously ill patients by specialists.
(Attachment #3A and 3B)

A review of all VA medical school affiliation partnerships was completed in 1997.
(Attachment #4)

The National Quality Scholars Fellowship Program, a new program initiated in 1998, provided a fellowship program in which physician-scholars learn to develop and apply new knowledge in quality improvement for the ongoing improvement of healthcare services for VA and the nation.
(Attachment #5)

Through a generous grant of nearly \$1million from the Robert Wood Johnson Foundation in 1998, the Office of Academic Affiliations launched a two-year initiative to focus greater attention on training of resident physicians in end of life care.
(Attachment #6)

The Resident Orientation Pocket Card and web site were introduced in 1998. They have become part of the orientation of medical and allied health students and residents to VA medical facilities. The initiative reflects a commitment to making the veteran patient aware that unique experiences as a veteran are of concern to VA clinicians. The card suggests opportunities to invite the veteran to tell his or her own story while the web site provides the student or resident with information that will offer greater insight into the veteran's story.
(Attachment #7)

A revised associated health education methodology to allocate trainee positions was developed in 1999 to include more emphasis on the quality of profession-specific and inter-professional clinical education at the facilities.
(Attachment #8)

OFFICE OF THE ACADEMIC AFFILIATIONS
Supporting Document Index

Attachment 1 - *Academic Affiliations Update*, April 1998, Volume1/No. 3

Attachment 2 - *Academic Affiliations Update*, October 1997, Volume1/No. 1

Attachment 3A and 3B - Program Announcements for ACCESS and PsyPCE

Attachment 4 - Under Secretary For Health's Academic Partnership Instruction #97-02
(February 26, 1997)

Attachment 5 - VA National Quality Scholars Fellowship Program Announcement (March 6, 1998)

Attachment 6 - *Academic Affiliations Update*, July 1998, Volume1/No. 4

Attachment 7 -Pocket Card Fact Sheet

Attachment 8 - Program Announcement, FY 1999 Trainee Support In Associated Health Professions Affiliated Education Programs

RESEARCH & DEVELOPMENT OFFICE
Summary Outline

Significant Research Study Results since 1993	1993 <i>Ongoing</i>	Various research findings, i.e., Colonoscopy may be the best way to screen for colon cancer 7/00; Estrogen and vaccine combination may stop Multiple Sclerosis 5/00; Animal model created for the study of bone cancer pain 12/99; Gene Therapy 6/99; Iron vs. Atherosclerosis, etc.
Environmental Hazards Research Centers	1994 <i>Ongoing</i>	Created four Environmental Hazards Research Centers to focus on toxic and other environmental health hazards.
Expansion of Health Services Research	1996 <i>Ongoing</i>	Expanded priorities at the interface of clinical and operational activities, including access to health care; managed care strategies; affect of facility integrations; changes in clinical services organization with line management; ethnic, cultural, and gender issues as they relate to health services use; rehabilitation patient outcomes research.
HSR Centers of Excellence	<i>Ongoing</i>	Brief description of HSR's 15 Research/Resource Centers
Revitalization of Cooperative Studies	1996 <i>Ongoing</i>	Previously under the realm of Medical Research Service, the Cooperative Studies Program (CSP) now includes research to investigate new treatments for mental health and stress related diseases; treatment of alcoholism; diseases prevalent among aging veterans; new therapies for cardiovascular diseases; primary prevention of disease through immunization; Gulf War related studies, diabetes, etc...
CSP Centers of Excellence	<i>Ongoing</i>	Brief description of CSP's 8 Research/Coordinating Centers
Refocus of Medical Research Service	1996 <i>Ongoing</i>	New studies focus on diabetes, environmental hazards, emerging infection, wound repair, and stress related studies; emphasis on Designated Research Areas, including aging, cancer, cardiovascular, chronic infectious diseases, central nervous system injury, degenerative diseases of bones and joints, dementia, diabetes, psychoses, sensory, and substance abuse.
Medical Research Centers of Excellence	<i>Ongoing</i>	Brief description of MRS's 5 Research Centers

Strengthening Rehabilitation Research Service	1996 <i>Ongoing</i>	Announced new requests for applications for research on the outcomes of rehabilitation services provided by the VA to include rehab for physical disabilities due to traumatic accidents and injuries, stroke, falls, and degenerative musculoskeletal or neurologic diseases. Also announced new Rehabilitation Centers of Excellence in sensory loss, brain injury, aging with a disability, patient outcomes from rehab care, and spinal cord regeneration.
Rehabilitation Research Centers of Excellence	<i>Ongoing</i>	Brief description of RR&D's 9 Research Centers
Creation of an Epidemiologic Research Capacity	1997	Created Epidemiologic Research and Information Centers (ERICs) to focus on the epidemiology of medical care and management of chronic conditions and chronically ill veterans.
Treatment Trials for Gulf War veterans	1997 <i>Ongoing</i>	Three new large scale treatment trials have begun in order to seek answers to explain illnesses of Gulf War veterans. They will be exploring symptoms and illnesses such as chronic fatigue syndrome, neurological abnormalities, and generalized body pain of unknown origin.
QUERI (Quality Enhancement Research Initiative)	1999 <i>Ongoing</i>	Quality Enhancement Research Initiative designed to translate research discoveries and innovations into better patient care and systems improvements.
REAP	1999 <i>Ongoing</i>	Research Enhancement Award Program supporting collaborations by groups of investigators through special funding, including a training program.
ORCA	1999 <i>Ongoing</i>	This office ensures VA's research programs place the highest priority on the welfare and dignity of patients who enroll in clinical studies by providing independent and routine assurance that VA research is conducted legally, safely, and with integrity.
Nursing Research Initiative	<i>Ongoing</i>	A commitment by VHA to increase research opportunities and the development of nurse investigators to conduct independent research aimed at high priority investigation areas.
Clinical Practice Guidelines	1997 <i>Ongoing</i>	Facilitate and increase the use of clinical practices that have proven effective and reduce the use of ineffective practices.

**Collaborative
Research Efforts**

Ongoing

Expanding collaborative research with other government, non-government, universities, and pharmaceutical companies. Joint centers have been funded with JDF for diabetes studies; joint studies with DoD funded for Gulf War illnesses research emerging pathogens, and combat casualty and wound repair; international research collaborations, etc.

**New ORD, HSR, MRS, Planned
RR&D, and CSP
Initiatives**

**Achievement and
Recognition Awards**

Ongoing

I.e., Magnuson, Middleton, Presidential Early Career Award, etc.

**Researcher Training
Programs**

Ongoing

Training programs within ORD, i.e., Career Development, etc.

Increasing Awareness

Ongoing

Educating and disseminating information regarding research to external and internal constituents.

RESEARCH & DEVELOPMENT OFFICE

Narrative

Quality Enhancement Research Initiative (QUERI)

In 1998, VA Research launched the VA Quality Enhancement Research Initiative. The QUERI mission is to translate research discoveries and innovations into better patient care and systems improvements. It is founded on the principle that practice needs determine the research agenda, and research results determine interventions that improve the quality of patient care. It is a comprehensive, data-driven, outcomes based, quality improvement program that utilizes a six-step process to facilitate the translation of research findings into better health care practices for veterans. QUERI integrates and disseminates this information on a continuous basis. The collaborative structure and systematic approach inherent in the QUERI process encourage continuous quality improvements in all areas of health care.

Research Enhancement Award Program (REAP)

Medical Research Service established the REAP in 1998 to promote and support groups of VA investigators studying medical areas of importance to the veteran population. The REAP enables researchers to integrate basic science and clinical research approaches to understanding and treating these conditions. The goals of the REAP include training new investigators in research areas of importance to veterans health, developing new and innovative research approaches to medical problems, and fostering collaboration among investigators working in common areas. Twenty programs from 18 VA medical centers have been selected for funding to date. These REAPs focus on a wide variety of medical areas of particular importance to veterans including pulmonary disease, bone disease, Parkinson's disease, vascular disease, renal disease, disorders of the gastrointestinal system, wound healing, multiple sclerosis, Hepatitis C, depression, and prostate cancer.

Office of Research Compliance and Assurance (ORCA)

The Office of Research Compliance and Assurance was created and it will report directly to VA's Under Secretary for Health. The office will ensure VA's research programs place the highest priority on the welfare and dignity of patients who enroll in clinical studies. It will ensure the VA's efforts to continuously improve high ethical standards in research. It will provide independent and routine assurance that VA research is conducted legally, safely and with integrity. The new office eventually will have a staff of compliance officers based in field offices across the country to provide guidance to VA and VA-affiliated researchers.

Nursing Research Initiative

Although nurses have always been an integral part of VA research teams, VHA nurses have been underrepresented as principal investigators (PIs). The Nursing Research Initiative (NRI) encourages the development of nurse investigators to conduct independent research aimed at high priority and VA mission-oriented areas of investigation. Initiated by the Under Secretary for Health and implemented by the Office for Research and Development in collaboration with the Nursing Strategic Healthcare Group, the NRI represents a commitment by VHA to increasing research opportunities for nurses. Nurses without prior research funding are encouraged to work with experienced investigators or preceptors. The NRI provides nurses with a unique opportunity to develop their research interests in a supportive environment.

Clinical Practice Guidelines

Evidence-based clinical practice guidelines have been widely accepted as a means to increase the use of appropriate clinical practices and to reduce the use of inappropriate practices, thereby improving quality of care and reducing unnecessary health care costs. The effectiveness of practice guidelines, however, depends on their consistent and accurate implementation. This initiative invites research to study alternative strategies for implementing evidence-based clinical practice guidelines in VHA and to identify implementation strategies that may be replicated system-wide. Only guidelines that were developed nationally and are based on scientific evidence are eligible for study. Investigators are to focus on general principles of guidelines implementation, as these relate to particular guidelines that are relevant to veterans (depression, diabetes, pressure ulcers, etc.). The research will focus on alternative ways of introducing guidelines into practice, for example, incentives, computerized reminders, administrative rules, and penalties. These studies will also address the impact of guideline implementation on such outcomes as quality and cost of care, practitioner knowledge and practice patterns, and patient behavior.

Treatment Trials for Gulf War veterans

Gulf War veterans are a particular focus as we learn more about their special health concerns. Three new large-scale treatment trials have begun in order to seek answers to explain illnesses for these veterans. They will be exploring symptoms and illnesses such as chronic fatigue syndrome, neurological abnormalities, and generalized body pain of unknown origin.

Newly Initiated and Planned Research Projects

Planned areas and newly initiated research includes topics such as Persian Gulf War Veterans' illnesses, Aging, Post-Traumatic Stress Disorder, Diabetes Mellitus (Type II), Prostate Cancer, Parkinson's disease and related neurodegenerative disorders, Hepatitis C virus study, Selenium and vitamin E cancer prevention, Amyotrophic Lateral Sclerosis, Colorectal cancer risk factors for advanced disease, Identifying genetic markers of high risk for prostate cancer; cholesterol reduction in the elderly, end-of-life care, homelessness, HIV and aids research, traumatic brain injury, neurorehabilitation, Multiple Sclerosis and special disability supplements.

SIGNIFICANT ACCOMPLISHMENTS AND ACTIONS OF PROGRAM OFFICES

Revitalization of Cooperative Studies

Previously under the realm of Medical Research Service, the Cooperative Studies Program (CSP) conducts multicenter clinical trials to determine the effectiveness of promising new therapies. As one of the most important large-scale clinical trial programs in the world, the CSP has achieved international recognition for its accomplishments in many areas, including ischemic heart disease, chronic lung disease, benign prostate disease, chronic renal failure, and schizophrenia, that are prevalent among our veterans as well as the general population. In addition, CSP investigators conduct population-based research focusing on critical health care issues, such as the epidemiology of hepatitis C, the occurrence of amyotrophic lateral sclerosis (Lou Gehrig's disease) in Gulf War veterans, and the progression of prostate cancer and rates of illness among deployed veterans. The CSP has four Coordinating Centers, a Clinical Research Pharmacy, and three Epidemiological Research and Information Centers (listed below). Clinical trials results obtained through the CSP inform VA's health care policy makers so that they can make the appropriate changes in clinical practice that result in improved patient care for veterans and the nation.

CSP Centers of Excellence

Cooperative Studies Program Clinical Research Pharmacy Coordinating Center,
New Mexico VA Health Care System
Cooperative Studies Program Coordinating Center, Hines, IL
Cooperative Studies Program Coordinating Center, Menlo Park, CA
Cooperative Studies Program Coordinating Center, Perry Point, MD
Cooperative Studies Program Coordinating Center, West Haven, CT
Massachusetts Veterans Epidemiology Research and Information Center (MAVERIC)
Seattle Epidemiologic Research and Information Center (SERIC)
Epidemiologic Research and Information Center at Durham, NC

Refocus of Medical Research Service

In fundamental biomedical research, new initiatives in diabetes, environmental hazards, emerging infections, and would repair reflect new priorities in medical research. VA's Medical Research Service (MRS) contributes to improved health care for veterans and the nation through the study of the cause, development, diagnosis and treatment of a wide variety of diseases and disorders. In conducting vital biomedical research, MRS investigators have contributed to such landmark medical advances as the first successful treatment for tuberculosis, the first successful liver and kidney transplants, and the development of the cardiac pacemaker. Exciting health care advances that lay the groundwork for improved patient care continues. Recently, MRS researchers reported advances against many health problems affecting veterans. For example, and MRS team studied gene therapy that may offer new hope to millions of diabetics who need daily insulin injections. Another MRS team identified a part of the brain that is involved in the thinking process, the motor cortex, an area scientists previously believed was limited to controlling voluntary movements. Investigators also developed a laboratory technique to grow mouse stem cells, the bone marrow 'mother' cells that evolve into all the different types of mouse blood cells. If human stem cells can be similarly grown, this VA finding could have a major impact on gene therapy for blood cell disorders and bone marrow transplantation for cancer and other diseases. Other new studies focus on stress related studies, emphasis on Designated Research Areas, including aging, cancer, cardiovascular, chronic infectious diseases, central nervous system injury, degenerative diseases of bones and joints, dementia, diabetes, psychoses, sensory, and substance abuse.

Medical Research Centers of Excellence

Diabetes Research Centers: Iowa City, IA; Nashville, TN; San Diego, CA.
Environmental Hazards Research Centers: Boston, MA; East Orange, NJ; Portland, OR;
Louisville, KY; San Antonio, TX.
Aids Research Centers: Atlanta, GA; Durham, NC; New York, NY; San Diego, CA.
Alcoholism Research Centers: Denver, CO; Omaha, NE; West Haven, CT.
Schizophrenia Research Centers: Denver, CO; Brockton, MA; West Haven, CT.

Strengthening Rehabilitation Research Service

New requests for applications for research on the outcomes of rehabilitation services provided by the VA include rehabilitation for physical disabilities due to traumatic accidents and injuries, stroke, falls, and degenerative musculoskeletal or neurologic diseases. New rehabilitation centers have also been established in the areas of sensory loss, brain injury, aging with a disability, patient outcomes from rehab care, and spinal cord regeneration (listed below). In addition, due to a lack in rehabilitation research training and career development, a predoctoral training program was created.

Rehabilitation Research Centers of Excellence

Atlanta, GA VAMC (Geriatric Rehabilitation)
Cleveland, OH VAMC (Functional Electrical Stimulation)
Houston, TX VAMC (Healthy Aging with Disability)
Palo Alto, CA VAMC (Mobility)
Portland, OR VAMC (Rehabilitative Auditory Research)
VA Puget Sound HCS (Amputation, Prosthetics, Limb Loss)
Gainesville, FL VAMC (Brain Rehabilitation Center)
VA Pittsburgh Healthcare System (Wheelchair & Related Technology)
VA Connecticut Healthcare System (Function Restoration for SCI & MS)

Expansion of Health Services Research

Health Services Research and Development Service (HSR&D) pursues research at the interface of health care systems, patients, and health care outcomes. The priorities have expanded to include access to health care, managed care strategies, affect of facility integrations, changes in clinical services organization with line management, and ethnic, cultural, and gender issues as they relate to health services use. The need for high quality health services research continues to grow to keep pace with and respond to the rapid changes underway within VHA, and the health care community as a whole. Many HSR&D studies have been used within and outside VA to assess new technologies, explore strategies for improving health outcomes, and evaluate the cost-effectiveness of services and therapies. HSR&D carries out its mission through peer reviewed research and through its key centers which include eleven Centers of Excellence, the Management Decision and Research Center, and the Veterans Affairs Information Resource Center (listed below). The newly funded VA Health Economics Resource Center will bring additional depth to HSR&D's expertise.

HSR Centers of Excellence

Center for Practice Management & Outcomes Research, Ann Arbor, MI VAMC
Center for Health Quality, Outcomes, and Economic Research, Bedford, MA VAMC
Center for Health Services Research in Primary Care, Durham, NC VAMC
Midwest Center for Health Services and Policy Research, Hines, IL VAMC
Center for Quality of Care and Utilization Studies, Houston, TX VAMC
Center for Mental Healthcare and Outcomes Research, Little Rock, AK VAMC
Center for Health Care Evaluation, Palo Alto, CA VAMC
Veterans Evidence-Based Research, Dissemination, and Implementation Center, San Antonio, TX VAMC
Northwest Center for Outcomes Research in Older Adults, Seattle, WA VAMC
Center for the Study of Healthcare Provider Behavior, Sepulveda, CA VAMC
Center for Chronic Disease Outcomes Research, Minneapolis, MN VAMC
Management Decision and Research Center, Boston, MA VAMC
VA Information Resource Center, Chicago, IL VAMC
Health Economics Resource Center, Palo Alto, CA VAMC
Special Projects Office, Perry Point, MD VAMC

Creation of an Epidemiologic Research Capacity

VA Research established three Epidemiological Research and Information Centers (ERICs) to enhance VA health care delivery by promoting VA-based population research and to convert those results into a format that VHA providers and administrators can apply to improve patient care.

Created Epidemiologic Research and Information Centers (ERICs) to focus on the epidemiology of medical care and management of chronic conditions and chronically ill veterans.

Environmental Hazards Research Centers

VA Research created four Environmental Hazards Research Centers in 1994 to focus on toxic and other environmental health hazards, particularly as such studies relate to veterans' potential exposure to chemical and biological hazards during active military duty. Research at these centers has identified even further needs for studies of environmental exposure. An additional center, the Environmental Hazards Research Center for Reproductive and Developmental Outcomes, was established to study the health of offspring to those veterans that served in military service and the concerns with respect to ionizing radiation, Vietnam Veterans and exposure to herbicides, and Persian Gulf veterans. These centers focus on topics such as carcinogenesis, autoimmune or allergic responses, neurobehavioral alterations, reproductive developmental outcomes, genotoxicity, or prevention or consequences of exposure.

Technology Transfer

VA Research established the Technology Transfer program in 1999 to assist VA investigators in identifying, protecting, and commercializing inventions. This office inventories and tracks all tech transfer activities to insure that documents are reviewed and evaluated and that recommendations are acted upon in an appropriate and timely manner. This will help clinicians concentrate on moving beyond creating prototypes of rehabilitation aids, such as wheelchairs and prosthetics, to putting them into practical use. Expanded efforts enhance these activities, bringing new discoveries into clinical practice. Investigators are assisted with patenting and necessary partnering with industry. The goal of this effort is commercial production of such devices so they may benefit the greatest number of people. Researchers are also enhancing the capacity for conducting clinical trials with newly devised technologies.

Significant Research Study Results since 1993

Some of the major research findings to date include:

- Computer-aided wheelchair prescription system assures better fit for veterans.
- New functional electrical stimulation walking system provides paraplegics with local are mobility.
- Identification of pathways linked to motor recovery from stroke.
- New computer technology advances orthopedic footwear design.
- Implantable insulin pump shows good results in multi-center trial.
- Optimal medical treatment for prostate disease identified.
- Smoking linked to abdominal aortic aneurysms.
- Shortened corticosteroid treatment for chronic obstructive pulmonary disease found to be cost-effective.
- Early treatment with corticosteroids reduces damage from SCI.
- Breakthrough in brain tumor treatment.
- Genes discovered in aging and Alzheimer's disease.
- Important link found between youthful drinking and later alcoholism.
- Study shows benefits of 'clot-busting' drugs compared with angioplasty.
- New kidney cancer treatment identified.
- Estrogen and vaccine combination may stop multiple sclerosis.
- Steroid therapy found to be effective for common forms of pulmonary disease.

- Colonoscopy may be the best way to screen for colon cancer.

Collaborative Research Efforts

Among joint research efforts are those by VA and Department of Defense (DOD) investigators. Shared research interests between the two federal departments initially prompted, and have since fueled, this VA/DOD Collaborative Research Program, which currently administers five initiatives: Prostate Diseases including Cancer; Military Operational Stress-related Illnesses; Mechanisms of Emerging Pathogens; Combat Casualty and Wound Repair; and Physiological Foundations of Physical Performance and Combat Readiness. Other joint collaborations include research with other government, non-government, universities, and pharmaceutical companies. Joint research centers have also been funded with the Juvenile Diabetes Foundation for diabetes research.

Achievement and Recognition Awards

The Paul B. Magnuson Award is presented annually to a VA Rehabilitation Research and Development investigator who exemplifies the entrepreneurship for humanitarianism and dedication to veterans displayed by Dr. Magnuson during his career. Paul B. Magnuson, MD, was a bone and joint surgeon who continuously sought new treatments and assisted his patients as they faced unique situations presented by their disability. The Award was established in 1998 and is the highest honor for VA Rehabilitation investigators. The Award confers a one-time cash award plus \$50,000 for up to 3 years to supplement ongoing peer-reviewed research.

The William S. Middleton Award is presented annually to a VA research for outstanding achievement in biomedical or behavioral research. It was established in 1960 in honor of William S. Middleton, MD, a distinguished educator, physician-scientist, and Chief Medical Director of the VA. Nominees are evaluated on originality of research, significance of the research to a field of science, evidence that the research has or will advance other scientific or clinical disciplines, recognition by peers through major research presentations or awards, leadership, and support and relevance to the VA mission. Each awardee receives a plaque and \$5,000, in addition to a \$50,000 research fund.

Under Secretary's Award for Excellence in Health Services Research recognizes and honors the highest level of achievement in health services research. It recognizes an individual who has conducted research that significantly enhances our understanding of factors affecting the health of veterans, or that has led to a major improvement in the quality of veterans' health care, has made a substantial contribution to the future by inspiring a new generation of investigators through excellence in training and mentorship, as well as enhanced the visibility and reputation of VA research through national leadership.

Researcher Training Programs

One of VA Research's greatest strengths is the high caliber of its investigators. Nurturing and supporting investigators in the early, mid and advanced stages of their careers is, therefore, a high priority for VA's Office of Research and Development. VA offers a wide array of career enhancement programs for clinicians and non-clinician scientists in Health Services, Medical and Rehabilitation Research Services. These awards provide salary support for investigators so that they have protected time to pursue important research or specific training to enhance their research skills. Developing and enhancing the careers of VA investigators is critical to ensuring VA's capacity to conduct research in areas of high relevance to the veterans health care system. VA's Office of Research and Development demonstrates its commitment to VA investigators by allocating up to ten percent of the research budget to support career

enhancement programs within the Office of Research and Development. Current career enhancement programs include:

For physicians:

Research Career Development Award - provides three years of support at the beginning stage of a clinician's research career.

Advanced Research Career Development Award - provides three years of support for clinician scientists who have some research experience, but need additional guided experience to become independent investigators.

Career Development Enhancement Award - supports established clinician scientists who wish to secure time to enter a new area of research specialization, especially in areas of importance to VA's mission.

For non-physician Ph.D. scientists:

Assistant Research Scientist - supports entry level non-clinician Ph.D. scientists seeking an independent career in VA.

Research Scientist - supports mid-career Ph.D. scientists who are principal investigators on non-mentored VA research projects.

Research Career Scientists - supports established independent investigators who have distinguished themselves through scientific achievement, and who are key contributors to the VA research program.

Senior Research Career Scientist - supports well established research career scientists who are recognized internationally as leaders in their fields.

Future Research

There is no doubt that we will need to solve the complex medical mysteries as we enter the new millennium, as well as deal with those that already affect our veterans. Fortunately, VA has always had a cadre of dedicated, talented, and committed clinicians and researchers who see change as an opportunity for innovation, and who welcome challenge as an opportunity for discovery. The future VA research depends on its clinicians and scientists conducting health care research to advance health care technology, providing innovations in rehabilitation, and discoveries leading to cures, or a better quality of life for those affected by disease. Many new advances are already underway, while several areas of exciting research are just beginning to show their potential. Over the next few decades we expect important advancements, such as genetic mapping and the identification of genes that cause disease that may lead to treatments for a host of inherited or acquired conditions, the evolving use of vaccines to target tumors and combating viruses, and new and improved medical technologies. VA's Office of Research and Development joins the broader health care community of this nation and others in embracing all the opportunities of the 21st Century so that we can continue to provide the best possible health care for veterans and the nation as a whole.

RESEARCH & DEVELOPMENT OFFICE
Supporting Document Index

- I. VA Office of Research and Development Annual Report, 1998, Washington, DC.
(<http://www.va.gov/resdev/annrpt.htm>)
- II. VA Office of Research and Development Annual Report, 1999, Washington, DC.
(<http://www.va.gov/resdev/annrpt.htm>)
- III. VA Office of Research and Development, Refining Research Priorities: New Initiatives Meeting Veterans Needs, 1997.
- IV. VA Office of Research and Development New Initiatives: Meeting Veterans Needs, 1999. (http://www.va.gov/resdev/prt/ni_final.pdf)
- V. Office of Research and Development Letter, VHA Directive 1201.8, Career Development Program, August 19, 1998. (<http://www.va.gov/resdev/cdp.htm>)
- VI. VHA Notice 98-02, Research Career Scientist Program and Awards, April 27, 1998.
(<http://www.va.gov/resdev/rcs498.doc>)
- VII. VHA Office of Research and Development Health Services Research and Development Service: Pre- and Post-Doctoral Training Programs, August 9, 2000.
(<http://www.va.gov/resdev/ps/pshsrd/ftp.htm>)
- VIII. VHA Office of Research and Development Health Services Research and Development Service: Medical Informatics Training Programs, August 21, 2000.
(<http://www.va.gov/resdev/ps/pshsrd/inform.htm>)
- IX. VA Office of Research and Development Information Letter, Paul B. Magnuson Award for Outstanding Achievement in Rehabilitation Research and Development, December 16, 1998. (<http://www.va.gov/resdev/fr/129812.htm>)
- X. VHA Office of Research and Development Investing in the Future of Veterans' Health Care, September, 1998. (<http://www.va.gov/resdev/prt/catalog.pdf>)
- XI. VHA Office of Research and Development Excellence Through Research: Health Services Research – Advancing Veterans Health Care, August 1997.
(http://www.va.gov/resdev/ps/pshsrd/hsrd_imp.pdf)
- XII. VHA Office of Research and Development Rehabilitation Research – Meeting the Challenge: Independence in Function, Vocation and Life, 1997.
(<http://www.va.gov/resdev/ps/psrrd/rehab.pdf>)
- XIII. VHA Office of Research and Development Cooperative Studies Program: A Legacy of Achievement, 1997. (<http://www.va.gov/resdev/fr/coopstu.pdf>)
- XIV. VHA Office of Research and Development Impacts, April 2000.
(<http://www.va.gov/resdev/prt/impacts2000.pdf>)

- XV. VHA Office of Research and Development Annual Report to Congress for Federally sponsored Research on Gulf War Veterans' Illnesses, 1998. (<http://www.va.gov/resdev/pgrpt97.htm>)
- XVI. VHA Office of Research and Development *Journal of Rehabilitation Research and Development*, Vol. 36, No. 1, January 1999. (<http://www.vard.org/jour/jourindx.htm>)

OFFICE OF RESEARCH COMPLIANCE AND ASSURANCE (10R)

Summary Outline

- On April 21, 1999, the establishment of the Office of Research Compliance and Assurance (ORCA) was announced before the House Committee on Veterans Affairs.
- The mission of ORCA is to provide VHA with the assurance that research conducted by our scientists is done with maximal regard for issue of human and animal subject protection, the safety of laboratory personnel, and research integrity.
- The Association for the Assessment and Accreditation of Laboratory Animal Care, International inspects and accredits research animal facilities in the United States and abroad every 3 years. No comparable mechanism exists for institutions conducting research involving human research. VA intends to address this vacuum.
- On December 6, 1999, John H. Mather, MD reported for duty in the position of Chief Officer, ORCA.
- On January 2, 2000, Dr. Joan Porter assumed the position as Associate Director, ORCA.
- In February 2001, ORCA introduced its mission both within and outside the VA via a series of meetings, teleconferences and memoranda.
- In March 2001, ORCA completed the first Special Inquiry Force Team (SIFT) review and report. In addition ORCA issued its first Information Letter.
- In April 2001, ORCA convened a Training, Education and Development Focus Group. Other April Activity included issuing a Report on Survey of frequency of scientific misconduct in VAMCs for FY'95 to '99 and FY 2000 Quarters 1 and 2.
- In May, ORCA issued the ORCA ALERT notices #1 and 2.
- In June 2001, educational efforts were continued with ORCA NEWSCLIPS. In addition ORCA conducted two surveys, a survey of frequency of and specific information on cases of scientific misconduct at VAMCs for FY 2000 Quarters 1, 2, and 3 and a survey of existence of IRB Standard Operating Procedure Manuals.
- In August 2001, the ORCA website came on-line. The Field Advisory Committee was also launched.
- ORCA's organization consists of Headquarters, four regional offices, and one virtual regional office.

• OFFICE OF RESEARCH COMPLIANCE AND ASSURANCE (10R)

Narrative

History

On April 21, 1999, Under Secretary for Health (USH), Dr. Kenneth Kizer testified before the House Committee on Veterans Affairs, announcing the establishment of the Office of Research Compliance and Assurance (ORCA), reporting directly to the USH. Dr. Kizer made the following statement:

ORCA's mission will be to provide VHA with the assurance that research conducted by our scientists is done with maximal regard for issue of: 1) human and animal subject protection; 2) safety of laboratory personnel (chiefly chemical and biological, and in consultation with the National Physics Program, radiological); and 3) research integrity (e.g. conflict of interest, scientific misconduct, research ethics). ORCA will operationalize its functions in a manner similar to that of OMI, but, in contrast, a majority of ORCA's compliance officers will be based in field offices located across the country (up to six) to: 1) enhance the ability of ORCA to rapidly respond to or consult on emergent incidents, and 2) facilitate a reduction in the costs of routine inspections. I want to particularly emphasize that ORCA will be independent, objective and unbiased in its compliance and oversight activities.

Of vital importance in Dr. Kizer's testimony was that, for the first time, the mandatory accreditation of programs conducting research involving human subjects was described in the following statement.

---, the Association for the Assessment and Accreditation of Laboratory Animal Care, International (AAALAC) inspects and accredits research animal facilities in the United States and abroad. VA animal laboratory facilities, along with scores of private-sector sites, are inspected every three years by AAALAC. No comparable mechanism exists for institutions conducting research involving human research. VHA intends to address this vacuum. --- I am particularly pleased that VHA will provide the leadership whereby, at last, nationwide accreditation in this area could be achievable. I hope other agencies will join with VA in this effort.

The accreditation effort will be coordinated by the Office for Research and Development (ORD) with the active participation of ORCA.

On June 2, the advertisement for a Chief Officer, ORCA, appeared, and, on August 25, John H. Mather MD accepted the position of Chief Officer, ORCA. Dr. Thomas Garthwaite, the Deputy Under Secretary for Health delineated the roles and responsibilities of ORCA at that time, as follows:

1] ORCA is an 'evolving' concept with agreement encompassing assurance and educational and training functions. 2] ORCA would be both proactive (assurance) and reactive (compliance) with a strong emphasis and orientation towards Continuing Quality Improvement (CQI) to promote enhancing of human subjects protection. 3] ORCA's Regional Offices could have special emphasis areas and should reach out to affiliates, as well, for expertise.

In October 1999, the Statement of Functions for Chief Officer, ORCA, was developed, and on November 18, the Secretary approved the appointment of John H. Mather, MD, reporting for duty in VHA as Chief Officer, ORCA, on December 6. Dr. Mather was preceded in ORCA by program assistant, Shannon McCormack.

During the month of December, ORCA worked on such issues as staffing plan and organizational chart through 2001. In a conference call, Dr. Mather presented the Chief Network Officers an introduction to the role and responsibility of ORCA and requested them to bring appropriate issues promptly to ORCA. Later on, ORCA prepared the Mission and Functional statement in relationship to ORD, and the rollout made on the support for Position Descriptions. Also in December, Dr. Mather made preliminary contacts with the VISN Directors and the VAMC for the siting of the ORCA's Regional Offices. In the last few days of December, Loma Linda staff assisted ORCA in drafting Position Descriptions, and both Regional Office Director Title 38 Descriptions, and DRAFT Mission and Functional statements and organizational chart were finalized (1 - 2).

On January 2, 2000, Dr. Joan Porter assumed the position as Associate Director, ORCA. During January 2000, further development of ORCA, including defining the scope and direction for ORCA, establishing priorities, discussing the role and responsibilities of ORCA vis-a vis ORD, developing a DRAFT Mission & Functional Statement, ORCA staff roster, and so forth (3).

In February, ORCA introduced its mission both within and outside the VA via a series of meetings, teleconferences and memoranda.

In March, ORCA began to set up meetings to examine issues related to ORCA's mission – visiting local VAMCs; talking to experts and other agencies on issues related to ORCA's areas of oversight, discussing outcome measures for a Human Subjects Accreditation Program, receiving VA MPA agreement letters and contracts from Office of Research and Development. During this time, ORCA also completed the first Special Inquiry Force Team (SIFT) review and report. On March 20, ORCA issued its first Information Letter (#1), one of the methods ORCA hoped would help educate the appropriate VA personnel on issues related to ORCA's mission. At this time, the advertisement was issued to recruit up to five ORCA Regional Office Directors. Finally at the end of the month, Dr. David Weber reported for duty as ORCA Deputy Chief Officer.

In April, ORCA convened a Training, Education and Development (TED) Focus Group. Other April activity included issuing a Report on Survey of frequency of scientific misconduct in VAMCs for FY 95 to 99 and FY 2000 Quarters 1 and 2 and the second ORCA Teleconference with IRB Chairpersons, R&D Committee Chairpersons and other concerned individuals, including ACOS/R&D. Finally, ORCA moved into its office space, 5th Floor Lafayette Building. Dr. Garthwaite cut the ribbon for the new quarters June 30.

In May, Ms. Paula Waterman joined the HQ staff as project analyst for program accreditation (both humans subject protection and animal welfare programs.) Also in May, ORCA issued the ORCA ALERT notices #1 & 2 were issued.

In June, ORCA continued its educational efforts with ORCA NEWSCLIPS. ORCA also initiated VALIDATION "exercise" of VA and OPRR MPAs and continued to have meetings/attend conferences related to ORCA's mission. In addition, ORCA conducted two surveys, a survey of frequency of and specific information on cases of scientific misconduct at VAMCs for FY 2000 Quarters 1, 2 and 3 and a survey of existence of IRB Standard Operating Procedure (SOP) manuals and collection of Independent" IRB manuals from at VAMCs.

In August, educational efforts were enhanced when the ORCA website came on-line and ORCA was featured in the August issue of the *Vanguard* (4). On August 13, 2000, the first Regional Director, Dr. David J Miller, reported to the Atlanta RO and, later in the month, two additional Regional Directors, Dr. Paul Hammond and Dr. Min-Fu Tsan, were chosen. ORCA staff attended and presented at a national conference, the OHRP Conference, "Ethical Research in the New Millennium" University of Oregon, Portland, OR. Senior ORCA staff visited the SMART/CSP office, in Albuquerque, NM. During this month, ORCA launched its Field Advisory Committee in Washington, DC, during which time, the three ORCA Regional Office Directors attended orientation.

So far in September, ORCA's activities continue as before with the issuance of ORCA NEWSCLIPS and information letters, and further ORCA teleconferences. Ms. Priscilla Craig joined the HQ staff as health science specialist to coordinate ORCA's VA MPA assurance program and ORCA selected Mr. Peter Poon as a health science specialist. Currently, ORCA's organization consists of Headquarters, four regional offices, and one virtual regional office. Future plans include continuing to pursue and strengthen ORCA's mission, while attending meetings and conferences related to ORCA's mission, especially a Focus Group Meeting: Mini-Assessment Program (MAP) Review.

OFFICE OF RESEARCH COMPLIANCE AND ASSURANCE (10R)
Supporting Documents Index

1. Mission and Vision Statement for the Office of Research Compliance and Assurance
2. Statement of Functions - Chief Officer, Office of Research Compliance and Assurance
3. Office of Research Compliance and Assurance Product Lines
4. VAnguard, August 2000, p. 3.

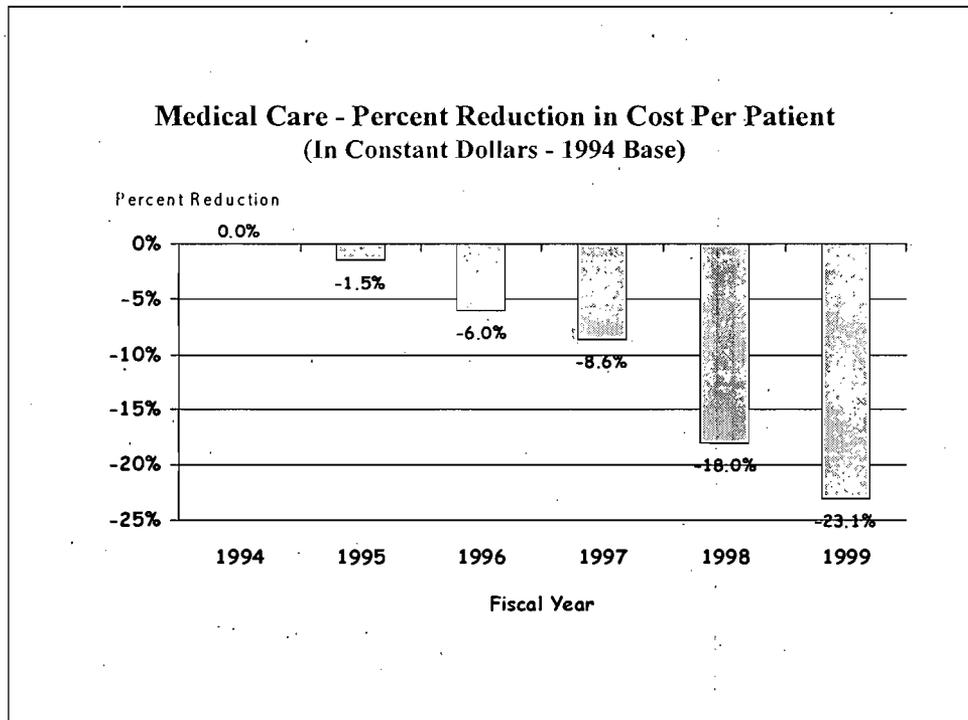
FINANCIAL OFFICE
Veterans Health Care Performance Target 30-20-10
Summary Outline

1. Veterans Health Care Performance Target: 30-20-10

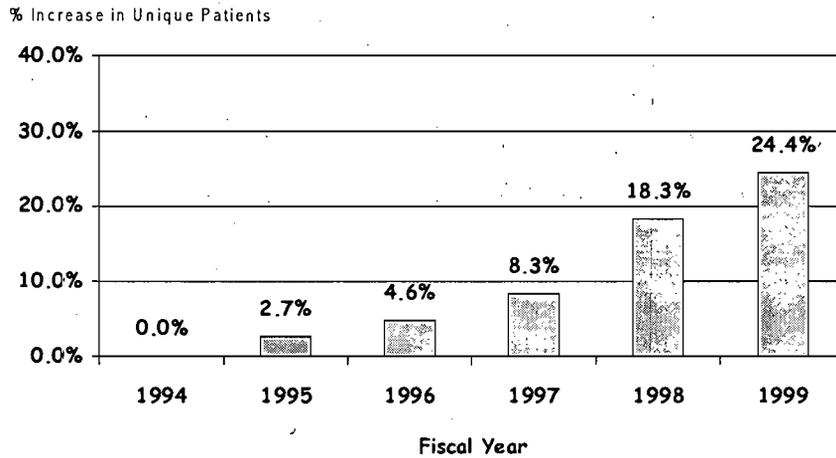
Over the past several years, VHA has emphasized, promoted and exercised significant change in the veteran health care delivery system from what was traditionally a hospital based system to an ambulatory network care-based system. VA focused on transforming from an inpatient, institutional specialty centric system to a team based primary care balanced delivery health care system, with the ultimate goal of providing better health care services to veterans.

As part of this strategy, VA set goals over a five year period (1997-2002) to reduce per patient care cost in constant dollars by 30 percent, expand the number of patients treated by 20 percent and increase non-appropriated funding sources to a level of 10 percent of all budgeted resources. This formed the performance goal called 30-20-10. VA has made significant progress towards meeting, and in some cases exceeding these goals. From 1997-1999 we reduced unique patient costs by 16 percent in constant dollars and increased the number of patients treated by 24 percent. Although progress was made, achievement of the 10 percent goal (increased alternative revenues to total budget) has been more difficult and was dependent on implementation of Medicare Subvention, enhanced collections, and a flat-line budget authority (not all of which occurred).

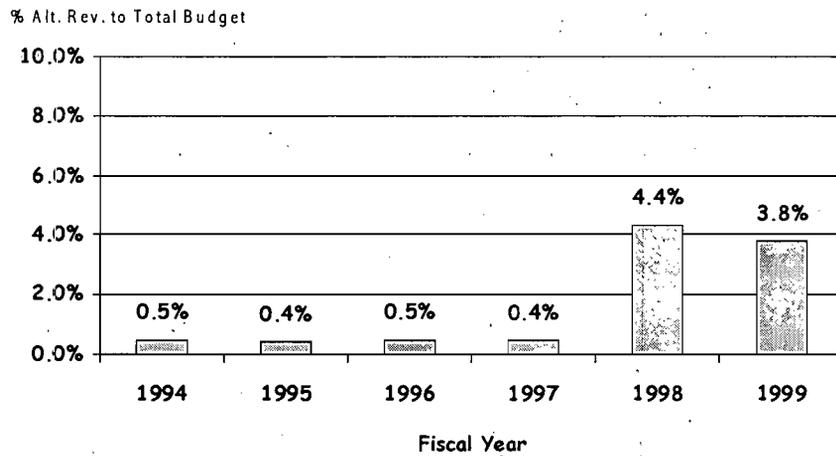
Under the adage of doing more for less, and doing it better, the following charts provide a sample of change over the period 1994-1999, which encapsulates the beginning of veterans health care transformation to today.



Percent Increase in Patients (1995-1999 from a 1994 Base)

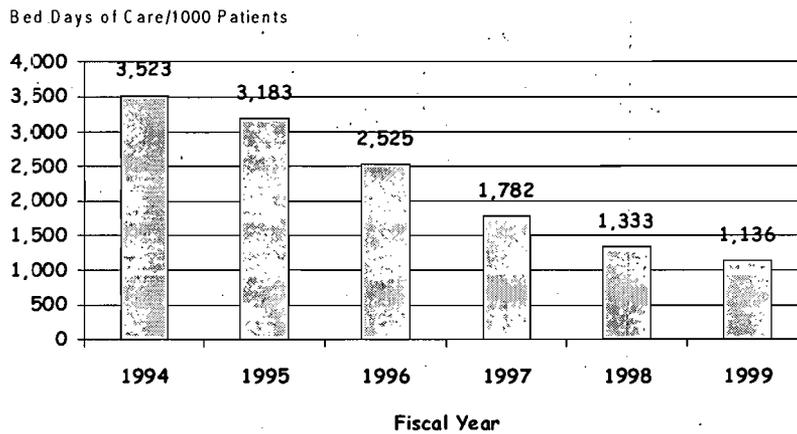


Alternative Revenue as a Percent of Budget (1994-1999)

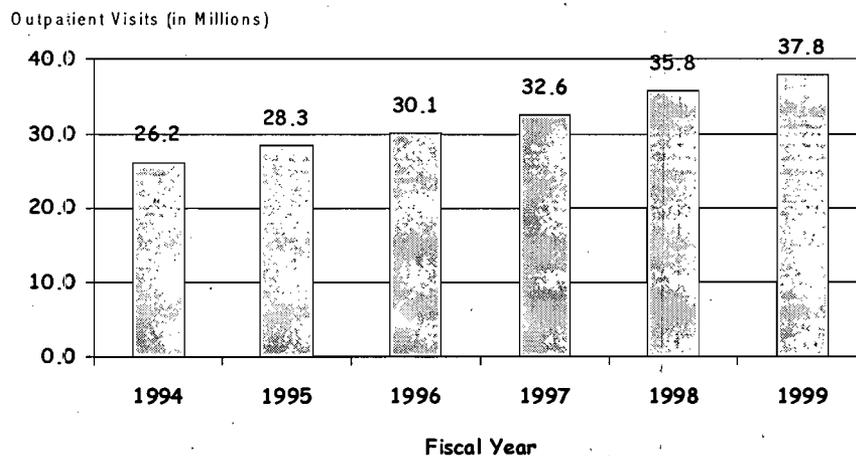


Besides progress on cost per patient, patients and alternative revenue, significant changes occurred in care settings, specifically the shift from inpatient acute to outpatient care, as shown in the next two charts:

Acute Bed Days of Care per 1000 Patients (1994-1999)

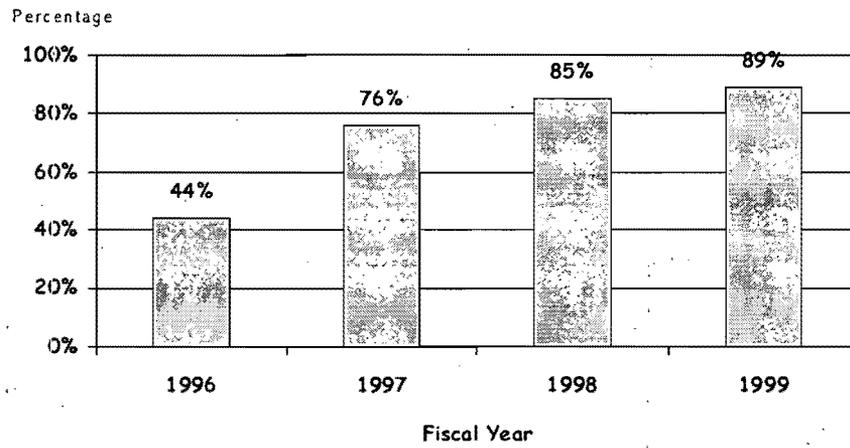


Outpatient Visits (1994-1999)

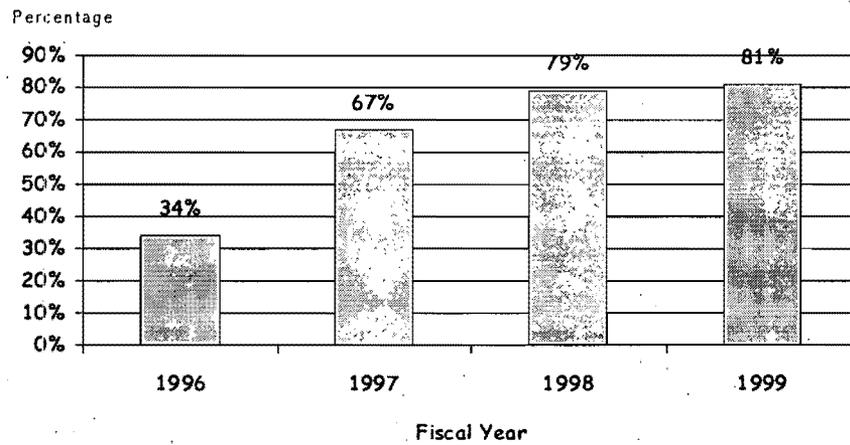


During the same time period, evidenced-based quality of care, as measured by the Chronic Disease Care and Prevention Indexes increased. Charts on both these quality outcome measures follow:

Quality - Chronic Disease Care Index (1996-1999)



Quality - Prevention Index (1996-1999)



2. VHA Instituted the 30-20-10 performance target

Date Completed

- Currently evolving into a more value-oriented performance measure

Description

- Over the past several years, VHA has emphasized, promoted and exercised significant change in the veteran health care delivery system from what was traditionally a hospital based system to an ambulatory network care-based system.
- As part of this strategy, VA set goals over a five year period (1997-2002) to reduce per patient care cost in constant dollars by 30 percent, expand the number of patients treated by 20 percent and increase non-appropriated funding sources to a level of 10 percent of all budgeted resources.
- VA has made significant progress towards meeting, and in some cases exceeding these goals. From 1997-1999 we reduced unique patient costs by 16 percent in constant dollars and increased the number of patients treated by 24 percent. Although improvements were made, progress made in the 10 percent goal were minimized due to unrealized assumptions related to the passage of Medicare Subvention.
- Under the adage of doing more for less, and doing it better, during the period 1994-1999, which encapsulates the beginning of veterans health care transformation to today:
 - Acute Bed Days of Care reduced 68%
 - Outpatient Visits increased 44%
 - Significant increases were made in evidenced-based quality of care, as measured by the Chronic Disease Care and Prevention Indexes increased

FINANCIAL OFFICE
Veterans Health Care Performance Target
Narrative

Veterans Health Care Performance Target: 30-20-10

Over the past several years, VHA has emphasized, promoted and exercised significant change in the veteran health care delivery system from what was traditionally a hospital based system to an ambulatory network care-based system. VA focused on transforming from an inpatient, institutional specialty centric system to a team based primary care balanced delivery health care system, with the ultimate goal of providing better health care services to veterans.

As part of this strategy, VA set goals over a five year period (1997-2002) to reduce per patient care cost in constant dollars by 10 percent, expand the number of patients treated by 20 percent and increase non-appropriated funding sources to a level of 10 percent of all budgeted resources. This formed the performance goal called 30-20-10. VA has made significant progress towards meeting, and in some cases exceeding these goals. From 1997-1999 we reduced unique patient costs by 16 percent in constant dollars and increased the number of patients treated by 24 percent. Although progress was made, achievement of the 10 percent goal (increased alternative revenues to total budget) has been more difficult and was dependent on implementation of Medicare Subvention, enhanced collections, and a flat-line budget authority (not all of which occurred).

Under the adage of doing more for less, and doing it better, the following tables provide a sample of change over the period 1994-1999, which encapsulates the beginning of veterans health care transformation to today.

Medical Care – Percent Reduction in Cost Per Patient						
Fiscal Year	1994	1995	1996	1997	1998	1999
% Change	Baseline	-1.5%	-6.0%	-8.6%	-18.0%	-23.1%

Medical Care – Percent Increase in Patients						
Fiscal Year	1994	1995	1996	1997	1998	1999
% Change	Baseline	+2.7%	+4.6%	+8.3%	+18.3%	+24.4%

Medical Care – Alternative Revenue as a Percentage of Budget						
Fiscal Year	1994	1995	1996	1997	1998	1999
% of Total	0.5%	0.4%	0.5%	0.4%	4.4%	3.8%

Besides progress on cost per patient, patients and alternative revenue, significant changes occurred in care settings, specifically the shift from inpatient acute to outpatient care, as shown in the next two charts:

Medical Care – Acute Bed Days of Care per 1000 Patients						
Fiscal Year	1994	1995	1996	1997	1998	1999
	3,523	3,183	2,323	1,782	1,333	1,136

Medical Care – Outpatient Visits						
Fiscal Year	1994	1995	1996	1997	1998	1999
In Millions	26.2	28.3	30.1	32.6	35.8	37.8

During the same time period, evidenced-based quality of care, as measured by the Chronic Disease Care and Prevention Indexes increased. Charts on both these quality outcome measures follow:

Medical Care – Chronic Disease Care Index				
Fiscal Year	1996	1997	1998	1999
CDI Index	44%	76%	85%	89%

Medical Care – Prevention Index				
Fiscal Year	1996	1997	1998	1999
PI Index	34%	67%	79%	81%

FINANCIAL OFFICE

VHA Logistics Office – Summary outline

VHA LOGISTICS OFFICE	Date	Comments
Logistics Office Approved by Secretary	4/2/99	New office established to improve logistics value within VHA by functioning as a liaison between Headquarters and the field, coordinating standardization on behalf of VHA, and improving Logistics Operations programs and processes.
Issued Directive/Handbook on VHA Standardization	6/8/99	Established comprehensive program within VHA to leverage purchasing of quality supplies and equipment, standardize price and quality of care throughout the system, and assure user involvement in the decision process.
Implemented Logistics Officer Network	6/10/99	Organized a network of Chief Logistics Officers from each VISN to improve logistics communication and facilitate implementation of Logistics policies and regulations.

FINANCIAL OFFICE
VHA Logistics Office
Narrative

The VHA Logistics Office was approved by the Secretary on April 2, 1999. This new office was established to improve logistics value within VHA. On June 7, 1999, a Directive/Handbook was issued which established a comprehensive program within VHA to leverage purchasing of quality medical supplies and equipment. On June 10, 1999, a Logistics Officer Network was implemented. This organized a network of Chief Logistics Officers within each VISN to improve logistics communication.

FINANCIAL OFFICE
VHA Revenue Office
Summary Outline

<u>Project or Accomplishment</u>	<u>Date Completed</u>	<u>Description</u>
• P.L. 105-33	July 1997	Allowed VA to retain health care collections
• Reasonable Charges	September 1999	Allowed VA to charge third-party providers local industry rates for health care
• Historical look at Health Care Recoveries	Not Applicable	Provides a description of health care collection accomplishments

FINANCIAL OFFICE
Narrative
VHA Revenue Office

The Revenue Office mission is to maximize the recovery of funds due VA for the provision of health care services to veterans, dependents and others using the VA system. "The Revenue Office will collect all appropriate revenue in a timely and efficient manner, and have appropriate data and information to demonstrate that this is the case. The Revenue Office will also work well and cooperatively with operating units in the field and at headquarters, and will succeed jointly with these units."

Authority and Legislative History

The Revenue Office oversees identification, billing and collection of the cost of care and services furnished by VA under Title 38 United States Code (U.S.C.), Chapter 17, and for the administration and collection of payments required under Section 1710(f), 1710(g) and 1711 for medical services, under Title 38, U.S.C., Section 1722A for medications, under Title 38 U.S.C., Section 1729 for recovery of cost of certain care and services and under Title 42, U.S.C., Section 2651 to 2653 for (tort feisor) medical services.

Public Law 99-272

Consolidated Omnibus Budget Reconciliation Act of 1985 established Third Party Billing authority and Means Test.

Public Law 101-508

Omnibus Budget Reconciliation Act of 1990

Established the Medical Care Cost Recovery Fund (MCCR), authorized per diem copayments and prescription copayments, and provided authority to bill insurance carriers for Nonservice-connected (NSC) treatment provided to Service-connected (SC) veterans.

Public Law 102-139

Department of Veterans Affairs/HUD Appropriations Act of 1992
Extended Co-payment Authority

Public Law 102-568

Veterans Benefit Act of 1992

Extended Co-payment Authority and authority to bill insurance carriers for NSC treatment for SC veterans

Public Law 103-66

Veterans Reconciliation Act of 1993

Extended Co-payment Authority and authority to bill insurance carriers for NSC treatment for SC veterans

Public Law 105-33

The Balanced Budget Act of 1997

Extended All Co-payment Authority. Provided for billing of insurance carriers for NSC treatment for SC veterans. Established Medical Care Collections Fund and Authority to establish Reasonable Charges for NSC medical treatment.

Public Law 106-117

Veterans Millennium Health Care Act

Provided the Secretary with authority to change existing long term care co-payment requirements.

Established authority for the Secretary to set outpatient and prescription copayments.

Established a maximum monthly and an annual cap on prescription copayments

Established a Health Services Improvement Fund and stipulated that additional prescription co-payment fees above the current \$2.00 rate be deposited in the Fund.

Provided exemption authority from medical copayments but not prescription copayments for veterans who received a Purple Heart.

Program Statistics

The VA now keeps all reimbursable health insurance and copayments collected for Nonservice-connected care. The funds provide supplement to the Medical Care Appropriation to provide better medical care to all veteran patients. Collections have grown from \$24 million in FY 1987 to \$574 million in FY 1999. The Veteran patient who receives billable NSC care is represented in a relatively small part of the entire patient population. Reimbursable Insurance provides the main source of collections. Collections per day are the highest they have ever been in Revenue Program History. (Attachments)

Program Accomplishments

The Revenue Office has aggressively pursued opportunities to increase collections and improve operating efficiencies. With the enactment of P.L. 105-33, the creation of the MCCF and retention of recoveries for medical care, Network and Medical Center Directors were been given responsibility for the alternative revenue program at individual medical centers and are evaluating more efficient ways to bill and collect to enhance recoveries. Currently, the facilities are involved in implementing process compliance. Through VISN leadership and action, corrective measures are in process to bring hospital programs into full compliance with VA revenue cycle guidelines and regulations, as well as with established best practices. VA will continue the development of consolidated applications, systems and operations, and outsourcing options.

The Revenue Office and its role within VHA's Finance Office have faced considerable change over the past few years. Some of the major accomplishments for the Revenue Office over the past 24 months include:

- Ability to bill TRICARE for services rendered to eligible veterans;
- Enhanced Sharing authority, enabling medical centers to optimize underutilized resources leading to new revenue streams for VHA;
- Development and implementation of a "Data Mart" project, providing VHA managers the ability to analyze financial and statistical data more easily and quickly;
- Completion of a major study on the outsourcing of parts of the Revenue Cycle in response to an administrative mandate and development of a business office modeling pilot study in four VA hospital networks;
- Implementation of a Consolidated Co-Payment Processing Center and First Party Lockbox project, lessening workload for revenue departments across the country;
- Completion of contracting venture with Transworld Systems, Inc. (TSI) providing assistance to medical centers with collection of third party receivables, and;

- Implementation of the Reasonable Charges initiative, which transformed VHA billing from a per diem basis to a standardized private sector-like model of calculating charges.

Implementation of Reasonable Charges

Prior to September 1, 1999, VA's Third Party Billing Rates were determined annually based on costs. The reasonable charges billing process was implemented nationally on September 1, 1999. Reasonable charges allow the VA to bill and collect more in line with the prevailing market rate for each VAMC. The expectation is that by enacting a system that is more comparable to the private sector, claims will be adjudicated more rapidly through insurance company edits, claims will be paid faster, and more revenue will be generated for the care provided. Once VA facilities and insurance companies have become experienced with the new system, and initial growing pains have been overcome, third party revenues are expected to increase. Combined with the ability to scan outpatient encounter forms, outpatient procedure rates are expected to increase outpatient recoveries. VA will be billing in a way that more accurately captures the care and services provided.

FINANCIAL OFFICE
VERA (Veterans Equitable Resource Allocation)
Summary Outline

<u>Project or Accomplishment</u>	<u>Date Completed</u>	<u>Description</u>
<ul style="list-style-type: none"> • Veterans Equitable Resource Allocation (VERA) System 	Implemented on 4/1/97 4-year phase-in completed in FY 2000. Ongoing refinement in progress	Equitably allocates Medical Care Resources and corrects funding inequities across the country

FINANCIAL OFFICE
VERA
Narrative

On April 1, 1997, the Veterans Health Administration (VHA) implemented the Veterans Equitable Resource Allocation (VERA) system to allocate its then \$17 billion medical care budget to its 22 healthcare networks. VERA was developed because previous VHA funding allocation systems perpetuated funding inequities across the country that resulted in wasted taxpayers' dollars and veterans not having equal access to healthcare. In addition, the previous systems were so complex that few employees or veterans' stakeholders could understand how funding was determined and the financing system had little credibility. In 1996, the General Accounting Office (GAO) reported that "changes [are] needed to provide for more equitable facility allocations," and that "VA has done little to change past facility allocations."

VERA has addressed the problems of funding inequities. Based on the VERA model, in 1997, VA began a three to four-year phase-in plan to shift \$500 million from facilities that were relatively inefficient, to facilities that have been historically under funded. The phase-in period has been completed with the FY 2000 network budget allocations. The new system re-allocated over \$500 million throughout the VHA health care system. As a result, VHA is treating more patients than ever, is spending these funds more efficiently while increasing health care quality, and veterans have more access to VHA health care. The VERA system is also more easily understood by VA employees and stakeholders and the financing system now has credibility. A September 1997, GAO report stated that VERA "improves equity of regional resource allocations." In the spring of 1997, The VA-HUD Senate Appropriations Committee Chairman, Christopher "Kit" Bond stated that, "...VA has overhauled its allocation methodology, vastly improving the fairness and appropriateness with which resources are allocated to facilities...the new system is a tremendous step forward." In addition, according to a study completed by PricewaterhouseCoopers LLP in March 1998, the VERA system is ahead of other global budgeting systems in the health care industry.

Supporting material for the information above include the Veterans Equitable Resource Allocation (VERA) book from 1997 to 2000.

FINANCIAL OFFICE
VERA
Supporting Document Index

Veterans Equitable Resource Allocation (VERA) book 1997

Veterans Equitable Resource Allocation (VERA) book 1998

Veterans Equitable Resource Allocation (VERA) book 1999

Veterans Equitable Resource Allocation (VERA) book 2000

FINANCIAL OFFICE
Health Administration Center
Summary Outline

<u>Project or Accomplishment</u>	<u>Date Completed</u>	<u>Description</u>
• Foreign Medical Program	10/1/94	Transfer of the Foreign Medical Program from the VAMC Washington, D.C. in an effort to address operational and financial deficiencies.
• Champva Inhouse Treatment Initiative	FY 1993	CHAMPVA beneficiaries can receive treatment in VA medical

facilities which allows appropriated dollars that would otherwise be spent in the private sector to be reinvested within VA.

- Combo Printing 4/96 Partnership between VHA and Dept. of Treasury to integrate the Treasury payment document with the detailed explanation of benefits.
- Spina Bifida Healthcare Program 10/1/97 To provide healthcare benefits to children of Vietnam veterans who were born with spina bifida.
- Meds by Mail FY 1999 Partnership with VAMC, Cheyenne and Leavenworth CMOP to provide mail out prescriptions to CHAMPVA beneficiaries at no cost to them.
- Scissors Award 10/95 Award for the successful transfer of the Foreign Medical Program from the VAMC, Washington, D.C. to the Health Administration Center. The transfer resulted in significant reduction of costs and increases in efficiency.
- Scissors Award 5/96 Award for the combo print initiative which integrated the Treasury payment document with the CHAMPVA explanation of benefits. The initiative resulted in reduced mailing costs and greatly increased customer service.
- Scissors Award 3/00 Award for a partnership with the VAMC, Cheyenne and CMOP, Leavenworth to provide mail order prescriptions to CHAMPVA beneficiaries. Initiative resulted in increased savings for the beneficiaries as well as VA, and significant increases in customer service.
- Hammer Award 12/95 Award received for the successful centralization of the CHAMPVA program to the VA Health Administration Center and the transfer of the Foreign Medical Program. The transfers resulted in savings of several million dollars and increased customer service.

FINANCIAL OFFICE
Health Administration Center
Narrative

Project or Accomplishment:

Foreign Medical Program

On October 1, 1994, administration of the Foreign Medical Program (FMP) was transferred from the Washington, D.C. VA Medical Center to the Health Administration Center. FMP is a health benefits program designed for veterans with adjudicated service-connected conditions who are residing or traveling abroad.

The primary motivation in transferring FMP to the Health Administration Center was to address long-standing operational and financial deficiencies/vulnerabilities identified by numerous program reviews and audits. In centralizing the activities to the Health Administration Center, the direct involvement by Embassy and VBA staff is eliminated, giving VHA complete administrative and financial control of the program. In addition, through its automated operations and claims processing experience, the Health Administration Center enhances program administration by: establishing on-line access to VBA's compensation records (eligibility source); creating claims histories to monitor utilization rates and fees; and monitoring quality of care and assessing medical necessity.

Awards: Received the VA Scissors Award 10/95 for the successful transfer of the program to the Health Administration Center. The transfer resulted in significant reduction of costs and increases in efficiencies.

Project or Accomplishment:

CHAMPVA Inhouse Treatment Initiative

Beginning in 1992, VHA solicited nationwide participation in the CHAMPVA In-house Treatment Initiative (CITI). The initiative, which was developed to improve utilization of VA medical facilities by offering underutilized services to CHAMPVA beneficiaries, provides a unique opportunity for VA medical facilities to generate revenue for supplementing operational accounts.

Currently, VA medical facilities are the largest health care provider for CHAMPVA beneficiaries, resulting in the direct transfer of supplemental funding in excess of \$13 million annually.

Project or Accomplishment:

Combo Printing

Prior to implementation, payment checks were sent from the Austin Treasury to designated recipients, with EOBs subsequently generated and mailed from respective program offices. While every effort was made to generate and mail EOBs simultaneously with the release of the Treasury payment, inevitably the process resulted in separate deliveries, which in turn caused

excessive payment inquiries, numerous returned checks, and customer dissatisfaction. The Combo Printing Solution, implemented in April, 1996, is a method through which payments generated by the Department of Treasury and EOB statements generated by the Health Administration Center are delivered in the same envelope.

Immediately after implementation, positive feedback was received and soon thereafter, the Center noted a reduction in the number of returned checks and inquiries due to inability to identify.

Awards: Received the VA Scissors Award 5/96 for the Combo Print Initiative which resulted in reduced mailing costs and greatly increased customer service.

Project or Accomplishment:

Spina Bifida Health Care Program

Section 421 of Public Law 104-204, effective October 1, 1997, authorized VA under Title 38, United States Code, Chapter 18, to provide a monthly monetary allowance along with healthcare to children born with spina bifida who are the natural children of Vietnam veterans.

Management of healthcare benefits was centralized to the VA Health Administration Center (HAC). The HAC is responsible for authorization and payment of medical services requested for the provision of healthcare under this program. Approximately 950 beneficiaries have enrolled in the program since it began.

This is a unique veterans healthcare benefits program in that it is the first time that veterans benefits for a child's birth defect have been granted to dependents based on a parent's exposure to harmful substances while on active duty.

Project or Accomplishment:

Meds by Mail

The Meds by Mail program is a mail-order prescription medicine program for CHAMPVA beneficiaries. As designed, Meds by Mail serves customers by providing maintenance medications at dramatically reduced costs through the VA's Consolidated Mail Outpatient Pharmacies. When beneficiaries submit prescription requests for up to 90-day supplies of needed medications, annual out of pocket expenses are reduced by approximately 50%.

In addition, CHAMPVA payments for medications have been reduced on average by 58% below current "average wholesale" prices.

Awards: Received the VA Scissors Award 3/00 for a successful partnership with the VAMC, Cheyenne and CMOP, Leavenworth to provide mail order prescriptions to CHAMPVA beneficiaries. Initiative resulted in increased savings for the beneficiaries as well as VA, and significant increases in customer service.

Project or Accomplishment:

Hammer Award for the Centralization of CHAMPVA

Received a Hammer Award in December, 1995 from Vice President Al Gore's National Partnership for Reinventing Government for the successful centralization of the CHAMPVA program from DOD to VA.

CHAMPVA is a health benefits program for dependents of permanent and totally disabled veterans, survivors of veterans who died from a service-connected condition, or who at the time of death were rated as permanently and totally disabled from a service-connected condition. Under CHAMPVA, VA shares the cost of covered medical services and supplies with eligible beneficiaries.

In the first five years of operation within VA, over \$115 million in savings was made available for reprogramming. In addition to the savings, the centralization of activities has resulted in improved customer service and responsiveness.

OFFICE OF THE MEDICAL INSPECTOR

Narrative

1. Background

The Office of the Medical Inspector (OMI) was established in 1980 to assist the Chief Medical Director (now the Under Secretary for Health or USH) by monitoring and reporting on the quality of medical care provided by VHA to its veteran patients. In addition, the Medical Inspector (MI) provides recommendations on the improvement of medical care to the USH. Although placed within VHA, the OMI operates as an independent entity in order to make objective evaluations of the quality of care and so enable the USH to act on unbiased information. The range of issues examined by the OMI is wide; the OMI might look at a problem of a single patient, study an issue in a particular Network (VISN), or make a quality assessment affecting the entire VHA. The MI must be a physician; the OMI staff is required to have a sizable complement of physicians and nurses.

The OMI staffing level has fluctuated over time. For the first few years, there were four to seven staff which rose to 19 in 1993. Over the following three years the staff level fell for a variety of reasons so that in late 1996 there were only eight staff, including the MI. Further, at this point, the MI position had been held by a non-physician in an acting capacity. The primary focus had then, by necessity, to be on responding to complaints of poor care and providing recommendations that were aimed at not only preventing a particular episode of poor care but would also prevent such episodes from occurring more generally in the VHA. There was little opportunity to examine wider and more systemic issues.

In 1994, a new USH was appointed and confirmed; the VHA since that time has undergone major overhaul as seen in the decrease in operating beds, the expansion of ambulatory care, the increase in the number of patients served, and the institution of a performance measurement and clinical guidelines system that focuses on assisting clinicians in assessing the best evidence for the management of disease and measurement of the results of this management.

2. Progress of the OMI since 1993-1994

Initially, the small staff continued its prior focus. Each investigation of a clinical problem resulted in a report that provided clear recommendations to the USH. In many cases these recommendations related to management and leadership issues, that is, the apparent individual nature of the problem in fact could be traced to a more generic problem in the management of the hospital or clinic. Each year between six and 20 such reports and their accompanying recommendations were sent to the USH for action. The OMI has the impression that these recommendations have helped improve the care of patients, both locally and systemically.

In 1996, a physician MI was appointed and led a major upgrading of the OMI. For a time, the OMI was merged into another Office in an attempt to create efficiencies; staffing remained as before and there were possibilities of RIFs throughout VA Headquarters. Although under new and experienced direction, the OMI was now constrained by shifting budgets; thus, it continued its previous focus on the investigations of specific instances of problematic care and the provision of further recommendations for improvement. Shortly after the appointment of the new MI, was once again placed directly under the USH.

After 1996, the USH began to provide further staff to the OMI; the Office was able to expand slowly over the next several years. As a result, the OMI was able to take on more of its original charge in addition to inquiries into specific cases, which latter continues as a major activity of the OMI. Hence, the OMI began to study the medical care provided by VHA more systemically and to build some of the tools needed for system-wide analyses. These tools include the development of several databases that will enable the OMI to assess system-wide variation in care and to assess changes in the quality of care over time (trends).

3. Current work.

Currently, the OMI is continuing to analyze the sentinel events reported in and by VHA over the last several years ("sentinel events" are those clinical episodes that describe serious adverse outcomes for patients, some of which are results of serious illnesses while others are potentially preventable). The tool here was the construction of a database of all reported sentinel events. An initial report was published in 1999; the report resonated with the almost concurrent report from the Institute of Medicine that noted serious outcomes from medical errors. The OMI report helped raise the consciousness of VHA clinicians to the need to focus on prevention of these adverse events and supported the thesis that one principal approach to prevention is to encourage more, rather than less, reporting of untoward outcomes in order to study better how to avoid these events in the first place.

Other similar tools are now in development. One will examine the extent of variation in clinical outcomes across the many VHA Medical Centers and Networks. The aim is to analyze any variation found and attempt to determine its reasons. The result will shed light on how care might be improved by pointing to areas of better outcomes. Another tool is a database of adverse drug events, i.e., untoward outcomes likely due to a medication. Again, the aim is to devise methods to avoid such events or, if unavoidable, to minimize them. Other projects and tools include a study of VHA's reporting to the National Practitioner Data Bank compared to the non-government sector and a database of recommendations for improvement made by organizations such as the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) that will allow Medical Centers to learn from each other.

Finally, the OMI is building a team that will provide oversight of medical care that VHA supports financially but does not take place in VHA facilities, e.g., care provided by community nursing homes under contract or by subsidy of State Veterans Homes.

National Center for Ethics Summary Outline

- The National Center for Ethics of the Veterans Health Administration (VHA) was created in 1991.
- The National Center for Ethics serves as VHA's primary office for addressing the complex ethical issues that arise in patient care, health care management, and research.
- The Center is directed by Ellen Fox, MD.
- The mission of the Center is to clarify and promote ethical health care practices within VHA and beyond. The Center achieves its mission through the following objectives:
 - Create and disseminate high quality programs and products.
 - Provide ethics consultation to local ethics committees and other field-based staff, national program offices, and organizations outside of VHA.
 - Develop and employ effective communications and networking tools to support individuals and facilities in addressing ethical issues at a local level.
 - Develop, analyze, and implement national policy relating to ethics.
 - Analyze pressing ethical issues and publish reports through the National Ethics Committee.
- Each year the Center offers dozens of educational programs at sites around the country. It is also responsible for various national educational programs for VA personnel. In addition Center staff members participate in many educational activities sponsored by other VA program offices, and frequently represent VHA's achievements to individuals and organizations outside of VHA.
- The Center has also published a number of educational materials. In recent years the Center has moved into electronic publishing, creating a web site, an interactive web-based educational program, and a CD-ROM.
- Another major role of the Center is to provide information and consultation on ethical questions to personnel throughout the VHA.
- The Center hosts four monthly teleconferences on ethical topics for interested parties nationwide and regularly publishes a newsletter containing information on topical ethics issues.
- Since 1994, the Center has been responsible for the development of three important policies: Informed Consent, Do Not Resuscitate, and Advance Health Care Planning.
- A collection of all National Ethics Committee reports between 1994 and 1999 was recently published.

NATIONAL CENTER FOR ETHICS Narrative

Through the National Center for Ethics and VHA, the administration has demonstrated its commitment to addressing the challenging ethical issues that arise in health care today. The National Center for Ethics of the Veterans Health Administration (VHA) was created in 1991. Since then the Center has made significant contributions in the field of bioethics to the benefit of both the Department of Veterans Affairs (VA) and the nation.

The National Center for Ethics is organizationally located within the Office of the Under Secretary for Health, but it is a geographically decentralized program. The Center's Director is located in VA headquarters in Washington DC, while the Center's main office is in White River Junction, Vermont. Center staff members are also placed in VA Medical Centers in New York and Seattle.

The National Center for Ethics serves as VHA's primary office for addressing the complex ethical issues that arise in patient care, health care management, and research. The National Center for Ethics is directed by Ellen Fox, MD, who serves as the primary advisor on ethical issues to the Under Secretary for Health. The mission of the Center is to clarify and promote ethical health care practices within VHA and beyond. The Center achieves its mission through the following objectives:

- Create and disseminate high quality education programs and products
- Provide ethics consultation to local ethics committees and other field-based staff, national program offices, and organizations outside of VHA
- Develop and employ effective communications and networking tools to support individuals and facilities in addressing ethical issues at a local level
- Develop, analyze, and implement national policy relating to ethics
- Analyze pressing ethical issues and publish reports through the National Ethics Committee

A. Education

Throughout its history, ethics education has been one of the Center's major strengths. Each year the Center offers dozens of educational programs at sites around the country. It is also responsible for various national ethics education programs for VA personnel. In addition, Center staff members participate in many educational activities sponsored by other VA program offices, and frequently represent VHA's achievements to individuals and organizations outside of VHA.

One of the Center's most popular educational initiatives is its annual five-day intensive ethics training program, which it sponsors each year in collaboration with the Employee Education System. The most recent training program, held in July 2000 in Park City Utah, attracted over 80 VA professionals from around the country who engaged in stimulating interactive sessions with nationally known experts. In November 1999, the Center sponsored its first National Bioethics Conference, a two-day program that featured an impressive collection of nationally recognized ethics experts from within VA and beyond. The Center has also published

a number of educational materials, including, for example, monographs on advance directives and informed consent (1). In recent years the Center has moved into electronic publishing, creating a widely used web site (2), an interactive web-based educational program on managed care ethics, and a CD-ROM containing resource materials for Ethics Advisory Committees (3).

B. Ethics Consultation

Another major role of the Center is to provide information and consultation on ethical questions to personnel throughout the VHA. The Center prides itself on providing helpful and accurate information in a timely fashion upon request. On the national level, Center staff provide ethical analysis of issues of concern to senior leadership and other national offices. The Director participates in the Policy Board and other senior management meetings and, when needed, offers ethical analysis of policies under consideration. The Center also answers questions about ethical issues from VA managers, clinicians, and researchers in the field. Local ethics committee chairs and VHA staff frequently contact the Center and seek assistance in resolving difficult clinical ethics issues, such as in cases involving withholding or withdrawing life-sustaining treatment. The Center is also frequently called upon to help interpret VHA ethics policies and to indicate whether local ethics policies are consistent with VHA national policies. The Center strives to provide the highest quality consultation in service to our veterans.

C. Communications and Networking

Achieving the Center's mission also requires effective communications and networking throughout the system. To this end, the Center hosts four monthly teleconferences on ethical topics for interested parties nationwide. The Center also regularly publishes a newsletter containing information on topical ethics issues and ethics-related news. The newsletter was redesigned in 2000 to be more practical and useful to VHA clinicians, managers, and researchers, as well as to the thousands of ethics committee members who serve in VA health care facilities. The Center has also hosted national satellite broadcasts to educate large numbers of VHA staff, such as when the new informed consent policy was adopted in 1996. In addition, the Center has been making increasing use of electronic media. For example, the Center sends out regular mailings via e-mail, sponsors an on-line discussion forum known as a Community of Practice, and recently updated its web site to be more comprehensive and user-friendly.

D. Policy Development

The Center is the program office responsible for developing and interpreting policies related to clinical ethics. Since 1994, the Center has been responsible for the development of three important policies: informed consent (4), do not resuscitate (5), and advance health care planning (6). Center staff members also frequently provide input on policies developed by other program offices, on topics ranging from resource allocation to the protection of human subjects of research. In addition, staff members serve as a resource to local facilities throughout the system on policy issues as they relate to ethics.

E. National Ethics Committee

The National Ethics Committee, supported by Center staff, has also made important contributions to clarifying and promoting ethical health care practices. Founded in 1986, the National Ethics Committee (NEC) is authorized by the Office of the Under Secretary for Health through the National Center for Ethics. The NEC is an interdisciplinary group charged by the Under Secretary to issue reports on ethics-related topics. Each report describes an ethical issue, summarizes its historical context, discusses its relevance to VHA, reviews current

controversies, and outlines practical recommendations. Scholarly yet practical, these reports are intended to heighten awareness of ethical issues and to improve the quality of health care, both within and beyond VHA. Over the years reports have served as resources for educational programs, guides for patient care practices, and catalysts for health policy reform. Topics range from futility to resource allocation to research on subjects with impaired consent capacity. The Center recently published a collection of all National Ethics Committee reports published between 1994 and 1999 (7).

Future Directions

The National Center for Ethics is continuing to build on VHA's commitment to quality care. A new direction for the Center is to develop tools to assess the ethical quality of health care practices within VHA. These tools, such as a performance measure to evaluate the quality of informed consent, will permit the VHA to assess the impact of policy changes and educational initiatives and thereby improve quality.

In addition, the Center has recently launched a campaign to improve the effectiveness and efficiency of local ethics committees. The Center is assisting facilities in the development of integrated ethics programs, through which ethics committees collaborate with offices devoted to quality improvement, compliance, protection of human research subjects, and other ethics-related activities. Both horizontal and vertical integration is needed to assure ethical issues are considered at every level of the organization – national, regional, and local. The National Center for Ethics and VHA are playing a leadership role in assuring that ethical health care practices are an integral part of health care quality, both within VHA and beyond.

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Office of Facilities Management

- 1 Change in Focus
- 2A Enhanced-Use Program
- 3A1 Major Construction Completed
- 3A2 Major Construction Funded
- 3B Leases

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1. Power Point Presentation, "Employee Education System, Delivering the Future Today"
2. "Delivering the Future Today" brochure
3. "The Learning Map Process – Three New Applications" brochure
4. "The Learning Map – Putting Employees in the Picture" videotape (See Media Section)

5. One VA Conference Handouts
6. "VA Knowledge Network" brochure

Office of Academic Affiliations

- Attachment 1 - *Academic Affiliations Update*, April 1998, Volume1/No. 3
- Attachment 2 - *Academic Affiliations Update*, October 1997, Volume1/No. 1
- Attachment 3A and 3B - Program Announcements for ACCESS and PsyPCE
- Attachment 4 - Under Secretary For Health's Academic Partnership Instruction #97-02 (February 26, 1997)
- Attachment 5 - VA National Quality Scholars Fellowship Program Announcement (March 6, 1998)
- Attachment 6 - *Academic Affiliations Update*, July 1998, Volume1/No. 4
- Attachment 7 - Pocket Card Fact Sheet
- Attachment 8 - Program Announcement, FY 1999 Trainee Support In Associated Health Professions Affiliated Education Programs

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- II. (<http://www.va.gov/resdev/annrpt.htm>)
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- V. VA Office of Research and Development, Refining Research Priorities: New Initiatives Meeting Veterans Needs, 1997.
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- XI. VA Office of Research and Development Information Letter, Paul B. Magnuson Award for Outstanding Achievement in Rehabilitation Research and Development, December 16, 1998. (<http://www.va.gov/resdev/fr/129812.htm>)
- XII. VHA Office of Research and Development Investing in the Future of Veterans' Health Care, September, 1998. (<http://www.va.gov/resdev/prt/catalog.pdf>)
- XIII. VHA Office of Research and Development Excellence Through Research: Health Services Research – Advancing Veterans Health Care, August 1997. (http://www.va.gov/resdev/ps/pshsrd/hsrd_imp.pdf)
- XIV. VHA Office of Research and Development Rehabilitation Research – Meeting the Challenge: Independence in Function, Vocation and Life, 1997. (<http://www.va.gov/resdev/ps/psrrd/rehab.pdf>)
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- XVI. VHA Office of Research and Development Impacts, April 2000. (<http://www.va.gov/resdev/prt/impacts2000.pdf>)
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- XVIII. VHA Office of Research and Development *Journal of Rehabilitation Research and Development*, Vol. 36, No. 1, January 1999. (<http://www.vard.org/jour/jourindx.htm>)

Office of Research Compliance and Assurance

- 1. Mission and Vision Statement for the Office of Research Compliance and Assurance
- 2. Statement of Functions-- Chief Officer, Office of Research Compliance and Assurance
- 3. Office of Research Compliance and Assurance Product Lines

4. VAnguard, August 2000, p. 3.

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