Department of Veterans Affairs

Volume II
Medical Programs and
Information Technology Programs

Congressional Submission

FY 2017 Funding and
FY 2018 Advance Appropriations

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Executive Summary of Medical Care

Mission
Honor America's Veterans by providing exceptional health care that improves their health and well-being.

To fulfill President Lincoln's promise – "To care for him who shall have borne the battle, and for his widow, and his orphan" – by serving and honoring the men and women who are America's Veterans.

President Lincoln's immortal words – delivered in his Second Inaugural Address more than 140 years ago – describe better than any others the mission of the Department of Veterans Affairs (VA). We care for Veterans, their families, and survivors – men and women who have responded when their Nation needed help. Our mission is clear-cut, direct, and historically significant. It is a mission that every employee is proud to fulfill.

VA fulfills these words by providing world-class benefits and services to the millions of men and women who have served this country with honor in the military. President Lincoln's words guide the efforts of all VA employees who are committed to providing the best medical care, benefits, social support, and lasting memorials that Veterans and their dependents deserve in recognition of Veterans' service to this Nation.

Vision
The Veterans Health Administration (VHA) will continue to work to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient-centered and evidence-based.

This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery and continuous improvement.

It will emphasize prevention and population health and contribute to the Nation's well-being through education, research and service in national emergencies.

National Contribution
VHA supports the public health of the Nation through medical, surgical, and mental health care, medical research, medical education and training. VHA also plays a key role in homeland security by serving as a resource in the event of a national emergency or natural disaster.

Stakeholders
Numerous stakeholders have a direct interest in VHA's delivery of health care, medical research and medical education. They include:

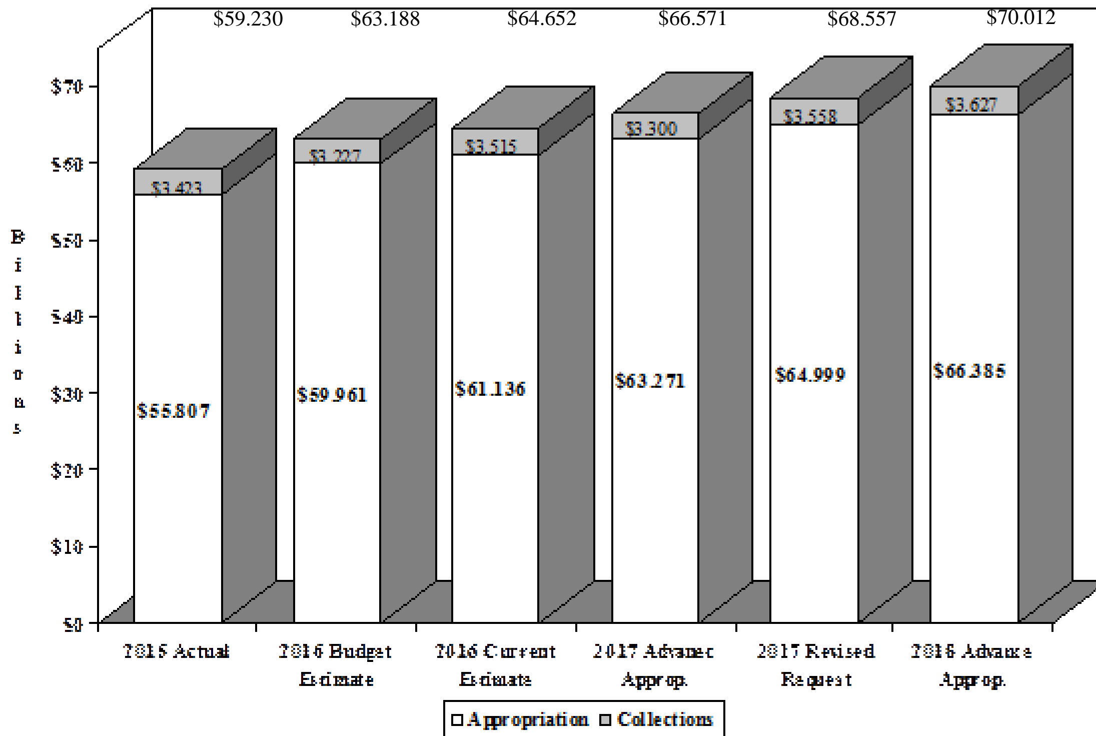
Veterans and their Families	Academic Affiliates
The President and Congress	Health Care Professional Trainees
Department of Defense (DOD) and other Federal Agencies	Researchers
Veteran Service Organizations	Health Care Contract Providers
State/County Veterans Offices	VA Employees
State Veterans Homes	Public-at-Large
Local Communities	Native American Tribes

VA Medical Care Overview

VA is committed to providing Veterans and other eligible beneficiaries timely access to high-quality health services. VA's health care mission covers the continuum of care providing inpatient and outpatient services, including pharmacy, prosthetics, and mental health; long-term care in both institutional and non-institutional settings; non-VA care, and other health care programs, such as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and readjustment counseling. VA will meet all of its commitments to treat Operation Enduring Freedom (OEF), Operating Iraqi Freedom (OIF), Operation New Dawn (OND), and Operation Inherent Resolve (OIR) Veterans and Servicemembers in 2017 and 2018.

The Future State of the VA Medical Care

On August 7, 2014, President Obama signed into law the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146) (Veterans Choice Act). The 2017 budget supports implementation of the Veterans Choice Act and the Administration's goal of providing timely, high-quality health care for our Nation's veterans. Section 802 of the Veterans Choice Act provided $10 billion in mandatory funding through 2017 to establish a temporary program ("Veterans Choice Program") to improve Veterans' access to health care by allowing eligible Veterans who meet certain wait-time or distance standards to use health care providers outside of the VA system. The 2017 President's Budget proposes to create a new Medical Community Care appropriation, which will include a transfer from Medical Services and complement the remaining Choice Fund appropriation in providing community care for Veterans. For more information please see the Medical Community Care Appropriation chapter.



1/Medical Care represents all four appropriations: Medical Services, Medical Community Care, Medical Support and Compliance, and Medical Facilities. Collections exclude the portion of Medical Care Collections Fund (MCCF) collections actually, or anticipated to be, transferred to the Joint DOD-VA Medical Facility Demonstration Fund, in support of the Captain James A. Lovell Federal Health Care Center (FHCC).

Medical Care Budgetary Resources
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Appropriation 1/:								
Medical Services	$45,195,886	$48,727,399	$49,972,360	$51,673,000	$52,751,993	$44,886,554	$2,779,633	($7,865,439)
Medical Community Care.................	$0	$0	$0	$0	$0	$9,409,118	$0	$9,409,118
Medical Support & Compliance.........	$5,874,091	$6,213,961	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Medical Facilities..............................	$4,737,000	$5,020,132	$5,020,132	$5,074,000	$5,723,000	$5,434,880	$702,868	($288,120)
Total Net Appropriations....................	$55,806,977	$59,961,492	$61,136,492	$63,271,000	$64,998,993	$66,385,032	$3,862,501	$1,386,039
MCCF Collections 2/.......................	$3,422,806	$3,226,548	$3,515,171	$3,299,954	$3,558,307	$3,627,255	$43,136	$68,948
Total..	$59,229,783	$63,188,040	$64,651,663	$66,570,954	$68,557,300	$70,012,287	$3,905,637	$1,454,987
Full Time Equivalent (FTE) 3/..............	284,370	295,434	291,032	307,216	306,621	313,078	15,589	6,457
Veterans Choice Act Sec. 801 FTE 4/.	5,147	9,613	11,797	0	6,628	0	(5,169)	(6,628)
Veterans Choice Act Sec. 802 FTE 5/.	29	137	29	137	29	0	0	(29)

1/ Includes all rescissions but not transfers to the two joint Department of Defense (DoD)-VA health care accounts.

2/ Excludes the portion of MCCF collections actually, or anticipated to be, transferred to the Joint DOD-VA Medical Facility Demonstration Fund, in support of the Captain James A. Lovell Federal Health Care Center (FHCC).

3/ *Does not include FTEs in the two joint DoD-VA health care accounts.*
4/ *Estimate assumes that Section 801 funding will be exhausted by the end of 2017; beginning in 2018, these additional FTEs are funded through the regular appropriation request. Information Technology FTE are excluded.*
5/ *Estimate assumes that Section 802 funding will be available through 2017.*

Medical Patient Caseload

Today's Veterans have a comprehensive medical benefits package, which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are readily available to all enrolled Veterans. Complementing the comprehensive benefits package and improved access is our ongoing commitment to providing the very best in quality service. VA's goal is to ensure our patients receive the finest quality health care regardless of the treatment program, regardless of the location. Enrollment in the VA health care system provides Veterans with the assurance that comprehensive health care services will be available when and where they are needed during that enrollment period.

Unique Patients 1/

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Priorities 1-6....................................	4,824,325	4,918,891	4,967,642	5,028,596	5,096,617	5,211,267	128,975	114,650
Priorities 7-8....................................	1,223,425	1,273,263	1,200,964	1,263,289	1,180,743	1,162,776	(20,221)	(17,967)
Subtotal Veterans............................	6,047,750	6,192,154	6,168,606	6,291,885	6,277,360	6,374,043	108,754	96,683
Non-Veterans 2/.............................	694,120	703,235	705,743	712,601	715,928	730,875	10,185	14,947
Total Unique Patients.......................	6,741,870	6,895,389	6,874,349	7,004,486	6,993,288	7,104,918	118,939	111,630
OEF/OIF/OND/OIR (Incl. Above)..	770,452	844,695	849,327	916,292	922,664	995,196	73,337	72,532

Unique Enrollees 3/

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Priorities 1-6....................................	6,867,722	7,056,268	7,003,462	7,180,635	7,135,440	7,249,646	131,978	114,206
Priorities 7-8....................................	2,098,201	2,326,337	2,121,250	2,323,770	2,112,363	2,096,266	(8,887)	(16,097)
Total Enrollees................................	8,965,923	9,382,605	9,124,712	9,504,405	9,247,803	9,345,912	123,091	98,109

1/ *Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.*
2/ *Non-veterans include active duty military and reserve, spousal collateral, consultations and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations such as Hepatitis A&B and flu vaccinations.*
3/ *Similar to unique patients, the count of unique enrollees represents the count of Veterans enrolled for Veterans health care sometime during the course of the year.*

Medical Care Program Funding Requirements

The President's Budget submission for Medical Care is based predominately on an actuarial model, known as the Enrollee Health Care Projection Model (EHCPM), founded on actuarial methods employed by the Nation's insurers and public providers, such as Medicare and Medicaid. The resource request is tied to actuarial estimates of the projected Veteran population, projected enrollment in VA health care and projected changes in the

demographic mix of enrollees over time. Demand is adjusted for expected utilization changes anticipated for an aging Veteran population and for services mandated by statute. The utilization projections are based on the following factors: private sector benchmarks adjusted to reflect the VA health care services package; Veteran enrollee age, gender, and morbidity; enrollee reliance on VA versus other health care providers; and VA's level of management in providing health care. The changing demand for VA health care reflects many factors, including changes in health care practice such as the increasing use of pharmaceuticals; the advanced aging of many World War II, Korean, and Vietnam Veterans in greater need of health care; and the outcome of high Veteran satisfaction with the health care delivery. Finally, the EHCPM projects the total cost of providing over 80 types of health care services by multiplying the expected VA utilization by the anticipated cost per service. Additional information on the EHCPM can be found in the separate chapter on the Enrollee Health Care Projection Model and the CHAMPVA Model. Not all requirements are projected by the EHCPM; see the "Model and Non-Model Obligations" chart in the Executive Summary Charts for more information.

The following table displays, on an obligation basis, the estimated resources by major category that VA projects to incur. For more information about each major category, please see the program narratives in the EHCPM chapter and the Programs excluded from the EHCPM chapter.

Total Medical Care Obligations by Program
Includes Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate 1/	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Health Care Services:								
Ambulatory Care 2/	$30,836,494	$29,164,351	$32,639,750	$30,881,037	$36,135,657	$30,935,829	$3,495,907	($5,199,828)
Inpatient Care	$11,705,181	$11,717,004	$12,218,801	$12,148,884	$12,691,101	$13,029,380	$472,300	$338,279
Rehabilitation Care	$843,321	$637,906	$868,608	$652,095	$898,563	$917,093	$29,955	$18,530
Mental Health	$6,851,643	$7,455,017	$7,484,555	$7,715,357	$7,831,890	$7,997,054	$347,335	$165,164
Prosthetics	$2,727,077	$2,841,942	$2,851,000	$3,039,353	$3,645,677	$3,376,159	$794,677	($269,518)
Dental Care	$1,005,107	$1,072,544	$1,035,391	$1,148,797	$1,433,385	$1,277,378	$397,994	($156,007)
Health Care Services [Total]	$53,968,823	$52,888,764	$57,098,105	$55,585,523	$62,636,273	$57,532,893	$5,538,168	($5,103,380)
Non-Add included above:								
Ending Veterans Homelessness	*$1,506,781*	*$1,393,000*	*$1,476,644*	*$1,393,000*	*$1,591,365*	*$1,122,398*	*$114,721*	*($468,967)*
New Hepatitis C Treatment 3/	*$1,218,398*	*$690,000*	*$1,500,000*	*$660,000*	*$1,500,000*	*$600,000*	*$0*	*($900,000)*
NRM 4/	*$1,290,904*	*$1,313,900*	*$1,009,286*	*$665,030*	*$1,072,985*	*$600,000*	*$63,699*	*($472,985)*
Activations	*$558,085*	*$598,174*	*$598,174*	*$598,174*	*$836,293*	*$497,808*	*$238,119*	*($338,485)*
VISTA Evolution	*$58,652*	*$159,596*	*$90,000*	*$208,265*	*$40,000*	*$0*	*($50,000)*	*($40,000)*
Long-Term Services and Supports:								
VA Community Living Centers (VA CLC)	$3,377,088	$3,453,246	$3,512,886	$3,621,640	$3,613,461	$3,861,735	$100,575	$248,274
Community Nursing Home	$861,464	$844,863	$969,603	$907,986	$1,012,378	$1,064,090	$42,775	$51,712
State Nursing Home	$1,049,756	$1,169,306	$1,166,253	$1,257,334	$1,268,888	$1,388,354	$102,635	$119,466
State Home Domiciliary	$58,298	$59,543	$62,855	$61,537	$66,361	$70,583	$3,506	$4,222
Subtotal Institutional Care	$5,346,606	$5,526,958	$5,711,597	$5,848,497	$5,961,088	$6,384,762	$249,491	$423,674
State Adult Day Care	$1,031	$1,203	$892	$1,312	$1,029	$1,195	$137	$166
Other Non-Institutional Care	$2,354,614	$1,932,352	$2,510,189	$2,025,853	$2,625,803	$2,738,508	$115,614	$112,705
Subtotal Non-Institutional Care	$2,355,645	$1,933,555	$2,511,081	$2,027,165	$2,626,832	$2,739,703	$115,751	$112,871
Long-Term Services and Supports [Total]	**$7,702,251**	**$7,460,513**	**$8,222,678**	**$7,875,662**	**$8,587,920**	**$9,124,465**	**$365,242**	**$536,545**
Other Health Care Programs:								
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,547,010	$1,883,882	$1,816,611	$2,061,930	$1,919,874	$2,063,652	$103,263	$143,778
Caregivers (Title 1)	$453,623	$555,096	$622,466	$641,509	$724,628	$839,828	$102,162	$115,200
Indian Health Servcies	$14,999	$28,062	$15,000	$28,062	$28,062	$29,358	$13,062	$1,296
Camp Lejeune - Veterans	$6,377	$7,220	$13,619	$7,120	$11,347	$11,794	($2,272)	$447
Camp Lejeune - Family	$3,556	$12,500	$10,273	$12,600	$9,840	$8,050	($433)	($1,790)
Readjustment Counseling	$221,158	$243,483	$258,000	$243,483	$243,483	$243,483	($14,517)	$0
Other Health Care Programs [Total]	$2,246,723	$2,730,243	$2,735,969	$2,994,704	$2,937,234	$3,196,165	$201,265	$258,931
VA Legislative Proposals:								
Total	$0	$49,375	$49,375	$49,390	$56,037	$57,997	$6,662	$1,960
Veterans Choice Act from 2016 PB (Medical Care Only) 1/								
Sec 801	*$0*	*$2,344,900*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Sec 802	*$0*	*$3,440,706*	*$0*	*$3,567,467*	*$0*	*$0*	*$0*	*$0*
SubTotal Obligations	**$63,917,797**	**$68,914,501**	**$68,106,127**	**$70,072,746**	**$74,217,464**	**$69,911,520**	**$6,111,337**	**($4,305,944)**
VA Prior Year Recoveries	$585,654	$0	$0	$736,500	$0	$0	*$0*	*$0*
Audit Adjustment 5/	($1,849,222)	$0	$1,849,222	$0	$0	$0	*($1,849,222)*	*$0*
Total Obligations	$62,654,229	$68,914,501	$69,955,349	$70,809,246	$74,217,464	$69,911,520	$4,262,115	($4,305,944)
Obligations by Account 6/								
Medical Services (0160)	*$49,248,944*	*$51,914,695*	*$53,516,204*	*$55,650,078*	*$48,785,758*	*$48,198,687*	*($4,730,446)*	*($587,071)*
Medical Support & Compliance (0152)	*$5,742,866*	*$6,210,300*	*$6,114,763*	*$6,519,914*	*$6,539,857*	*$6,639,834*	*$425,094*	*$99,977*
Medical Facilities (0162)	*$4,725,414*	*$5,003,900*	*$4,680,429*	*$5,071,787*	*$5,722,478*	*$5,413,881*	*$1,042,049*	*($308,597)*
Subtotal	*$59,717,224*	*$63,128,895*	*$64,311,396*	*$67,241,779*	*$61,048,093*	*$60,252,402*	*($3,263,303)*	*($795,691)*
Medical Community Care (0140)	*$0*	*$0*	*$0*	*$0*	*$7,496,181*	*$9,659,118*	*$7,496,181*	*$2,162,937*
Veterans Choice Act (Public Law 113-146)								
Section 801 (Medical Care Only):								
Medical Services 0160XA)	*$609,715*	*$1,572,900*	*$1,415,001*	*$0*	*$821,597*		*($593,404)*	*($821,597)*
Medical Support & Compliance (0152XA)	*$412*	*$17,000*	*$19,778*	*$0*	*$16,262*		*($3,516)*	*($16,262)*
Medical Facilities (0162XA)	*$545,461*	*$755,000*	*$877,910*	*$0*	*$15,512*		*($862,398)*	*($15,512)*
Subtotal	*$1,155,588*	*$2,344,900*	*$2,312,689*	*$0*	*$853,371*		*($1,459,318)*	*($853,371)*
Section 802: (Medical Care Only)								
Administration (0172XA)	*$222,057*		*$200,000*		*$158,441*		*($41,559)*	*($158,441)*
Medical Care (0172XB)	*$412,872*		*$1,531,264*		*$4,661,378*		*$3,130,114*	*($4,661,378)*
Emergency Hepatitis C (0172XC)	*$407,661*		*$0*		*$0*		*$0*	*$0*
Emergency Community Care (0172XE)	*$738,827*		*$1,600,000*		*$0*		*($1,600,000)*	*$0*
Subtotal	*$1,781,417*	*$3,440,706*	*$3,331,264*	*$3,567,467*	*$4,819,819*		*$1,488,555*	*($4,819,819)*
Obligations Grand Total	*$62,654,229*	*$68,914,501*	*$69,955,349*	*$70,809,246*	*$74,217,464*	*$69,911,520*	*$4,262,115*	*($4,305,944)*

Note: Dollars may not add due to rounding in this and subsequent charts.

1/ *Obligations from Section 801 and 802 of the Veterans Choice Act were not included in 2016 Budget Estimate chart. Lines were in the table above to show comparable total Medical Care obligations, but the 801 and 802 funding in the 2016 Budget Estimate and 2017 Advance Appropriation columns remain*

undistributed into Health Care Services.

2/ *In the 2016 Budget Estimate Ambulatory Care removed funding for Ending Veterans Homelessness, VISTA Evolution and Activations from this line and displayed in their respective sections, below, so that the full amount of funding for these programs is displayed. This year's budget table does not reduce Ambulatory Care obligations to display full value and instead displays their full obligation values in the italicized non-add section. Ambulatory Care in the 2016 Budget Estimate and 2017 Advance Appropriation columns includes the Veterans Choice Program cost-shift.*

3/ *The cost of New Hepatitis C treatment is accounted for in Ambulatory Care*

4/ *In the 2016 Budget Estimate, the obligations for Non-Recurring Maintenance (NRM) were excluded from Health Care Services and displayed on its own row. This year, obligations for NRM included within Health Care Services and the full value displayed in the italicized non-add section. NRM includes Section 801 obligations.*

5/ *2015 Financial Statement Audit Adjustment.*

6/ *Obligations include adjustments for Prior Year Recoveries and Financial Statement Audit Adjustment.*

Funding Highlights:

- In 2017, the Budget requests $64.999 billion to expand VA capacity for providing Veterans' medical care, purchasing more care in the community, supporting continuing improvements in the delivery of mental health care, specialized care for women veterans, new treatments for Hepatitis C, and benefits for Veterans' caregivers. In addition, the Budget includes $3.558 billion in estimated medical care collections for a combined resource of approximately $68.557 billion.

- Requests $66.385 billion in 2018 Advance Appropriations for medical care programs, to ensure continuity of Veterans' health care services. In addition, the Budget includes $3.627 billion in estimated medical care collections for a combined resource of approximately $70.012 billion.

- Provides $1.591 billion in 2017 to sustain the Administration's ongoing efforts to end Veteran homelessness, including $300 million for the Supportive Services for Veteran Families (SSVF) program, to prevent Veterans from becoming homeless in the future.

- Provides $1.500 billion in 2017 for new Hepatitis C treatment.

- Provides $7.831 billion in 2017 to ensure the availability of a range of mental health services, from treatment of common mental health conditions in primary care to more intensive interventions in specialty mental health programs for more severe and persisting mental health conditions.

- Provides $836 million in 2017 to ensure timely activation of new and renovated medical facilities already under construction.

- Invests $536 million in 2017, within the Medical Care accounts, to support medical and prosthetic research efforts to advance the care and quality of life for Veterans, such as the Million Veteran Program (MVP), a genomic medicine program that seeks to collect genetic samples and general health information; and post-deployment mental health studies.

2017 Highlights
The 2017 President's Budget is requesting direct appropriations of $64.999 billion, $1.728 billion in additional funding above the 2017 advance enacted level to meet Veterans' medical care needs, a 6.3 percent increase over the 2016 enacted level. In addition to the 2017 appropriation request, VA anticipates the Medical Care Collections Fund (MCCF) will achieve $3.581 billion in collections, of which $3.308 billion will be transferred to Medical Services, $250 million will be transferred to Medical Community Care, and the remainder to the Joint DoD-VA Medical Facility Demonstration Fund (to support the operations of the Captain James A. Lovell Federal Health Care Center (FHCC)). VA will transfer at least $15 million to the DoD-VA Health Care Sharing Incentive Fund (known as the "JIF"), as mandated by law, and $267.430 million in support of the FHCC from the Medical Services, Medical Support and Compliance, and Medical Facility appropriations. VA also estimates that it will receive $184 million in reimbursements largely from the Department of Defense (DoD) for treating their patients. In addition, VA estimates it will obligate the remaining $853 million and $4.820 billion from sections 801 and 802 of the Veterans Choice Act, which will allow VHA to meet its 2017 total obligation authority of $74.217 billion and support 7.0 million unique patients and 9.2 million enrolled Veterans.

Compared to the enacted 2017 advance appropriations level, as requested in the 2016 President's Budget, this year's 2017 request for VA health care services is $1.728 billion higher. This request for additional funding is necessary to ensure the delivery of high-quality and timely health care services to veterans and other eligible beneficiaries. VA is requesting an increase above the enacted advance appropriation in all two Medical Care accounts: $1.079 billion in Medical Services and $649 million in Medical Facilities.

The total net increase of $1.728 billion is due to the following factors:

- Ongoing health care services estimate increased by $3.554 billion, driven largely by estimates of the cost of new Hepatitis C treatments, care in the community, Medical Services FTE, infrastructure enhancements, and updated actuarial trends based on the latest actual data.

- Long-Term Services and Supports estimate has increased by $641.9 million, reflecting trends in the most recent actuals and the continued investment into non-institutional settings.

- Ongoing health service programs not projected by the EHCPM decreased by $57.5 million. The Caregivers program cost estimate increased by $83.1 million, driven largely by an increase in the projected number of Caregivers receiving stipend payments. The combined sum of the estimates for CHAMPVA, reimbursement to the Indian Health Service and tribal health programs, caring for eligible Camp Lejeune Veterans and families, and readjustment counseling decreased by $140.6 million based on updated actuals and revised assumptions in workload for Camp Lejeune and Indian Health Service.

- VA programs to end Veterans' homelessness increased by $198 million, for a total of $1.591 billion. The increased estimate allows VA to fully support projected utilization in its homeless programs, including the Supportive Services for Veterans Families (SSVF) program and the Department of Housing and Urban Development-VA Supportive Housing program (HUD-VASH).

- Healthcare Infrastructure Enhancements increased by $477.8 million from the 2017 Advance Appropriation to the 2017 Revised Request. Facility activation costs have increased by $238.1 million over the initial advance appropriation estimate of $598.2 million to $836.3 million; the initial estimate was based on construction delays that have caused under-execution of activations in recent years. However, VA has made progress in resolving these issues, and as a result has increased confidence that no additional funding will be required in 2017. The cost estimate of supporting the Veterans Integrated System Technology Architecture (VISTA) evolution project has been revised downward from $208.3 million to $40.0 million. Estimated non-recurring maintenance obligations grew from $665 million to $1,073.0 million, to address high-priority emerging capital needs as identified through the Strategic Capital Investment Planning (SCIP) process; this increase includes funding provided by the Veterans Choice Act. See Volume 4, Chapter 7 for additional information on the SCIP process and the NRM program.

Total Medical Care Infrastructure Obligations by Program
Includes Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
NRM	$1,290,904	$1,313,900	$1,009,286	$665,030	$1,072,985	$600,000	$63,699	($472,985)
Activations................	$558,085	$598,174	$598,174	$598,174	$836,293	$497,808	$238,119	($338,485)
VISTA Evolution	$58,652	$159,596	$90,000	$208,265	$40,000	$0	($50,000)	($40,000)
Total	$1,907,641	$2,071,670	$1,697,460	$1,471,469	$1,949,278	$1,097,808	$251,818	($851,470)

- The cost of VHA proposed legislation increased by $6.6 million. The 2017 budget includes estimates for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) healthcare benefits for beneficiaries up to age 26.

- Additional budgetary resources increased by $1.680 billion (collections, reimbursements, transfers, changes in unobligated balances, and prior year recoveries). The estimate for the Medical Care Collections Fund increased by $258.4 million. Reimbursements decreased by $30.6 million and transfers to the Joint DoD-VA Medical Facility Demonstration Fund decreased by $1.8 million. Changes in unobligated balances from Medical Care increased by $85 million, from Veterans Choice Act Section 801 by $853 million, and from Section 802 by $1.252 billion. Prior year recoveries are longer estimated in out-year obligation projections, causing a reduction of $736.5 million from the 2017 Advance Appropriation obligation estimate.

Update to the 2017 Advance Appropriations Request
Includes Veterans Choice Act
(dollars in thousands)

Description	2017 Advance Approp.	2017 Revised Estimate	Increase/ Decrease
Health Care Services:			
Medical Care Appropriations	$56,318,523	$56,963,083	$644,560
Veterans Choice Act, Section 801	$0	$853,371	$853,371
Veterans Choice Act, Section 802	$3,567,467	$4,819,819	$1,252,352
Veterans Choice Program Cost-Shift	($733,000)	$0	$733,000
Health Care Services [Subtotal]	$59,152,990	$62,636,273	$3,483,283
Non-Add included above:			
Ending Veterans Homelessness	*$1,393,000*	*$1,591,365*	*$198,365*
New Hepatitis C Treatment	*$660,000*	*$1,500,000*	*$840,000*
NRM	*$665,030*	*$1,072,985*	*$407,955*
Activations	*$598,174*	*$836,293*	*$238,119*
VISTA Evolution	*$208,265*	*$40,000*	*($168,265)*
Long-Term Services and Supports:			
Institutional	$5,848,497	$5,961,088	$112,591
Non-Institutional	$2,027,165	$2,626,832	$599,667
Long-Term Services and Supports [Total]	$7,875,662	$8,587,920	$712,258
Other Health Care Programs:			
CHAMPVA, Spina Bifida, FMP & CWVV	$2,061,930	$1,919,874	($142,056)
Caregivers (Title 1)	$641,509	$724,628	$83,119
Indian Health Services (P.L. 111-148)	$28,062	$28,062	$0
Camp Lejeune - Veterans and Family (P.L. 112-154)	$19,720	$21,187	$1,467
Readjustment Counseling	$243,483	$243,483	$0
Other Health Care Programs [Subtotal]	$2,994,704	$2,937,234	($57,470)
VA Legislative Proposals	$49,390	$56,037	$6,647
Prior Year Recoveries	$736,500	$0	($736,500)
Obligations [Total]	$70,809,246	$74,217,464	$3,408,218
Funding Availability:			
Appropriation	$63,271,000	$63,271,000	$0
Trns to North Chicago Demo. Fund	($265,675)	($267,430)	($1,755)
Trns to DoD-VA Health Care Sharing Incentive Fund	($15,000)	($15,000)	$0
Medical Care Collections Fund	$3,299,954	$3,558,307	$258,353
Reimbursements	$215,000	$184,404	($30,596)
Change in Unobligated Balances	$0	$85,000	$85,000
Veterans Choice Act Section 801	$0	$853,371	$853,371
Veterans Choice Act Section 802	$3,567,467	$4,819,819	$1,252,352
Prior Year Recoveries	$736,500	$0	($736,500)
Funding Availability [Total]	$70,809,246	$72,489,471	$1,680,225
Annual Appropriation Adjustment	$0	$1,727,993	$1,727,993

2018 Advance Appropriations Request

The President's Budget requests $66.385 billion in advance appropriations for the VA medical care program in 2018, a 2.1 percent increase over the 2017 request. VA anticipates transferring $273.4 million to the FHCC and $15 million to JIF from the 2018 appropriation request. In addition to the appropriation request, MCCF is estimated to reach $3.650 billion, with $3.377 billion will be transferred to Medical Services, $250 million transferred to Medical Community Care, and $22.780 million transferred to the FHCC. VA also estimates that it will receive $188 million in reimbursements largely from DOD for treating their patients and begin 2018 with no unobligated balances. Advance Appropriations enable timely and predictable funding for VA's medical care to prevent our Nation's Veterans from being adversely affected by budget delays, and provides opportunities to more effectively use resources in a constrained fiscal environment. This request for advance appropriations will support over 7.1 million unique patients and 9.3 million enrolled Veterans fulfilling our commitment to Veterans to provide timely and accessible high-quality medical services.

The $1.386 billion dollar 2018 Advance Appropriation increase over the 2017 appropriation request is due to the following factors:

- Long-Term Services and Supports increase by $607 million, driven largely by cost estimates provided by the EHPCM and projected State Nursing Home growth.
- CHAMPVA, Caregivers and other health care programs increase by $259 million to fund annual increases in workload.
- Care in the Community is maintained equal to the 2016 Medical Services operating budget level.
- The 2017 level of core Medical Services FTE is sustained into 2018. The 2018 President's Budget will revisit the continuing costs of sustaining the new VACAA hires.
- These increases in the initial 2018 estimate are offset by partial decreases from the 2017 levels for other programs, including healthcare infrastructure enhancements, Hepatitis C treatment, and programs to end Veterans Homelessness.

Total Medical Care Infrastructure Obligations by Program
Includes Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
Description	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Request	Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
NRM	$1,290,904	$1,313,900	$1,009,286	$665,030	$1,072,985	$600,000	$63,699	($472,985)
Activations................	$558,085	$598,174	$598,174	$598,174	$836,293	$497,808	$238,119	($338,485)
VISTA Evolution	$58,652	$159,596	$90,000	$208,265	$40,000	$0	($50,000)	($40,000)
Total	$1,907,641	$2,071,670	$1,697,460	$1,471,469	$1,949,278	$1,097,808	$251,818	($851,470)

Performance

VHA tracks performance measures that cover a range of clinical, administrative and financial activity, which in turn, help support VHA's three strategic goals: (1) empower

Veterans to improve their well-being, (2) enhance and develop trusted partnerships, and (3) mange and improve VA operations to deliver seamless and integrated support.

Fourteen performance measures have been identified that meet the strategic intent of VA's mission and vision. The performance measures cover a range of clinical, administrative, and financial actions required to support VHA's Strategic Framework.

To be included, the measure will meet the mandatory criteria:

1. Specific interest to the public and
2. Collectively cover a substantial portion of the organization's budget request.

The performance measures contained in the 2017 VHA Performance Plan have been screened and determined to satisfy the above criteria and are an appropriate platform for assessing VHA health care services and programs.

For further detail, please see the VHA Performance Plan chapter.

Medical Care Collections Fund (MCCF)

In 2017, VA estimates collections of $3.581 billion, representing an increase of $43.4 million, 1.2 percent over the 2016 current estimate.

Medical Care Collections Fund 1/ 3/
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual 2/	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Medical Care Collections Fund:								
Pharmacy Co-payments..................................	$646,880	$592,608	$642,046	$573,847	$530,026	$451,390	($112,020)	($78,636)
3rd Party Insurance Collections......................	$2,416,753	$2,295,552	$2,510,048	$2,382,422	$2,660,671	$2,805,106	$150,623	$144,435
3rd Party RX Insurance..................................	$102,355	$94,000	$108,554	$99,000	$112,505	$116,472	$3,951	$3,967
1st Party Other Co-payments..........................	$202,164	$193,793	$199,021	$194,597	$199,850	$199,536	$829	($314)
Enhanced-Use Revenue..................................	$1,272	$2,000	$2,000	$2,000	$2,000	$2,000	$0	$0
Long-Term Care Co-Payments........................	$2,586	$2,705	$2,604	$2,678	$2,571	$2,531	($33)	($40)
Comp. Work Therapy Collections....................	$67,418	$61,000	$67,000	$61,000	$67,000	$67,000	$0	$0
Parking Fees..	$4,076	$4,000	$4,000	$4,000	$4,000	$4,000	$0	$0
Comp. & Pension Living Expenses.................	$1,632	$2,000	$2,000	$2,000	$2,000	$2,000	$0	$0
Total Collections..	$3,445,136	$3,247,658	$3,537,273	$3,321,544	$3,580,623	$3,650,035	$43,350	$69,412
FHCC collections (included above)..............	*$22,330*	*$21,110*	*$22,102*	*$21,590*	*$22,316*	*$22,780*	*$214*	*$464*

1/ Estimates include collections actually or anticipated to be transferred to the Joint DoD-VA Medical Facility Demonstration Fund, in support of the FHCC.

2/ Collections of $3,451,384,385 were received by VA in 2015. Due to a one month lag in timing from when the funds are received and transferred into the Medical Services account, $3,422,805,991 was transferred to the Medical Services and $22,330,493 to the Joint DoD-VA Medical Demonstration Fund from September 2014 through August 2015 for an overall total of $3,445,136,484. The funds collected in September 2015 were transferred in fiscal year 2016.

3/ Includes legislative proposal to expand VA's Income Verification Matching Authority.

The Balanced Budget Act of 1997 (P.L. 105-33) established the VA Medical Care Collections Fund. The legislation required that amounts collected or recovered after June 30, 1997, be deposited into the MCCF and used to furnish medical care and services to

Veterans and to cover expenses incurred to collect amounts owed for the medical care and services furnished.

The VHA Chief Business Office (CBO) has implemented an expanded revenue enhancement plan including a series of tactical and strategic objectives. This plan targets a combination of immediate, mid-term, and long-term improvements to the broad range of business processes encompassing VA revenue activities. This CBO-directed effort is a formalized validation of viable activities being pursued that are successful in addressing national issues, such as coding, payer agreements, site visits to lower performing facilities, and improved financial controls to increase collections.

MCCF collections totaled nearly $3.445 billion in 2015, reflecting a $317 million, 10% increase over 2014 from increased workload and an emphasis on improving revenue-cycle processes. VA is expecting MCCF total collections to be approximately $3.537 billion in 2016. Third-party collections have made significant improvements since the economic downturn and VA continues to pursue opportunities for improved revenue performance as addressed by initiatives described below.

Tiered Copayment Structure

VA is currently in the process of a rulemaking to implement a tiered copayment structure for medication copayments, which will further align VA's medication copayment structure with other Federal agencies and the commercial sector.

Consolidated Patient Account Centers

A major driver of VA's revenue optimization strategy is the Congressionally-mandated deployment of Consolidated Patient Account Centers (CPACs). In 2012, traditional VHA business office functions were consolidated into seven regional Centers of Excellence. This initiative has transformed VHA billing and collections activities to more closely align with industry best practices including standardized operating processes, extensive use of business tools and increased levels of accountability at all levels of the organization.

National Revenue Contracts Office

This initiative is designed to leverage VHA's size and financial purchasing power to develop national/regional contracts for vendors who provide support for revenue-cycle activities. The CPAC Payer Relations Office (PRO) continues to aggressively pursue strategies to effectively manage relationships with third-party payers. The CPAC PRO staff is currently working on new or re-verification of existing third-party payer agreements. VHA is also providing mentoring and training to payer relations staff to improve the operationalizing of completed payer agreements.

eBusiness Initiatives

In an effort to leverage the health care industry's migration to national standard electronic data exchanges under the Health Insurance Portability and Accountability Act (HIPAA) and to comply with other legal requirements, VA implemented a number of eBusiness initiatives to add efficiencies to the billing and collections processes, including Medicare-

equivalent Remittance Advices; insurance verification; inpatient/outpatient/pharmacy billing; and payments, including Electronic Funds Transfer. These electronic processes require ongoing updating to maintain compliance with industry standards for Electronic Data Interchange (EDI) processing.

Reimbursements

Reimbursements
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Reimbursements..........................	$170,162	$215,000	$180,448	$215,000	$184,404	$187,663	$3,956	$3,259
Appropriation:								
Medical Services........................	$145,979	$171,106	$149,770	$171,106	$153,243	$156,005	$3,473	$2,762
Medical Community Care...........	$0	$0	$0	$0	$0	$0	$0	$0
Medical Support & Compliance.	$10,671	$23,671	$13,823	$23,671	$14,063	$14,193	$240	$130
Medical Facilities........................	$13,512	$20,223	$16,855	$20,223	$17,098	$17,465	$243	$367
Appropriation [Total].................	$170,162	$215,000	$180,448	$215,000	$184,404	$187,663	$3,956	$3,259

Reimbursements in 2017 are projected to be $184 million, which represents a 14% decrease from the 2017 Advance Appropriation estimate, in the 2016 President's Submission. The decrease in 2017 is the result of seeing fewer Department of Defense patients than anticipated resulting in a decrease in reimbursements through Sharing Agreements revenue estimates. Estimates for all future years have been reevaluated based on 2015 actuals.

Prior Year Recoveries

Prior Year Recoveries
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Prior Year Recoveries..................	$585,654	$0	$0	$736,500	$0	$0	$0	$0
Appropriation:								
Medical Services........................	$574,411	$0	$0	$721,190	$0	$0	$0	$0
Medical Care in the Community..	$0	$0	$0	$0	$0	$0	$0	$0
Medical Support & Compliance.	$589	$0	$0	$310	$0	$0	$0	$0
Medical Facilities........................	$10,654	$0	$0	$15,000	$0	$0	$0	$0
Appropriation [Total].................	$585,654	$0	$0	$736,500	$0	$0	$0	$0

This is an accounting change to record prior year recoveries as required by Federal accounting policy under OMB Circular No. A-11 guidance and is being reflected for the first time in the 2015 Actuals. Because this is a technical change that does not affect the actual resource levels provide for Veterans services, there are no projections for future years. VA has modified its financial accounting system to be able to accurately monitor and record recoveries.

Financial Statement Audit Adjustment

In November 2015, VA's auditors reported that they believed that VA overestimated its fiscal year 2015 obligations by $1.8 billion because those obligations did not have sufficient supporting documentation. VA and the auditors, in the time allowed, could not identify the overstatement by appropriation. VA management agreed to reflect the finding with the understanding that VA would identify which accounts and to what extent the overstatement occurred and take corrective actions to remediate the audit condition. VA is undertaking the necessary analysis and corrective actions to address this issue.

Medical Care Support for Medical and Prosthetic Research

VA estimates that $536 million of the Medical Care appropriation will support Medical and Prosthetic Research in 2017. These dollars provide resources for the station to establish and maintain the infrastructure necessary to conduct research. Support dollars compensate for clinician investigator salaries for time assigned to research activities, the Associate Chief of Staff for Research and the support and compliance staff, various committee support costs, and administrative and facility services such as financial services, human resources, housekeeping, and engineering support. For further detail on VHA's research program, please see the Medical and Prosthetic Research chapter.

Executive Summary Charts

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*Fiscal Years include Medical Services, Medical Support & Compliance, Medical Facilities, VACAA Sections 801 and 802 unless otherwise noted.

Medical Care Budget Authority
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Medical Services:								
Advance Appropriation	$45,015,527	$47,603,202	$47,603,202	$51,673,000	$51,673,000	$44,886,554	$4,069,798	($6,786,446)
Annual Appropriation Adjustment	$209,189	$1,124,197	$2,369,158	$0	$1,078,993	$0	($1,290,165)	($1,078,993)
Subtotal Appropriation Request	$45,224,716	$48,727,399	$49,972,360	$51,673,000	$52,751,993	$44,886,554	$2,779,633	($7,865,439)
Rescission, P.L. 113-235	($28,830)	$0	$0	$0	$0	$0	$0	$0
Net Appropriations	$45,195,886	$48,727,399	$49,972,360	$51,673,000	$52,751,993	$44,886,554	$2,779,633	($7,865,439)
Transfers:								
To North Chicago Demo. Fund	($190,185)	($195,358)	($196,323)	($200,172)	($201,604)	($206,127)	($5,281)	($4,523)
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	$0	$0
To Major Contruction	($6,494)	$0	($39,051)	$0	$0	$0	$39,051	$0
To Medical Community Care	$0	$0	$0	$0	($7,246,181)	$0	($7,246,181)	$7,246,181
To Med. Services from Med. Support and Compliance	$57,741	$0	$0	$0	$0	$0	$0	$0
Subtotal Transfers	($153,938)	($210,358)	($250,374)	($215,172)	($7,462,785)	($221,127)	($7,212,411)	$7,241,658
Medical Care Collections Fund	$3,422,806	$3,226,548	$3,515,171	$3,299,954	$3,308,307	$3,377,255	($206,864)	$68,948
Subtotal Budget Authority	$48,464,754	$51,743,589	$53,237,157	$54,757,782	$48,597,515	$48,042,682	($4,639,642)	($554,833)
Medical Community Care:								
Advance Appropriation	$0	$0	$0	$0	$0	$9,409,118	$0	$9,409,118
Transfers:								
From Medical Services	$0	$0	$0	$0	$7,246,181	$0	$7,246,181	($7,246,181)
Subtotal Transfers	$0	$0	$0	$0	$7,246,181	$0	$7,246,181	($7,246,181)
Medical Care Collections Fund	$0	$0	$0	$0	$250,000	$250,000	$250,000	$0
Subtotal Budget Authority	$0	$0	$0	$0	$7,496,181	$9,659,118	$7,496,181	$2,162,937
Medical Support & Compliance								
Advance Appropriation	$5,879,700	$6,144,000	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Annual Appropriation Adjustment	$0	$69,961	$0	$0	$0	$0	$0	$0
Subtotal Appropriation Request	$5,879,700	$6,213,961	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Rescission, P.L. 113-235	($5,609)	$0	$0	$0	$0	$0	$0	$0
Net Appropriations	$5,874,091	$6,213,961	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Transfers:								
To North Chicago Demo. Fund	($26,608)	($27,332)	($27,405)	($28,067)	($28,206)	($28,839)	($801)	($633)
To Major Contruction	($1,611)	$0	($84,687)	$0	$0	$0		
To Med. Services from Med. Support and Compliance	($57,741)	$0	$0	$0	$0	$0	$0	$0
Subtotal Transfers	($85,960)	($27,332)	($112,092)	($28,067)	($28,206)	($28,839)	($801)	($633)
Subtotal Budget Authority	$5,788,131	$6,186,629	$6,031,908	$6,495,933	$6,495,794	$6,625,641	$379,199	$129,847
Medical Facilities								
Advance Appropriation	$4,739,000	$4,915,000	$4,915,000	$5,074,000	$5,074,000	$5,434,880	$159,000	$360,880
Annual Appropriation Adjustment	$0	$105,132	$105,132	$0	$649,000	$0	$543,868	($649,000)
Subtotal Appropriation Request	$4,739,000	$5,020,132	$5,020,132	$5,074,000	$5,723,000	$5,434,880	$702,868	($288,120)
Rescission, P.L. 113-235	($2,000)	$0	$0	$0	$0	$0	$0	$0
Net Appropriations	$4,737,000	$5,020,132	$5,020,132	$5,074,000	$5,723,000	$5,434,880	$702,868	($288,120)
Transfers:								
To North Chicago Demo. Fund	($35,490)	($36,455)	($36,635)	($37,436)	($37,620)	($38,464)	($985)	($844)
To Major Contruction 1/	($80,735)	$0	($312,539)	$0	$0	$0		
Subtotal Transfers	($116,225)	($36,455)	($349,174)	($37,436)	($37,620)	($38,464)	($985)	($844)
Subtotal Budget Authority	$4,620,775	$4,983,677	$4,670,958	$5,036,564	$5,685,380	$5,396,416	$701,883	($288,964)
Subtotal, Medical Care Appropriations	$55,806,977	$59,961,492	$61,136,492	$63,271,000	$64,998,993	$66,385,032	($3,351,696)	($782,898)
Collections	$3,422,806	$3,226,548	$3,515,171	$3,299,954	$3,558,307	$3,627,255	($206,864)	$68,948
Total Medical Care Appropriations	$59,229,783	$63,188,040	$64,651,663	$66,570,954	$68,557,300	$70,012,287	($3,558,560)	($713,950)
Subtotal, Medical Care Transfers	($356,123)	($274,145)	($711,640)	($280,675)	($282,430)	($288,430)	$159,000	$360,880
Subtotal, Medical Care Budget Authority	$58,873,660	$62,913,895	$63,940,023	$66,290,279	$68,274,870	$69,723,857	$582,919	($649,000)

1/ The $312.5 million transfer to Major Construction for Aurora, CO is reflected as an appropriation transfer instead of an unobligated balance transfer, as shown in the 2017 President's Budget appendix, due to publication deadlines.

2015 Actual
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

Description	Medical Care	Services 0160	Support & Compl. 0152	Facilities 0162
Advance Appropriation	$55,634,227	$45,015,527	$5,879,700	$4,739,000
Annual Appropriation Adjustment	$209,189	$209,189	$0	$0
Appropriation Request Subtotal	$55,843,416	$45,224,716	$5,879,700	$4,739,000
Rescission	($36,439)	($28,830)	($5,609)	($2,000)
Net Appropriation	$55,806,977	$45,195,886	$5,874,091	$4,737,000
Transfers:				
To North Chicago Demo. Fund	($252,283)	($190,185)	($26,608)	($35,490)
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	$0	$0
To Major Construction	($88,840)	($6,494)	($1,611)	($80,735)
To Medical Services	($57,741)	$0	($57,741)	$0
Fr Medical Support & Compl	$57,741	$57,741	$0	$0
Transfers Subtotal	($356,123)	($153,938)	($85,960)	($116,225)
Collections	$3,422,806	$3,422,806	$0	$0
Budget Authority Total	$58,873,660	$48,464,754	$5,788,131	$4,620,775
Reimbursements	$170,162	$145,979	$10,671	$13,512
Adjustments to Obligations				
Unobligated Balance (SOY)				
No-Year	$170,075	$168,251	$1,503	$321
H1N1 No-Year (P.L. 111-32)_	$113	$113	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$6,018	$6	$0	$6,012
2-Year	$187,769	$59,739	$41,149	$86,881
Unobligated Balance (SOY) Subtotal	$363,975	$228,109	$42,652	$93,214
Unobligated Balance (EOY)				
No-Year	($15,772)	($14,907)	($248)	($617)
Financial Statement Audit Adjustment	($149,222)	($149,222)	$0	$0
H1N1 No-Year (P.L. 111-32)_	($142)	($142)	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	($7,376)	($6)	$0	($7,370)
2-Year	($103,413)	$0	($98,784)	($4,629)
Unobligated Balance (EOY) Subtotal	($275,925)	($164,277)	($99,032)	($12,616)
Change in Unobligated Balances (Non-Add)	$88,050	$63,832	($56,380)	$80,598
Lapse	($302)	($32)	($145)	($125)
Obligations Subtotal (Excluding Prior Year Recoveries)	$59,131,570	$48,674,533	$5,742,277	$4,714,760
Prior Year Recoveries	$585,654	$574,411	$589	$10,654
Obligations Total (Including Prior Year Recoveries)	$59,717,224	$49,248,944	$5,742,866	$4,725,414

Veterans Access, Choice, & Accountability Act 0f 2014, Section 801

Description	Medical Care Total	Services 0160XA	Support & Compl. 0152XA	Facilities 0162XA	Minor Construction 0111XA	Information Technology Development 0167XD	Information Technology Sustainment 0167XO	Information Technology Pay & Adm 0167XZ	Overall Total
Unobligated Balance (SOY)	$5,000,000	$5,000,000	$0	$0	$0	$0	$0	$0	$5,000,000
Transfer of Unobligated Balance	($887,800)	($2,686,900)	$27,500	$1,771,600	$511,200	$151,400	$186,200	$39,000	$0
Trns of Unobl. Balance, Information Technology (IT)	$14,100	$14,100	$0	$0	$0	$0	($14,100)	$0	$0
Unobligated Balance (EOY)	($2,970,712)	($1,717,485)	($27,088)	($1,226,139)	($413,678)	($131,413)	($139,872)	($37,649)	($3,693,324)
VACAA Section 801 Obligations Total	$1,155,588	$609,715	$412	$545,461	$97,522	$19,987	$32,228	$1,351	$1,306,676
Medical Care Obligation Total (Incl. VACAA Section 801)	**$60,872,812**	**$49,858,659**	**$5,743,278**	**$5,270,875**					

2015 Actual (continued)
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

	Total
Medical Care Obligation Total (Incl. VACAA Section 801)...	$60,872,812

Veterans Access, Choice, & Accountability Act 0f 2014, Section 802

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emerg. Comm. Care 0172XE	Information Technology Dev. 0172XD	Information Technology Sustain. 0172XO	Information Technology Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)	$9,932,000	$523,520	$6,059,980	$500,000	$2,848,500	$45,937	$21,809	$254	$10,000,000
Unobligated Balance (EOY)	($6,450,583)	($201,463)	($5,647,108)	($92,339)	($509,673)	($43,974)	($6,036)	($233)	($6,500,826)
Obligations Subtotal Prior to Audit Adjustment	$3,481,417	$322,057	$412,872	$407,661	$2,338,827	$1,963	$15,773	$21	$3,499,174
Financial Statement Audit Adjustment (Unobl. Bal. (EOY))	($1,700,000)	($100,000)	$0	$0	($1,600,000)	$0	$0	$0	($1,700,000)
Obligations Total After Adjustment	$1,781,417	$222,057	$412,872	$407,661	$738,827	$1,963	$15,773	$21	$1,799,174

Medical Care Grand Total...	**$62,654,229**

2016 Budget Estimate
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

Description	Medical Care	Services 0160	Support & Compl. 0152	Facilities 0162
Advance Appropriation	$58,662,202	$47,603,202	$6,144,000	$4,915,000
Annual Appropriation Adjustment	$1,299,290	$1,124,197	$69,961	$105,132
Appropriation Request Subtotal	$59,961,492	$48,727,399	$6,213,961	$5,020,132
Rescission	$0	$0	$0	$0
Net Appropriation	$59,961,492	$48,727,399	$6,213,961	$5,020,132
Transfers:				
To North Chicago Demo. Fund	($259,145)	($195,358)	($27,332)	($36,455)
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	$0	$0
Transfers Subtotal	($274,145)	($210,358)	($27,332)	($36,455)
Collections	$3,226,548	$3,226,548	$0	$0
Budget Authority Total	$62,913,895	$51,743,589	$6,186,629	$4,983,677
Reimbursements	$215,000	$171,106	$23,671	$20,223
Adjustments to Obligations				
Unobligated Balance (SOY)				
No-Year	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0
2-Year	$0	$0	$0	$0
Unobligated Balance (SOY) Subtotal	$0	$0	$0	$0
Unobligated Balance (EOY)				
No-Year	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0
2-Year	$0	$0	$0	$0
Unobligated Balance (EOY) Subtotal	$0	$0	$0	$0
Change in Unobligated Balances (Non-Add)	$0	$0	$0	$0
Lapse	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$63,128,895	$51,914,695	$6,210,300	$5,003,900
Prior Year Recoveries	$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$63,128,895	$51,914,695	$6,210,300	$5,003,900

Veterans Access, Choice, & Accountability Act 0f 2014, Section 801

Description	Medical Care Total	Services 0160XA	Support & Compl. 0152XA	Facilities 0162XA	Minor Construction 0111XA	Information Technology	Overall Total
Unobligated Balance (SOY)	$2,344,900	$1,572,900	$17,000	$755,000	$128,000	$173,400	$2,646,300
Unobligated Balance (EOY)	$0	$0	$0	$0	$0		$0
VACAA Section 801 Obligations Total	$2,344,900	$1,572,900	$17,000	$755,000	$128,000	$173,400	$2,646,300
Medical Care Obligation Total (Incl. VACAA Section 801)	**$65,473,795**	**$53,487,595**	**$6,227,300**	**$5,758,900**			

2016 Budget Estimate (continued)
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

	Total
Medical Care Obligation Total (Incl. VACAA Section 801)	$65,473,795

Veterans Access, Choice, & Accountability Act 0f 2014, Section 802

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Overall Total
Unobligated Balance (SOY)	$7,008,173	$367,419	$6,640,754	$7,008,173
Unobligated Balance (EOY)	($3,567,467)	($183,621)	($3,383,846)	($3,567,467)
Obligations Total After Adjustment	$3,440,706	$183,798	$3,256,908	$3,440,706

Medical Care Grand Total	**$68,914,501**

2016 Current Estimate
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

Description	Medical Care	Services 0160	Support & Compl. 0152	Facilities 0162
Advance Appropriation	$58,662,202	$47,603,202	$6,144,000	$4,915,000
Annual Appropriation Adjustment (POTUS Request)	$1,299,290	$1,124,197	$69,961	$105,132
Omnibus Bill (P.L. 114-113)	$1,175,000	$1,244,961	($69,961)	$0
Appropriation Request Subtotal	$61,136,492	$49,972,360	$6,144,000	$5,020,132
Rescission	$0	$0	$0	$0
Net Appropriation	$61,136,492	$49,972,360	$6,144,000	$5,020,132
Transfers:				
To North Chicago Demo. Fund	($260,363)	($196,323)	($27,405)	($36,635)
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	$0	$0
To Major Construction*	($436,277)	($39,051)	($84,687)	($312,539)
To Medical Services	$0	$0	$0	$0
Fr Medical Support & Compl	$0	$0	$0	$0
Transfers Subtotal	($711,640)	($250,374)	($112,092)	($349,174)
Collections	$3,515,171	$3,515,171	$0	$0
Budget Authority Total	$63,940,023	$53,237,157	$6,031,908	$4,670,958
Reimbursements	$180,448	$149,770	$13,823	$16,855
Adjustments to Obligations				
Unobligated Balance (SOY)				
No-Year	$15,772	$14,907	$248	$617
Financial Statement Audit Adjustment	$149,222	$149,222	$0	$0
H1N1 No-Year (P.L. 111-32)_	$142	$142	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$7,376	$6	$0	$7,370
2-Year	$103,413	$0	$98,784	$4,629
Unobligated Balance (SOY) Subtotal	$275,925	$164,277	$99,032	$12,616
Unobligated Balance (EOY)				
No-Year	($35,900)	($34,850)	($250)	($800)
Financial Statement Audit Adjustment	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	($144)	($144)	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	($7,606)	($6)	$0	($7,600)
2-Year	($41,350)	$0	($29,750)	($11,600)
Unobligated Balance (EOY) Subtotal	($85,000)	($35,000)	($30,000)	($20,000)
Change in Unobligated Balances (Non-Add)	$190,925	$129,277	$69,032	($7,384)
Lapse	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$64,311,396	$53,516,204	$6,114,763	$4,680,429
Prior Year Recoveries	$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$64,311,396	$53,516,204	$6,114,763	$4,680,429

*The $312.5 million transfer to Major Construction for Aurora, CO is reflected as an appropriation transfer instead of an unobligated balance transfer, as shown in the 2017 President's Budget appendix, due to publication deadlines.

Veterans Access, Choice, & Accountability Act of 2014, Section 801

Description	Medical Care Total	Services 0160XA	Support & Compl. 0152XA	Facilities 0162XA	Minor Construction 0111XA	Information Technology Development 0167XD	Information Technology Sustainment 0167XO	Information Technology Pay & Adm 0167XZ	Overall Total
Unobligated Balance (SOY)	$2,970,712	$1,717,485	$27,088	$1,226,139	$413,678	$131,413	$139,872	$37,649	$3,693,324
Transfer of Unobligated Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0
Trns of Unobl. Balance, Information Technology (IT)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	($658,023)	($302,484)	($7,310)	($348,229)	($311,178)	$0	$0	$0	($969,201)
VACAA Section 801 Obligations Total	$2,312,689	$1,415,001	$19,778	$877,910	$102,500	$131,413	$139,872	$37,649	$2,724,123
Medical Care Obligation Total (Incl. VACAA Section 801)	**$66,624,085**	**$54,931,205**	**$6,134,541**	**$5,558,339**					

2016 Current Estimate (continued)
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

	Total
Medical Care Obligation Total (Incl. VACAA Section 801)...	$66,624,085

Veterans Access, Choice, & Accountability Act of 2014, Section 802

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emerg. Comm. Care 0172XE	Information Technology Dev. 0172XD	Information Technology Sustain. 0172XO	Information Technology Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)	$8,150,583	$301,463	$5,647,108	$92,339	$2,109,673	$43,974	$6,036	$233	$8,200,826
Unobligated Balance (EOY)	($4,819,319)	($101,463)	($4,115,844)	($92,339)	($509,673)	$0	($500)	$0	($4,819,819)
Obligations Total After Adjustment 1/	$3,331,264	$200,000	$1,531,264	$0	$1,600,000	$43,974	$5,536	$233	$3,381,007

Medical Care Grand Total	**$69,955,349**

1/ Includes $1.7 billion in obligations as a result of the financial statement audit adjustment

2017 Advance Appropriation
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

Description	Medical Care	Services 0160	Support & Compl. 0152	Facilities 0162
Advance Appropriation	$63,271,000	$51,673,000	$6,524,000	$5,074,000
Appropriation Request Subtotal	$63,271,000	$51,673,000	$6,524,000	$5,074,000
Rescission	$0	$0	$0	$0
Net Appropriation	$63,271,000	$51,673,000	$6,524,000	$5,074,000
Transfers:				
To North Chicago Demo. Fund	($265,675)	($200,172)	($28,067)	($37,436)
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	$0	$0
Transfers Subtotal	($280,675)	($215,172)	($28,067)	($37,436)
Collections	$3,299,954	$3,299,954	$0	$0
Budget Authority Total	$66,290,279	$54,757,782	$6,495,933	$5,036,564
Reimbursements	$215,000	$171,106	$23,671	$20,223
Adjustments to Obligations				
Unobligated Balance (SOY)				
No-Year	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0
2-Year	$0	$0	$0	$0
Unobligated Balance (SOY) Subtotal	$0	$0	$0	$0
Unobligated Balance (EOY)				
No-Year	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0
2-Year	$0	$0	$0	$0
Unobligated Balance (EOY) Subtotal	$0	$0	$0	$0
Change in Unobligated Balances (Non-Add)	$0	$0	$0	$0
Lapse	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$66,505,279	$54,928,888	$6,519,604	$5,056,787
Prior Year Recoveries	$736,500	$721,190	$310	$15,000
Obligations Total (Including Prior Year Recoveries)	$67,241,779	$55,650,078	$6,519,914	$5,071,787

Veterans Access, Choice, & Accountability Act 0f 2014, Section 802

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Overall Total
Unobligated Balance (SOY)	$3,567,467	$183,621	$3,383,846	$3,567,467
Unobligated Balance (EOY)	$0	$0	$0	$0
Obligations Total After Adjustment	$3,567,467	$183,621	$3,383,846	$3,567,467

Medical Care Grand Total.. $70,809,246

2017 Revised Estimate
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

Description	Medical Care	Services 0160	Support & Compl. 0152	Facilities 0162	Medical Community Care
Advance Appropriation	$63,271,000	$51,673,000	$6,524,000	$5,074,000	$0
Annual Appropriation Adjustment	$1,727,993	$1,078,993	$0	$649,000	$0
Appropriation Request Subtotal	$64,998,993	$52,751,993	$6,524,000	$5,723,000	$0
Rescission	$0	$0	$0	$0	$0
Net Appropriation	$64,998,993	$52,751,993	$6,524,000	$5,723,000	$0
Transfers:					
To North Chicago Demo. Fund	($267,430)	($201,604)	($28,206)	($37,620)	$0
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	$0	$0	$0
To Medical Community Care	$0	($7,246,181)	$0	$0	$7,246,181
Transfers Subtotal	($282,430)	($7,462,785)	($28,206)	($37,620)	$7,246,181
Collections	$3,558,307	$3,308,307	$0	$0	$250,000
Budget Authority Total	$68,274,870	$48,597,515	$6,495,794	$5,685,380	$7,496,181
Reimbursements	$184,404	$153,243	$14,063	$17,098	$0
Adjustments to Obligations					
Unobligated Balance (SOY)					
No-Year	$35,900	$34,850	$250	$800	$0
H1N1 No-Year (P.L. 111-32)_	$144	$144	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$7,606	$6	$0	$7,600	$0
2-Year	$41,350	$0	$29,750	$11,600	$0
Unobligated Balance (SOY) Subtotal	$85,000	$35,000	$30,000	$20,000	$0
Unobligated Balance (EOY)					
No-Year	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
Unobligated Balance (EOY) Subtotal	$0	$0	$0	$0	$0
Change in Unobligated Balances (Non-Add)	$85,000	$35,000	$30,000	$20,000	$0
Lapse	$0	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$68,544,274	$48,785,758	$6,539,857	$5,722,478	$7,496,181
Prior Year Recoveries	$0	$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$68,544,274	$48,785,758	$6,539,857	$5,722,478	$7,496,181

Veterans Access, Choice, & Accountability Act of 2014, Section 801

Description	Medical Care Total	Services 0160XA	Support & Compl. 0152XA	Facilities 0162XA		Minor Construction 0111XA	Information Technology Development 0167XD	Information Technology Sustainment 0167XO	Information Technology Pay & Adm 0167XZ	Overall Total
Unobligated Balance (SOY)	$658,023	$302,484	$7,310	$348,229		$311,178	$0	$0	$0	$969,201
Transfer of Unobligated Balance	$195,348	$519,113	$8,952	($332,717)		($195,348)	$0	$0	$0	$0
Unobligated Balance (EOY)	$0	$0	$0	$0		$0	$0	$0	$0	$0
VACAA Section 801 Obligations Total	$853,371	$821,597	$16,262	$15,512		$115,830	$0	$0	$0	$969,201
Medical Care Obligation Total (Incl. VACAA Section 801)	**$69,397,645**	**$49,607,355**	**$6,556,119**	**$5,737,990**	**$7,496,181**					

2017 Revised Estimate (continued)
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

	Total
Medical Care Obligation Total (Incl. VACAA Section 801)...	$69,397,645

Veterans Access, Choice, & Accountability Act of 2014, Section 802

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emerg. Comm. Care 0172XE	ormation Technology Dev. 0172XD	Sustain. 0172XO	Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)	$4,819,319	$158,441	$4,660,878	$0	$0	$0	$500	$0	$4,819,819
Transfer of Unobligated Balances	$500	$0	$500	$0	$0	$0	($500)	$0	$0
Unobligated Balance (EOY)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Obligations Total After Adjustment	$4,819,819	$158,441	$4,661,378	$0	$0	$0	$0	$0	$4,819,819

Medical Care Grand Total.. **$74,217,464**

2018 Advance Appropriation
Medical Care (Excluding Veterans Choice Act)
(dollars in thousands)

Description	Medical Care	Services 0160	Support & Compl. 0152	Facilities 0162	Medical Community Care
Advance Appropriation	$66,385,032	$44,886,554	$6,654,480	$5,434,880	$9,409,118
Appropriation Request Subtotal	$66,385,032	$44,886,554	$6,654,480	$5,434,880	$9,409,118
Rescission	$0	$0	$0	$0	$0
Net Appropriation	$66,385,032	$44,886,554	$6,654,480	$5,434,880	$9,409,118
Transfers:					
To North Chicago Demo. Fund	($273,430)	($206,127)	($28,839)	($38,464)	$0
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	$0	$0	$0
Transfers Subtotal	($288,430)	($221,127)	($28,839)	($38,464)	$0
Collections	$3,627,255	$3,377,255	$0	$0	$250,000
Budget Authority Total	$69,723,857	$48,042,682	$6,625,641	$5,396,416	$9,659,118
Reimbursements	$187,663	$156,005	$14,193	$17,465	$0
Adjustments to Obligations					
Unobligated Balance (SOY)					
No-Year	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
Unobligated Balance (SOY) Subtotal	$0	$0	$0	$0	$0
Unobligated Balance (EOY)					
No-Year	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
Unobligated Balance (EOY) Subtotal	$0	$0	$0	$0	$0
Change in Unobligated Balances (Non-Add)	$0	$0	$0	$0	$0
Lapse	$0	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$69,911,520	$48,198,687	$6,639,834	$5,413,881	$9,659,118
Prior Year Recoveries	$0	$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$69,911,520	$48,198,687	$6,639,834	$5,413,881	$9,659,118

Unique Patients [1/]

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Priorities 1-6............	4,824,325	4,918,891	4,967,642	5,028,596	5,096,617	5,211,267	128,975	114,650
Priorities 7-8............	1,223,425	1,273,263	1,200,964	1,263,289	1,180,743	1,162,776	(20,221)	(17,967)
Subtotal Veterans......	6,047,750	6,192,154	6,168,606	6,291,885	6,277,360	6,374,043	108,754	96,683
Non-Veterans 2/.......	694,120	703,235	705,743	712,601	715,928	730,875	10,185	14,947
Total Unique Patients.	6,741,870	6,895,389	6,874,349	7,004,486	6,993,288	7,104,918	118,939	111,630

Unique Enrollees [3/]

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Priorities 1-6............	6,867,722	7,056,268	7,003,462	7,180,635	7,135,440	7,249,646	131,978	114,206
Priorities 7-8............	2,098,201	2,326,337	2,121,250	2,323,770	2,112,363	2,096,266	(8,887)	(16,097)
Total Enrollees..........	8,965,923	9,382,605	9,124,712	9,504,405	9,247,803	9,345,912	123,091	98,109

Users as a Percent of Enrollees

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Priorities 1-6............	70.2%	69.7%	70.9%	70.0%	71.4%	71.9%	0.5%	0.5%
Priorities 7-8............	58.3%	54.7%	56.6%	54.4%	55.9%	55.5%	-0.7%	-0.4%
Total Enrollees..........	67.5%	66.0%	67.6%	66.2%	67.9%	68.2%	0.3%	0.3%

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.

2/ Non-Veterans include active duty military and reserve, spousal collateral, consultations and instruction, CHAMPVA workload, reimbursable reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations such as Hepatitis A&B and flu vaccinations.

3/ Similar to unique patients, the count of unique enrollees represents the count of Veterans enrolled for Veterans health care sometime during the course of the year.

Summary of Workloads for VA and Non-VA Facilities

Description	2015 Actual	2016 Budget Estimate 1/	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Outpatient Visits (000):								
Ambulatory Care:								
Staff	83,269	84,564	87,511	86,628	91,038	85,840	3,527	(5,198)
Fee	16,674	14,965	17,537	15,337	22,319	19,169	4,782	(3,150)
Subtotal	99,943	99,529	105,048	101,965	113,357	105,009	8,309	(8,348)
Readjustment Counseling:								
Visits	1,661	1,680	1,711	1,720	1,762	1,815	51	53
Grand Total	101,604	101,209	106,759	103,685	115,119	106,824	8,360	(8,295)
Patients Treated:								
Inpatient Care	606,116	612,966	599,070	610,353	590,856	583,461	(8,214)	(7,395)
Rehabilitation Care	16,440	16,234	16,627	16,234	16,769	16,917	142	148
Mental Health Care Total	152,485	155,232	152,105	155,608	151,289	150,570	(816)	(719)
Acute Psychiatry	*89,292*	*89,200*	*86,452*	*87,694*	*83,932*	*81,547*	*(2,520)*	*(2,385)*
Contract Hospital (Psych)	*21,252*	*22,796*	*23,461*	*24,160*	*25,052*	*26,572*	*1,591*	*1,520*
Psy Residential Rehab	*17,518*	*18,326*	*17,523*	*18,649*	*17,526*	*17,529*	*3*	*3*
Dom Residential Rehab	*24,423*	*24,910*	*24,669*	*25,105*	*24,779*	*24,922*	*110*	*143*
Long-Term Care: Institutional	113,130	117,276	115,372	119,455	117,395	119,111	2,023	1,716
Subacute Care	1,844	1,516	1,780	1,351	1,694	1,624	(86)	(70)
Inpatient Facilities, Total	890,015	903,224	884,954	903,001	878,003	871,683	(6,951)	(6,320)
Average Daily Census:								
Inpatient Care	8,754	8,920	8,662	9,009	8,584	8,464	(78)	(120)
Rehabilitation Care	1,143	1,163	1,134	1,171	1,135	1,131	1	(4)
Mental Health Care Total	9,311	9,487	9,261	9,542	9,204	9,169	(57)	(35)
Acute Psychiatry	*2,513*	*2,474*	*2,428*	*2,435*	*2,356*	*2,281*	*(72)*	*(75)*
Contract Hospital (Psych)	*462*	*421*	*533*	*437*	*598*	*665*	*65*	*67*
Psy Residential Rehab	*1,926*	*2,123*	*1,915*	*2,181*	*1,900*	*1,892*	*(15)*	*(8)*
Dom Residential Rehab	*4,410*	*4,469*	*4,385*	*4,489*	*4,350*	*4,331*	*(35)*	*(19)*
Long-Term Care: Institutional	41,430	40,970	41,772	41,354	42,596	43,404	824	808
Subacute Care	93	75	92	72	92	96	0	4
Inpatient Facilities, Total	60,731	60,615	60,921	61,148	61,611	62,264	690	653
Length of Stay:								
Inpatient Care	5.3	5.3	5.3	5.4	5.3	5.3	0.0	0.0
Rehabilitation Care	25.4	26.2	25.0	26.3	24.7	24.4	(0.3)	(0.3)
Mental Health Care	22.3	22.4	22.3	22.4	22.2	22.2	(0.1)	0.0
Long-Term Care: Institutional	133.7	127.9	132.5	126.4	132.4	133.0	(0.1)	0.6
Subacute Care	18.4	18.1	18.9	19.5	19.8	21.6	0.9	1.8
Dental Procedures (000)	4,747	4,783	4,975	4,932	5,163	5,031	188	(132)
CHAMPVA/FMP/Spina Bifida:								
Outpatient Workloads (000)	14,143	15,655	14,778	16,356	15,132	17,142	354	2,010

Employment Summary (FTE)

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Medical Services	211,278	217,205	215,773	227,485	230,062	223,016	14,289	(7,046)
Medical Community Care	0	0	0	0	0	0	0	0
Medical Support & Compliance	49,477	54,020	51,050	55,300	52,350	52,350	1,300	0
Medical Facilities	23,644	24,209	24,209	24,431	24,209	24,209	0	0
Total	284,399	295,434	291,032	307,216	306,621	299,575	15,589	(7,046)

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp. 1/	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Veterans Choice Act, Sec. 801, FTE	5,147	9,613	11,797	0	6,628	0	(5,169)	(6,628)
Veterans Choice Act, Sec. 802, FTE	30	137	40	137	40	0	0	(40)

1/ Section 801 FTE merge into Medical Services; Support & Compliance; and Facilities appropriations.

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Estimate	Increase/ Decrease 2016 to 2017
Canteen Service	3,351	3,475	3,351	3,351	0
Medical & Prosthetic Research	3,521	3,551	3,551	3,606	55
DOD-VA Health Care Sharing Fund	57	44	57	57	0
Joint DoD-VA Med. Fac. Demo. Fund:					
Civilian	2,127	2,167	2,167	2,172	5
DoD Uniformed Military	928	836	836	836	0
Joint DoD-VA Med. Fac. Demo. Fund Total	3,055	3,003	3,003	3,008	5

FTE by Type
Medical Care

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Physicians	19,311	20,594	19,682	22,447	21,099	20,851	1,417	(248)
Dentists	1,028	1,118	1,067	1,122	1,170	1,081	103	(89)
Registered Nurses	54,283	56,165	55,841	57,764	59,875	57,242	4,034	(2,633)
LP Nurse/LV Nurse/Nurse Assistant	24,587	25,428	25,045	26,236	26,398	25,617	1,353	(781)
Non-Physician Providers	12,925	13,861	13,129	14,996	14,013	14,186	884	173
Health Technicians/Allied Health	65,306	66,882	66,686	69,696	70,590	67,649	3,904	(2,941)
Wage Board/Purchase & Hire	25,974	26,575	26,482	26,797	26,654	26,411	172	(243)
All Other 1/	80,899	84,811	83,100	88,158	86,822	86,538	3,722	(284)
SubTotal	284,313	295,434	291,032	307,216	306,621	299,575	15,589	(7,046)
Veterans Choice Act, Sec. 801, FTE	5,147	9,613	11,797	0	6,628	0	(5,169)	(6,628)
Veterans Choice Act, Sec. 802, FTE	30	137	40	137	40	0	0	(40)
Total	289,490	305,184	302,869	307,353	313,289	299,575	10,420	(13,714)

1/ All Other category includes personnel such as medical support assistance, administrative support clerks, administrative specialist, police, personnel management specialists, management and program analysts, medical records clerks/technicians, budget/fiscal, contract administrators, supply technicians, and other staff that are necessary for the effective operations of VHA medical facilities.

FTE by Type
Medical Services

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Physicians	18,744	19,943	19,116	21,781	20,533	20,285	1,417	(248)
Dentists	1,016	1,108	1,056	1,111	1,159	1,070	103	(89)
Registered Nurses	51,432	52,800	52,843	54,323	56,877	54,244	4,034	(2,633)
LP Nurse/LV Nurse/Nurse Assistant	24,511	25,323	24,965	26,129	26,318	25,537	1,353	(781)
Non-Physician Providers	12,732	13,634	12,904	14,763	13,788	13,961	884	173
Health Technicians/Allied Health	64,132	65,643	65,570	68,427	69,474	66,533	3,904	(2,941)
Wage Board/Purchase & Hire	5,442	5,647	5,526	5,663	5,698	5,455	172	(243)
All Other 1/	33,183	33,107	33,793	35,288	36,215	35,931	2,422	(284)
SubTotal	211,192	217,205	215,773	227,485	230,062	223,016	14,289	(7,046)
Veterans Choice Act, Sec. 801, FTE	5,145	9,577	11,585	0	6,458	0	(5,127)	(6,458)
Total	216,337	226,782	227,358	227,485	236,520	223,016	9,162	(13,504)

1/ Details on Medical Services "All Other" FTE occupation types can be found in the chart on the next page.

FTE by Type
Medical Support & Compliance

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Physicians	567	651	566	666	566	566	0	0
Dentists	12	10	11	11	11	11	0	0
Registered Nurses	2,850	3,365	2,998	3,441	2,998	2,998	0	0
LP Nurse/LV Nurse/Nurse Assistant	71	105	80	107	80	80	0	0
Non-Physician Providers	192	227	225	233	225	225	0	0
Health Technicians/Allied Health	1,057	1,119	996	1,148	996	996	0	0
Wage Board/Purchase & Hire	954	993	1,021	1,016	1,021	1,021	0	0
All Other 1/	43,774	47,550	45,153	48,678	46,453	46,453	1,300	0
SubTotal	49,477	54,020	51,050	55,300	52,350	52,350	1,300	0
Veterans Choice Act, Sec. 801, FTE	2	36	200	0	170	0	(30)	(170)
Total	49,479	54,056	51,250	55,300	52,520	52,350	1,270	(170)

1/ All Other category includes: Administrative Support Clerk, Administrative Specialist, Police , Personnel Management Specialist, Management And Program Analyst, Medical Records Clerk/Technician, Budget/Fiscal, Contract Administrator, Supply Technician, Medical Support Assistance, and other staff that are necessary for the effective operations of VHA Medical Support & Compliance.

FTE by Type
Medical Facilities

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Physicians	0	0	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0	0
Registered Nurses	1	0	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	5	0	0	0	0	0	0	0
Non-Physician Providers	1	0	0	0	0	0	0	0
Health Technicians/Allied Health	117	120	120	121	120	120	0	0
Wage Board/Purchase & Hire	19,578	19,935	19,935	20,118	19,935	19,935	0	0
All Other 1/	3,942	4,154	4,154	4,192	4,154	4,154	0	0
SubTotal	23,644	24,209	24,209	24,431	24,209	24,209	0	0
Veterans Choice Act, Sec. 801, FTE	0	0	12	0	0	0	(12)	0
Total	23,644	24,209	24,221	24,431	24,209	24,209	(12)	0

1/All Other category includes maintenance controllers, engineers/architects, administrative support clerks, safety and occupational health specialists, fire protection and prevention staff, engineering technicians, hospitals housekeepers and managers, industrial hygienists, administrative specialists, and other staff that are necessary for the effective operations of VHA medical facilities.

2017 Revised Estimate and 2018 Advance Appropriation
Obligations - Model and Non-Model
Includes Veterans Choice Act
(dollars in thousands)

Description	2017 Revised Estimate			2018 Advance Appropriation		
	Model	Non-Model	Total	Model	Non-Model	Total
Health Care Services............	$60,946,564	$1,689,709	$62,636,273	$58,975,692	($1,442,799)	$57,532,893
Non-Add Included Above:						
Non Recurring Maintenance............	*$0*	*$1,072,985*	*$1,072,985*	*$0*	*$600,000*	*$600,000*
Non Veterans............	*$0*	*$400,385*	*$400,385*	*$0*	*$409,021*	*$409,021*
Long-Term Care............	$7,251,642	$1,336,278	$8,587,920	$7,664,333	$1,460,132	$9,124,465
Non-Add Included Above:						
State Home Programs............	*$0*	*$1,336,278*	*$1,336,278*	*$0*	*$1,460,132*	*$1,460,132*
Other Health Care Programs:						
CHAMPVA............	$1,715,000	$115,368	$1,830,368	$1,850,000	$121,700	$1,971,700
Foreign Medical Program (includes Foreign C&P Exams)............	$0	$31,280	$31,280	$0	$34,151	$34,151
Spina Bifida Program............	$0	$58,026	$58,026	$0	$57,601	$57,601
Children of Women Vietnam Veterans............	$0	$200	$200	$0	$200	$200
Caregivers (Title 1)............	$0	$724,628	$724,628	$0	$839,828	$839,828
Indian Health Service (PL 111-148)............	$0	$28,062	$28,062	$0	$29,358	$29,358
Camp Lejeune - Veterans	$11,347	$0	$11,347	$11,794	$0	$11,794
Camp Lejeune - Family............	$0	$9,840	$9,840	$0	$8,050	$8,050
Readjustment Counseling............	$0	$243,483	$243,483	$0	$243,483	$243,483
VA Legislative Proposals............	$0	$56,037	$56,037	$0	$57,997	$57,997
Obligations [Grand Total]............	$69,924,553	$4,292,911	$74,217,464	$68,501,819	$1,409,701	$69,911,520

FY 2015 Actuals

Dollars in Thousands ($000)

Medical Care Description	Services	Support & Compliance	Facilities	Total
10 Personal Compensation & Benefits.................	$24,313,280	$4,514,678	$1,658,640	$30,486,598
21 Travel & Transportation of Things...................	$914,638	$44,179	$33,047	$991,864
22 Transportation of Things.................................	$18,027	$10,034	$14,058	$42,119
23 Rent, Communications, & Utilities...................	$323,147	$115,916	$1,057,676	$1,496,739
24 Printing & Reproduction.................................	$14,359	$12,300	$177	$26,836
25 Other Contractual Services.............................	$10,429,326	$934,900	$629,286	$11,993,512
26 Supplies & Materials......................................	$10,284,793	$87,891	$309,799	$10,682,483
31 Equipment..	$843,670	$22,166	$69,129	$934,965
32 Lands & Structures...	$802	$179	$942,743	$943,724
41 Grants, Subsidies & Contributions...................	$1,681,713	$34	$11	$1,681,758
43 Imputed Interest...	$0	$0	$194	$194
Subtotal...	$48,823,755	$5,742,277	$4,714,760	$59,280,792
Prior Year Recoveries...	$574,411	$589	$10,654	$585,654
Financial Statement Audit Adjustment..................	($149,222)	$0	$0	($149,222)
Obligations Total...	$49,248,944	$5,742,866	$4,725,414	$59,717,224

VACAA Section 801 Description	Services	Support & Compliance	Facilities	Total
10 Personal Compensation & Benefits.................	$562,567	$410	$0	$562,977
21 Travel & Transportation of Things...................	$2	$2	$0	$4
22 Transportation of Things.................................	$26	$0	$0	$26
23 Rent, Communications, & Utilities...................	$484	$0	$29,083	$29,567
24 Printing & Reproduction.................................	$0	$0	$0	$0
25 Other Contractual Services.............................	$2,220	$0	$1,664	$3,884
26 Supplies & Materials......................................	$15,206	$0	$2,823	$18,029
31 Equipment..	$29,210	$0	$0	$29,210
32 Lands & Structures...	$0	$0	$511,891	$511,891
41 Grants, Subsidies & Contributions...................	$0	$0	$0	$0
43 Imputed Interest...	$0	$0	$0	$0
Obligations Total...	$609,715	$412	$545,461	$1,155,588

Medical Care + VACAA Section 801 Total Description	Services	Support & Compliance	Facilities	Total
10 Personal Compensation & Benefits.................	$24,875,847	$4,515,088	$1,658,640	$31,049,575
21 Travel & Transportation of Things...................	$914,640	$44,181	$33,047	$991,868
22 Transportation of Things.................................	$18,053	$10,034	$14,058	$42,145
23 Rent, Communications, & Utilities...................	$323,631	$115,916	$1,086,759	$1,526,306
24 Printing & Reproduction.................................	$14,359	$12,300	$177	$26,836
25 Other Contractual Services.............................	$10,431,546	$934,900	$630,950	$11,997,396
26 Supplies & Materials......................................	$10,299,999	$87,891	$312,622	$10,700,512
31 Equipment..	$872,880	$22,166	$69,129	$964,175
32 Lands & Structures...	$802	$179	$1,454,634	$1,455,615
41 Grants, Subsidies & Contributions...................	$1,681,713	$34	$11	$1,681,758
43 Imputed Interest...	$0	$0	$194	$194
Subtotal...	$49,433,470	$5,742,689	$5,260,221	$60,436,380
Prior Year Recoveries...	$574,411	$589	$10,654	$585,654
Financial Statement Audit Adjustment..................	($149,222)	$0	$0	($149,222)
Obligations Total...	$49,858,659	$5,743,278	$5,270,875	$60,872,812

VACAA Section 802 (0172) Description	Grand Total
10 Personal Compensation & Benefits.................	$2,235
21 Travel & Transportation of Things...................	$10,303
22 Transportation of Things.................................	$0
23 Rent, Communications, & Utilities...................	$0
24 Printing & Reproduction.................................	$4,169
25 Other Contractual Services.............................	$3,047,172
26 Supplies & Materials......................................	$417,538
31 Equipment..	$0
32 Lands & Structures...	$0
41 Grants, Subsidies & Contributions...................	$0
43 Imputed Interest...	$0
Subtotal...	$3,481,417
Prior Year Recoveries...	$0
Financial Statement Audit Adjustment..................	($1,700,000)
Obligations Total...	$1,781,417
GRAND TOTAL..	$62,654,229

* VACAA 802 excludes Information Technology

** VACAA 801 excludes Minor Construction and Information Technology

FY 2016 Estimates

Dollars in Thousands ($000)

Medical Care Description	Services	Support & Compliance	Facilities	Total
10 Personal Compensation & Benefits.................	$25,589,722	$4,775,563	$1,732,572	$32,097,857
21 Travel & Transportation of Things...................	$927,000	$48,000	$34,000	$1,009,000
22 Transportation of Things.................................	$21,000	$13,000	$15,000	$49,000
23 Rent, Communications, & Utilities...................	$344,327	$117,000	$1,094,001	$1,555,328
24 Printing & Reproduction.................................	$23,000	$15,000	$0	$38,000
25 Other Contractual Services.............................	$11,713,233	$1,025,200	$821,222	$13,559,655
26 Supplies & Materials......................................	$12,116,000	$96,000	$311,634	$12,523,634
31 Equipment..	$887,700	$25,000	$74,000	$986,700
32 Lands & Structures...	$0	$0	$598,000	$598,000
41 Grants, Subsidies & Contributions...................	$1,745,000	$0	$0	$1,745,000
43 Imputed Interest...	$0	$0	$0	$0
Subtotal...	$53,366,982	$6,114,763	$4,680,429	$64,162,174
Prior Year Recoveries...	$0	$0	$0	$0
Financial Statement Audit Adjustment..................	$149,222	$0	$0	$149,222
Obligations Total...	$53,516,204	$6,114,763	$4,680,429	$64,311,396

VACAA Section 801 Description	Services	Support & Compliance	Facilities	Total
10 Personal Compensation & Benefits.................	$1,331,002	$18,000	$857	$1,349,859
21 Travel & Transportation of Things...................	$0	$1,000	$0	$1,000
22 Transportation of Things.................................	$0	$0	$0	$0
23 Rent, Communications, & Utilities...................	$0	$0	$285,605	$285,605
24 Printing & Reproduction.................................	$0	$0	$0	$0
25 Other Contractual Services.............................	$27,000	$778	$0	$27,778
26 Supplies & Materials......................................	$17,999	$0	$0	$17,999
31 Equipment..	$39,000	$0	$0	$39,000
32 Lands & Structures...	$0	$0	$591,448	$591,448
41 Grants, Subsidies & Contributions...................	$0	$0	$0	$0
43 Imputed Interest...	$0	$0	$0	$0
Obligations Total...	$1,415,001	$19,778	$877,910	$2,312,689

Medical Care + VACAA Section 801 Total Description	Services	Support & Compliance	Facilities	Total
10 Personal Compensation & Benefits.................	$26,920,724	$4,793,563	$1,733,429	$33,447,716
21 Travel & Transportation of Things...................	$927,000	$49,000	$34,000	$1,010,000
22 Transportation of Things.................................	$21,000	$13,000	$15,000	$49,000
23 Rent, Communications, & Utilities...................	$344,327	$117,000	$1,379,606	$1,840,933
24 Printing & Reproduction.................................	$23,000	$15,000	$0	$38,000
25 Other Contractual Services.............................	$11,740,233	$1,025,978	$821,222	$13,587,433
26 Supplies & Materials......................................	$12,133,999	$96,000	$311,634	$12,541,633
31 Equipment..	$926,700	$25,000	$74,000	$1,025,700
32 Lands & Structures...	$0	$0	$1,189,448	$1,189,448
41 Grants, Subsidies & Contributions...................	$1,745,000	$0	$0	$1,745,000
43 Imputed Interest...	$0	$0	$0	$0
Subtotal...	$54,781,983	$6,134,541	$5,558,339	$66,474,863
Prior Year Recoveries...	$0	$0	$0	$0
Financial Statement Audit Adjustment..................	$149,222	$0	$0	$149,222
Obligations Total...	$54,931,205	$6,134,541	$5,558,339	$66,624,085

VACAA Section 802 (0172) Description	Grand Total
10 Personal Compensation & Benefits.................	$0
21 Travel & Transportation of Things...................	$0
22 Transportation of Things.................................	$0
23 Rent, Communications, & Utilities...................	$0
24 Printing & Reproduction.................................	$0
25 Other Contractual Services.............................	$3,331,264
26 Supplies & Materials......................................	$0
31 Equipment..	$0
32 Lands & Structures...	$0
41 Grants, Subsidies & Contributions...................	$0
43 Imputed Interest...	$0
Subtotal...	$3,331,264
Prior Year Recoveries...	$0
Financial Statement Audit Adjustment..................	$0
Obligations Total...	$3,331,264
GRAND TOTAL..	$69,955,349

* VACAA 802 excludes Information Technology

** VACAA 801 excludes Minor Construction and Information Technology

FY 2017 Estimates

Dollars in Thousands ($000)

Medical Care Description	Services	Support & Compliance	Facilities	Medical Community Care	Total
10 Personal Compensation & Benefits.................	$28,022,072	$4,985,080	$1,750,277	$0	$34,757,429
21 Travel & Transportation of Things...................	$962,000	$49,000	$34,000	$0	$1,045,000
22 Transportation of Things................................	$22,000	$13,000	$15,000	$0	$50,000
23 Rent, Communications, & Utilities...................	$357,302	$120,000	$1,415,001	$0	$1,892,303
24 Printing & Reproduction................................	$23,000	$15,000	$0	$0	$38,000
25 Other Contractual Services............................	$4,506,192	$1,230,777	$857,424	$6,159,903	$12,754,296
26 Supplies & Materials.....................................	$13,389,192	$99,000	$323,776	$0	$13,811,968
31 Equipment...	$989,000	$28,000	$83,000	$0	$1,100,000
32 Lands & Structures...	$0	$0	$1,244,000	$0	$1,244,000
41 Grants, Subsidies & Contributions...................	$515,000	$0	$0	$1,336,278	$1,851,278
43 Imputed Interest..	$0	$0	$0	$0	$0
Subtotal...	$48,785,758	$6,539,857	$5,722,478	$7,496,181	$68,544,274
Prior Year Recoveries...	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment..................	$0	$0	$0	$0	$0
Obligations Total..	$48,785,758	$6,539,857	$5,722,478	$7,496,181	$68,544,274

VACAA Section 801 Description	Services	Support & Compliance	Facilities	Total
10 Personal Compensation & Benefits.................	$774,999	$15,000	$0	$789,999
21 Travel & Transportation of Things...................	$0	$1,262	$0	$1,262
22 Transportation of Things................................	$0	$0	$0	$0
23 Rent, Communications, & Utilities...................	$0	$0	$0	$0
24 Printing & Reproduction................................	$0	$0	$0	$0
25 Other Contractual Services............................	$0	$0	$0	$0
26 Supplies & Materials.....................................	$17,598	$0	$0	$17,598
31 Equipment...	$29,000	$0	$15,512	$44,512
32 Lands & Structures...	$0	$0	$0	$0
41 Grants, Subsidies & Contributions...................	$0	$0	$0	$0
43 Imputed Interest..	$0	$0	$0	$0
Obligations Total..	$821,597	$16,262	$15,512	$853,371

Medical Care + VACAA Section 801 Total Description	Services	Support & Compliance	Facilities	Medical Community Care	Total
10 Personal Compensation & Benefits.................	$28,797,071	$5,000,080	$1,750,277	$0	$35,547,428
21 Travel & Transportation of Things...................	$962,000	$50,262	$34,000	$0	$1,046,262
22 Transportation of Things................................	$22,000	$13,000	$15,000	$0	$50,000
23 Rent, Communications, & Utilities...................	$357,302	$120,000	$1,415,001	$0	$1,892,303
24 Printing & Reproduction................................	$23,000	$15,000	$0	$0	$38,000
25 Other Contractual Services............................	$4,506,192	$1,230,777	$857,424	$6,159,903	$12,754,296
26 Supplies & Materials.....................................	$13,406,790	$99,000	$323,776	$0	$13,829,566
31 Equipment...	$1,018,000	$28,000	$98,512	$0	$1,144,512
32 Lands & Structures...	$0	$0	$1,244,000	$0	$1,244,000
41 Grants, Subsidies & Contributions...................	$515,000	$0	$0	$1,336,278	$1,851,278
43 Imputed Interest..	$0	$0	$0	$0	$0
Subtotal...	$49,607,355	$6,556,119	$5,737,990	$7,496,181	$69,397,645
Prior Year Recoveries...	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment..................	$0	$0	$0	$0	$0
Obligations Total..	$49,607,355	$6,556,119	$5,737,990	$7,496,181	$69,397,645

VACAA Section 802 (0172) Description	Grand Total
10 Personal Compensation & Benefits.................	$0
21 Travel & Transportation of Things...................	$0
22 Transportation of Things................................	$0
23 Rent, Communications, & Utilities...................	$0
24 Printing & Reproduction................................	$0
25 Other Contractual Services............................	$4,819,819
26 Supplies & Materials.....................................	$0
31 Equipment...	$0
32 Lands & Structures...	$0
41 Grants, Subsidies & Contributions...................	$0
43 Imputed Interest..	$0
Subtotal...	$4,819,819
Prior Year Recoveries...	$0
Financial Statement Audit Adjustment..................	$0
Obligations Total..	$4,819,819
GRAND TOTAL...	$74,217,464

* VACAA 802 excludes Information Technology

** VACAA 801 excludes Minor Construction and Information Technology

FY 2018 Advanced Appropriation

Dollars in Thousands ($000)

Medical Care Description	Services	Support & Compliance	Facilities	Medical Community Care	Total
10 Personal Compensation & Benefits.................	$28,031,574	$5,106,735	$1,776,483	$0	$34,914,792
21 Travel & Transportation of Things...................	$1,003,000	$50,400	$35,100	$0	$1,088,500
22 Transportation of Things.................................	$26,100	$13,400	$15,400	$0	$54,900
23 Rent, Communications, & Utilities..................	$365,400	$122,700	$1,405,300	$0	$1,893,400
24 Printing & Reproduction.................................	$25,100	$15,400	$0	$0	$40,500
25 Other Contractual Services.............................	$5,470,634	$1,218,199	$1,016,698	$8,198,986	$15,904,517
26 Supplies & Materials......................................	$12,476,845	$99,000	$334,400	$0	$12,910,245
31 Equipment...	$542,000	$14,000	$44,000	$0	$600,000
32 Lands & Structures...	$0	$0	$786,500	$0	$786,500
41 Grants, Subsidies & Contributions...................	$258,034	$0	$0	$1,460,132	$1,718,166
43 Imputed Interest...	$0	$0	$0	$0	$0
Subtotal..	$48,198,687	$6,639,834	$5,413,881	$9,659,118	$69,911,520
Prior Year Recoveries...	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment.................	$0	$0	$0	$0	$0
Obligations Total..	$48,198,687	$6,639,834	$5,413,881	$9,659,118	$69,911,520

* VACAA 801 and 802 ended in FY 2017

Medical Care

VA's health care mission is met through the obligations detailed in the chart below. A description of the Medical Care programs listed below is detailed in the proceeding narrative.

Total Medical Care Obligations by Program
Includes Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
Description	2015 Actual	Budget Estimate 1/	Current Estimate	Advance Approp. 1/	Revised Request	Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Health Care Services:								
Ambulatory Care 2/	$30,836,494	$29,164,351	$32,639,750	$30,881,037	$36,135,657	$30,935,829	$3,495,907	($5,199,828)
Inpatient Care	$11,705,181	$11,717,004	$12,218,801	$12,148,884	$12,691,101	$13,029,380	$472,300	$338,279
Rehabilitation Care	$843,321	$637,906	$868,608	$652,095	$898,563	$917,093	$29,955	$18,530
Mental Health	$6,851,643	$7,455,017	$7,484,555	$7,715,357	$7,831,890	$7,997,054	$347,335	$165,164
Prosthetics	$2,727,077	$2,841,942	$2,851,000	$3,039,353	$3,645,677	$3,376,159	$794,677	($269,518)
Dental Care	$1,005,107	$1,072,544	$1,035,391	$1,148,797	$1,433,385	$1,277,378	$397,994	($156,007)
Health Care Services [Total]	$53,968,823	$52,888,764	$57,098,105	$55,585,523	$62,636,273	$57,532,893	$5,538,168	($5,103,380)
Non-Add included above:								
Ending Veterans Homelessness	*$1,506,781*	*$1,393,000*	*$1,476,644*	*$1,393,000*	*$1,591,365*	*$1,122,398*	*$114,721*	*($468,967)*
New Hepatitis C Treatment 3/	*$1,218,398*	*$690,000*	*$1,500,000*	*$660,000*	*$1,500,000*	*$600,000*	*$0*	*($900,000)*
Long-Term Services and Supports:								
VA Community Living Centers (VA CLC)	$3,377,088	$3,453,246	$3,512,886	$3,621,640	$3,613,461	$3,861,735	$100,575	$248,274
Community Nursing Home	$861,464	$844,863	$969,603	$907,986	$1,012,378	$1,064,090	$42,775	$51,712
State Nursing Home	$1,049,756	$1,169,306	$1,166,253	$1,257,334	$1,268,888	$1,388,354	$102,635	$119,466
State Home Domiciliary	$58,298	$59,543	$62,855	$61,537	$66,361	$70,583	$3,506	$4,222
Subtotal Institutional Care	$5,346,606	$5,526,958	$5,711,597	$5,848,497	$5,961,088	$6,384,762	$249,491	$423,674
State Adult Day Care	$1,031	$1,203	$892	$1,312	$1,029	$1,195	$137	$166
Other Non-Institutional Care	$2,354,614	$1,932,352	$2,510,189	$2,025,853	$2,625,803	$2,738,508	$115,614	$112,705
Subtotal Non-Institutional Care	$2,355,645	$1,933,555	$2,511,081	$2,027,165	$2,626,832	$2,739,703	$115,751	$112,871
Long-Term Services and Supports [Total]	**$7,702,251**	**$7,460,513**	**$8,222,678**	**$7,875,662**	**$8,587,920**	**$9,124,465**	**$365,242**	**$536,545**
Other Health Care Programs:								
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,547,010	$1,883,882	$1,816,611	$2,061,930	$1,919,874	$2,063,652	$103,263	$143,778
Caregivers (Title 1)	$453,623	$555,096	$622,466	$641,509	$724,628	$839,828	$102,162	$115,200
Indian Health Servcies	$14,999	$28,062	$15,000	$28,062	$28,062	$29,358	$13,062	$1,296
Camp Lejeune - Veterans	$6,377	$7,220	$13,619	$7,120	$11,347	$11,794	($2,272)	$447
Camp Lejeune - Family	$3,556	$12,500	$10,273	$12,600	$9,840	$8,050	($433)	($1,790)
Readjustment Counseling	$221,158	$243,483	$258,000	$243,483	$243,483	$243,483	($14,517)	$0
Other Health Care Programs [Total]	$2,246,723	$2,730,243	$2,735,969	$2,994,704	$2,937,234	$3,196,165	$201,265	$258,931
VA Legislative Proposals:								
Total	$0	$49,375	$49,375	$49,390	$56,037	$57,997	$6,662	$1,960
Veterans Choice Act from 2016 PB (Medical Care Only) 1/.								
Sec 801	*$0*	*$2,344,900*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Sec 802	*$0*	*$3,440,706*	*$0*	*$3,567,467*	*$0*	*$0*	*$0*	*$0*
SubTotal Obligations	**$63,917,797**	**$68,914,501**	**$68,106,127**	**$70,072,746**	**$74,217,464**	**$69,911,520**	**$6,111,337**	**($4,305,944)**
VA Prior Year Recoveries	$585,654	$0	$0	$736,500	$0	$0	*$0*	*$0*
Financial Statement Audit Adjustment 5/	($1,849,222)	$0	$1,849,222	$0	$0	$0	*($1,849,222)*	*$0*
Total Obligations	$62,654,229	$68,914,501	$69,955,349	$70,809,246	$74,217,464	$69,911,520	$4,262,115	($4,305,944)

Note: Dollars may not add due to rounding in this and subsequent charts.

1/ Obligations from Section 801 and 802 of the Veterans Choice Act were not included in 2016 Budget Estimate chart. Lines were in the table above to show comparable total Medical Care obligations, but the 801 and 802 funding in the 2016 Budget Estimate and 2017 Advance Appropriation columns remain undistributed into Health Care Services.

2/ In the 2016 Budget Estimate Ambulatory Care removed funding for Ending Veterans Homelessness, VISTA Evolution and Activations from this line and displayed in their respective sections, below, so that the full amount of funding for these programs is displayed. This year's budget table does not reduce Ambulatory Care obligations to display full value and instead displays their full obligation values in the italicized non-add section. Ambulatory Care in the 2016 Budget Estimate and 2017 Advance Appropriation columns includes the Veterans Choice Program cost-shift.
3/ The cost of New Hepatitis C treatment is accounted for in Ambulatory Care
4/ In the 2016 Budget Estimate, the obligations for non-recurring maintenance (NRM) were excluded from Health Care Services and displayed on its own row. This year, obligations for NRM included within Health Care Services and the full value displayed in the italicized non-add section. NRM includes Section 801 obligations.
5/ 2015 Financial Statement Audit Adjustment, $149.222 million from Medical Services and $1.7 billion from the Veterans Choice Act Section 802.

Ambulatory Care

Ambulatory Care
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$30,836,494	$29,164,351	$32,639,750	$30,881,037	$36,135,657	$30,935,829	$3,495,907	($5,199,828)

This health service category includes funding for ambulatory care in VA hospital- and community-based clinics. Non-VA care is provided to eligible beneficiaries when VA facilities are not geographically accessible, services are not available at a particular facility, or when care cannot be provided in a timely manner within existing resources. For more details about Ambulatory care, please see the Enrollee Healthcare Projection and CHAMPVA Models chapter.

2015 Accomplishments

- Implemented a streamlined Patient Aligned Care Team (PACT) education and training strategy that resulted in a 75 percent reduction in time away from clinic for basic training on PACT.
- Transitioned basic training on PACT to a virtual delivery model to reduce travel expenditures and increase timeliness of training availability.
- Primary Care Services collaborated with Mental Health to increase Primary Care Mental Health Integration (PCMHI) penetration rates 7 percent overall during 2015 (from 6.8 percent to 7.3 percent), and increase rates 23 percent at facilities with low baseline (beginning of 2015) levels of program activity.
- Published VHA Handbook 1101.11(2): Coordinated Care For Traveling Veterans

Future Goals (2016-2018)

- Publish Patient Centered Management Module (PCMM) Handbook in 2016.
- Continue PACT PCMHI implementation with emphasis on chronic disease management and improving team effectiveness.
- Achieve open access and team-based continuity of care in Primary Care.
- Enhance Telehealth presence in rural areas.

- Implement a virtual PACT University that provides a tiered curriculum targeting all PACT staff.
- Expand PACT curriculum to include a training series for Primary Care leaders
- Publish Primary Care Roadmaps, which contains uniform implementation guidance in high priority areas for primary care, such as Access, Pain Management, and Post-Deployment Care.

Inpatient Care

Inpatient Care
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Total Medical Care.....	$11,705,181	$11,717,004	$12,218,801	$12,148,884	$12,691,101	$13,029,380	$472,300	$338,279

- VA delivers inpatient acute care in its hospitals and through inpatient contract care.
- Inpatient Evaluation Center (IPEC) data on how VA compares to private sector for mortality and readmissions, patient safety indications, and health care-associated infections is shown in the following chart.

  VA tracks industry-standard measures of patient outcomes during hospitalization, which include risk-adjusted 30-day mortality and readmission rates; rates of potentially preventable complications (Patient Safety Indicators - PSIs); and Health Care Associated Infections (HAIs). The comparisons listed below are based on most recent published data. The following overall trends are noted:

  - VA risk-adjusted mortality is on par or lower than the private sector
  - VA readmission rates are slightly higher than the private sector
  - Rates of PSIs compare favorably with the private sector overall
  - Rates of health care associated infection are lower than the private sector

	VA* July 1, 2009 - June 30, 2012	Centers for Medicare & Medicaid Services (CMS) 1/ July 1, 2010 – June 30, 2013
Mortality & Readmissions	**Rate**	**Rate**
30-day risk standardized mortality rate – Congestive Heart Failure (CHF RSMR)	10.8	11.9
30-day risk standardized morality rate – Pneumonia (Pneumonia RSMR)	11.8	11.9
30-day risk standardized readmission rate – Congestive Heart Failure (CHF RSRR)	24.1	22.7
30-day risk standardized readmission rate – Pneumonia (CHF RSRR)	18.6	17.3
30-day risk standardized readmission rate – Acute Myocardial Infarction (AMI RSRR)	19.0	17.8
	VA* Jan 1, 2011 – Dec 31, 2014	**Agency for Health Care Research & Quality (AHRQ) 2/ Jan 1, 2012 – Dec 31, 2012**
Patient Safety Indicators (PSIs)	**Rate**	**Rate**
Pressure Ulcer Rate (PSI 03)	0.35	0.5
Inpatient Surgical Deaths (PSI 04)	109.27	118.62
Collapsed lung due to medical treatment	0.31	0.34
Postoperative Hip Fracture (PSI 08)	0.07	0.04
Perioperative Bleeding/Bruise (PSI 09)	6.04	5.11
Postoperative Kidney & Diabetic Complications (PSI 10)	1.04	0.69
Postoperative Respiratory Failure (PSI 11)	10.33	10.05
Perioperative Blood Clot/Embolism (PSI 12)	3.94	4.99
Postoperative Sepsis (PSI 13)	7.35	9.61
A wound that splits open after surgery on the abdomen or pelvis (PSI 14)	3.41	1.86
Accidental puncture or laceration from medical treatment (PSI 15)	1.57	1.89

	VA* Oct 1, 2013 – Sept 30, 2014	National Health Care Safety Network (NHSN) 3/ Jan 1,2012 – Dec 31, 2012
Healthcare-Associated Infections (HAIs)	**Mean**	**Mean**
1. Central Line Associated Bloodstream Infection Rate (CLABSI) per 1,000 line days		
Acute Care***	0.7	0.8
ICU+	0.9	1.2
2. Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 catheter days		
Acute Care***	1.4	1.4
ICU+	1.2	2.4
3. Ventilator Associated Pneumonia (VAP) per 1,000 vent days		
ICU+	1.2	1.6
	VA* Oct 1, 2013 – Sept 30, 2014	**National Health Care Safety Network (NHSN) 4/ Jan 1, 2007 – Mar 31, 2011**
	Rate	**Rate**
4. Total Bloodstream (BSI) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.8	1.27
5. Access-Related Bloodstream (ARB) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.6	0.88

Data Sources
*Veterans Affairs – Inpatient Evaluation Center – Veterans Health Administration (VHA) (Rate – The number of patients with primary diagnosis who die within 30 days of hospital discharge divided by the total number of patients with same primary diagnosis x 100)
1/ Centers for Medicare & Medicaid Services – http: //www.medicare.gov/hospitalcompare/search.htm
2/ AHRQ – http///www.ahrq.gov version 4.5 (Rate= per 1,000 hospital discharges)
3/National Healthcare Safety Network (NHSn) – American Journal Infection Control 2013; 41:1148-66
4/NHSN – Unpublished rate

- A recent report by outside consultants on VHA successes in inpatient care is located at: http://prospect.org/article/report-va-outperforms-private-sector-key-measures

2015 Accomplishments

- A review, "Enhanced Discharge Planning Task Force Recommendations: A Population Approach to Comprehensive Transitional Care for Hospitalized Veterans (sponsoring office Quality Safety Value)" was completed.
- The National Office of Patient Care Services (PCS) and the VA Pittsburgh Veterans Engineering Resource Center (VERC) piloted Reducing Readmissions Through Improving Care Transitions (RRTICT) at seven sites.
- Support for development of pending legislation to apply expanded flexible schedule process, currently in place for part-time physicians, to include full-time physicians. The result will be improved efficiency and flexibility in scheduling hospitalist and emergency medicine physicians.

Future Goals (2016-2018)

- Expand Pittsburgh VERC at pilot sites from 1 unit/ward implementation to facility-wide. The objectives below outline proposed next steps to expand the program. The project completion time would be 1 year and 8 months.
- Dedication of resources to develop and deploy Information Technology. Ensure there is software to support effective medication reconciliation, patient education and instructions, interdisciplinary communication and other critical steps in transitions of care. Creation of a VHA Transitional Care Program Office.
- The Program Office will centralize oversight of transitional care programs and support for an inter-professional model of transitional care, which includes but is not limited to, nurses, physicians, pharmacists, and social workers. One of the major functions of this Office is to develop and manage policies, procedures and performance metrics related to VHA transitional care.
- Inpatient groups will collaborate with the National Center on Homelessness among Veterans to improve transitions of care for homeless, or previously homeless, Veterans who require hospitalization. The goal will be to assure respite care for vulnerable homeless Veterans, and to maintain housing for previously homeless Veterans after acute care hospitalization.
- Multi-disciplinary multi-office collaborations to address inpatient safety issues—including infections, adverse medication events, use of medications to prevent adverse events—that are of national importance within VA and across Federal agencies.

Rehabilitation Care

Rehabilitation Care Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act (dollars in thousands)								
		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$843,321	$637,906	$868,608	$652,095	$898,563	$917,093	$29,955	$18,530

Blind Rehabilitation Service (BRS) programs include: inpatient and outpatient blind and vision rehabilitation programs, adjustment to blindness and benefits counseling, patient and family education, and recommendation and training in the use of access technology that supports family and community integration, and highest level of functional independence. The mission of Spinal Cord Injury and Disorders (SCI/D) Services is to promote the health, independence, quality of life and productivity of individuals with spinal cord injury and disorders through efficient delivery of acute rehabilitation, psychological, social, vocational, medical and surgical care, professional training, as well as patient and family education.

Blind Rehabilitation Service

2015 Accomplishments

- Partnered with Prosthetic and Sensory Aids Service (PSAS) and the Denver Acquisitions and Logistics Center (DALC) to deploy a contract for access technology most used by blind Veterans.
- Partnered with PSAS and Office of Administrative and Regulatory Affairs to develop regulations for the provision of blind aids. The drafted regulations have been reviewed and will be published in the Federal Register.
- Supported dramatic increase in connected health encounters, and regional memoranda of understanding for tele-rehabilitation between inpatient blind rehabilitation and case managers for blind Veterans.
- Deployed International Classification of Disease (ICD) crosswalk from version 9 to version 10 for vision and blind rehabilitation care. These codes are used by VHA blind rehabilitation professionals to indicate the level of impairment for patients with vision loss.
- Partnered with Office of Workforce and Management Consulting to provide 15 Visual Impairment and Orientation and Mobility Professionals Program scholarships mandated in compliance with P.L. 111-163 to assure a vital workforce.
- Supported Joint Commission accreditation preparedness for all BRS programs involved in providing care in Veterans' home and eligible for survey under the Home Care standards.
- Completed the field deployment of a comprehensive set of Event Capture System data products that are linked to specific Current Procedural Terminology codes and Relative Value Units used in all inpatient Blind Rehabilitation Centers. This

standardized methodology allows consistent, system wide productivity and workload data capture and monitoring that promotes staff efficiency, enhances patient care and promotes effective stewardship of resources by allowing identification of outlier utilization and costs and provides the ability to conduct in-depth trending and comparison analyses across inpatient programs in BRS.

- Partnered with VHA Office of Productivity, Efficiency, and Staffing, and Decision Support Refine benchmarks to assist in assessing provider productivity for Rehabilitation Services disciplines.
- Deployed Universal Stakeholder Participation and Experience Questionnaire (uSPEQ) Consumer Experiences Survey to measure and assess Veteran Patient Experience and Satisfaction.
- In partnership with key VHA staff and Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, BRS refined new guidance on Catastrophic Disability and legal blindness ICD-10 codes.
- Partnering with VA and VHA Human Resources to revise BRS and Blind Rehabilitation Outpatient Specialist (BROS) Hybrid Title 38 Qualification Standards.
- Collaborated with VHA Office of Enrollment and Forecasting to build model for projecting/right-sizing in-patient beds and resources needed for Blind Rehabilitation.
- Conducted an accessibility deep-dive to better understand blind Veterans ability to access points of contact such as kiosk, MyhealtheVet and secure messaging. Report is being shared with affected offices.
- Expanded Telehealth services delivered for blind Veterans. Between 2014 and 2015, there was a 21 percent increase in clinical video Telehealth (CVT) encounters. Vision Impairment Service Team Coordinators are primary users for Telehealth Services and reflect a 35 percent increase in encounters.
- Organized a National Blind Rehabilitation Conference for blind rehabilitation professions to facilitate face-to-face discussion of BRS initiatives and priorities, strategic planning, and to share best practices for delivering coordinated care for blind Veterans.

2016 – 2018 Future Goals

- Partner with VHA Office of Productivity, Efficiency, and Staffing, and Decision Support Refine benchmarks to assist in assessing provider productivity for Rehabilitation Services disciplines.
- Develop guidelines and best practices. Include labor mapping examples, from different programs and various BRS position types.

- Partner with DoD and VHA Patient Care Services to roll out the "one mission- one policy-one plan" to ensure interagency complex care coordination process across the full spectrum of care, benefits and services for Veterans and Servicemembers.
- Partner with the Denver Acquisition and Logistics Center, and Prosthetics & Sensory Aids Service to contract with vendors for provision of access technology, peripherals, and provision of helpdesk services for blind Veterans.
- Continue partnership with VA and VHA Human Resources to refresh BRS and BROS Hybrid Title 38 Qualification Standards.
- Continue collaboration with VHA Office of Enrollment and Forecasting to project costs and right-size number of in-patient beds needed for Blind Rehabilitation.
- Revise and enhance discipline-based Preferred Practice Patterns, and deploy information across VHA.
- Conduct an access to care review related to Veteran VA experience within BRS programs as well as community blind rehabilitation services.
- Partner with VHA Procurement and Logistics Office, Strategic Acquisition Center (SAC) and Prosthetics and Sensory Aids Services (PSAS) to convene an Integrated Product Team (IPT) for a Closed Circuit Television (CCTVs) Contract.

The mission of Blind Rehabilitation Service (BRS) is to assist eligible blind and visually impaired Veterans and Servicemembers in developing the skills needed for personal independence and successful reintegration into the community and family environment.

BRS is an integrated system of care that includes:

- 13 inpatient blind rehabilitation centers;
- 9 outpatient blind rehabilitation clinics;
- 44 low vision clinics;
- 161 blindness case managers (called Visual Impairment Services Team (VIST) Coordinators) for the most severely disabled blind Veterans; and
- 85 BROS who provide care at VA medical facilities and in Veterans' homes. BROS are assigned to Polytrauma Centers and sites of care to partner for the care of Servicemembers and Veterans whose injuries and disorders include vision loss.

Rehabilitation in BRS is interdisciplinary and patient-centered, using integrated plans of care that address the Veterans' needs and goals to guide service delivery. Family members, included as members of the team, are provided with education and training that allows them to understand visual impairment and provide support for goals. The specialized blind rehabilitation database provides a mechanism for coordinated system-wide care, management and data analysis. BRS personnel evaluate and determine best practices for cutting-edge technology that provides blind Veterans and Servicemembers with peak performance.

BRS programs provide a model of care that extends from the Veteran's home to the local VA care site, regional low vision clinics, and lodger and inpatient training programs. Components of the model include the following.

Intermediate and Advanced Low-Vision Clinics
When basic low-vision services available at all VA eye clinics are no longer sufficient, intermediate and advanced low-vision clinics provide clinical examinations, a full spectrum of vision-enhancing devices and specialized training in visual perceptual and visual motor skills as well as ergonomic and environmental enhancements. Eye care specialists and blind rehabilitation specialists work together in interdisciplinary teams to ensure that individuals with low vision are provided with technology and techniques to enhance their remaining sight in the performance of daily activities in order to remain independent and active.

Vision Impairment Service in Outpatient Rehabilitation (VISOR) Programs
VISOR programs provide intense, short-term (about two weeks) outpatient blind rehabilitation. They provide comfortable overnight accommodations for distant patients who require temporary lodging. Those who attend VISOR must be able to perform basic activities of daily living independently, including the ability to self-medicate.

Visual Impairment Services Team (VIST) Coordinators
VIST coordinators are case managers who have responsibility for the information, referral, coordination of services, adjustment counseling and education for severely visually impaired Veterans and active duty Servicemembers and their families. Every VA Medical Center is required to provide a Visual Impairment Service Team to assure that severely disabled blind Veterans are providing all benefits to which they are entitled.

Blind Rehabilitation Outpatient Specialists (BROS)
BROS are multi-skilled professionals who provide direct blind and vision rehabilitation care. BROS serve Veterans in their homes, VA medical centers or clinics, colleges or universities, work sites, and long-term care environments.

Inpatient Blind Rehabilitation Centers (BRC)
The inpatient BRCs provide the most intense and in-depth rehabilitation. Comprehensive, individualized blind rehabilitation services are provided in an inpatient VA medical center environment by a multidisciplinary team of rehabilitation specialists that includes not only blindness professions, but also nursing, social work, psychology and optometry. The management of chronic medical conditions is addressed as part of the training regimen as well. Blind rehabilitation specialists guide the individual through a rehabilitation process that leads to adjustment to blindness, new skill development, use of specialized technology, and reorganization of the person's life. New skills and attitudes foster new abilities to contribute to family and community life.

VA continually improves access to specialized rehabilitation services for Veterans with visual impairment and blindness. Programs include:

- Low vision services to maximize remaining vision – these programs include access to optical and electronic devices that enhance vision.
- Orientation and mobility training to assure that Veterans are able to move safely in their environments, are able to way find using orientation techniques and small

mobile global positioning systems, and are able to travel safely on public transportation.

- Enhanced activities of daily living training to assure that Veterans are able to clean and organize their homes, manage medication and healthcare regimens, manage time effectively, shop, cook, dress, manage finances, and provide care for other family members.
- Cutting edge technology assessment and training for the use of personal computers, tablets and smartphones and their applications, global positioning systems, Braille, speech-output devices, etc.
- Manual skills training that lead to successful abilities to resume leisure activities, home maintenance, carpentry, car repair and maintenance, etc.
- Inpatient transitional rehabilitation programs, focusing on independent living and community re-integration.
- Telehealth assessment, treatment, and monitoring options for Veterans with visual impairment.
- Partnerships with Recreational Therapy so that Veterans may participate in leisure sports and games, as well as competitive sports.
- Partnership with Care Management and Social Work Service to assure that PACT social workers identify, counsel and refer Veterans with visual impairment appropriately.
- Partnerships with Optometry and Ophthalmology to assure that Veterans, whose visual impairment cannot be managed with basic low vision care, are identified and referred for care in BRS programs.
- Partnerships with other programs in VHA national programs to assure standardization in workload reporting, guidance on best practices, devising appropriate medical coding practices, and prosthetic and sensory aids guidelines for emerging technology.

BRS also partners with external agencies to ensure that VA provides world-class care for Veterans with visual impairment and blindness:

- VA blind and vision rehabilitation programs are accredited by the Joint Commission and by the Commission on Accreditation of Rehabilitation Facilities (CARF) – an internationally recognized standard of excellence for rehabilitation programs. CARF accreditation is mandatory for all VA BRS inpatient centers and outpatient clinics.
- In collaboration with the DoD Vision Center of Excellence, BRS staff partner to provide early identification and support case managers to coordinate vision and rehabilitation care services for active duty Servicemembers; and to assess technology gaps for Servicemembers and Veterans with visual impairments and perform a gap analysis for assistive technology.

- BRS staff members serve on a workgroup for the Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP) to develop and deploy a certification in Blindness Assistive Technology.
- BRS and Prosthetics and Sensory Aids Service (PSAS) partner with guide dog training schools to ensure that Veterans who are interested in working with a guide dog are assessed for appropriateness, understand the responsibilities in acquiring and working with a guide dog, and are referred to schools that meet the highest international standards. After referral and procurement, PSAS supports the health and equipment costs of working dog partners.

Spinal Cord Injury and Disorders

The mission and commitment of the VA Spinal Cord Injury & Disorders (SCI/D) System of Care for Veterans with SCI/D is to support and maintain their health, independence, quality of life, and productivity from initial injury or illness through their lifespan. This core of this system of care is 25 SCI/D inpatient care units and its associated SCI specialty outpatient clinics, located in designated VA Medical Centers.

Interdisciplinary teams of professionals specifically trained in the care of SCI/D Veterans provide medical, surgical, rehabilitation, psychosocial, and long term care needs of Veterans with SCI and SCI related disorders. The SCI/D system of care also includes 126 spokes sites that provide specialty primary care utilizing the PACT model and six SCI/D Long Term Care Centers.

While the Veterans with SCI/D are aging, new SCI/D patients are continually added as a result of degenerative disease of the spine, resulting in spinal cord compressions and injuries, falls, and motor vehicle accidents. It is anticipated that the demand for SCI/D Long Term Care beds is also expected to increase, as the population of Veterans with SCI/D being treated by VA is aging.

2015 Accomplishments

- There were many major transitions, initiatives, new processes, and accomplishments in the Spinal Cord Injury/Disorders (SCI/D) System of Care during 2015. The fundamental transition that occurred during 2015 was the move of the SCI/D program office from 10P4 (Policy) to 10NC9 (Operations) in the beginning of the fiscal year. This change required extensive development of new organizational, procedural, business, and communication processes. As part of the transition, a new RN-5 Nurse, Associate Director position was developed in the SCI/D program office.
- During 2015, the PVA site visit processes was revamped and improved. The SCI/D System of Care Program Office (10NC9) is now intimately involved in each step, there is additional clarity and explication of processes, there is direct involvement of problem solving with leadership from SCI Centers, facilities, and VISNs, and there are periodic site-specific and summary reports for the Undersecretary of Health (USH). In 2015, the SCI National Executive Director

leadership team visited and/or provided intensive one-on-one review for five SCI Centers.

- There was continued growth of the SCI Telehealth program in 2015. Also, a national Telehealth workload ranking system for the SCI program was developed. This ranking program is now used to identify barriers, share common solutions to problems, and identify best practices to improve the quality and frequency of virtual health activities in the SCI/D population. In addition, 10NC9 began work on a national memorandum of understanding for SCI telehealth to allow telehealth encounters between all medical centers and CBOCs for the care of Veterans with SCI/D.
- A major focus in 2015 was outreach and access of care to Veterans with SCI/D. A methodology and road map was developed to increase outreach nationally and regionally. Accomplishments during 2015 included development of a clean list of Veterans with SCI/D for each SCI Center and catchment area, identification of Veterans that did not have contact during the previous year, and review of geographic barriers and distances to centers. These ongoing efforts will result in increased access to timely care for Veterans with SCI/D.
- To improve Customer satisfaction (where key stakeholders include Veterans with SCI/D who are or who are not yet enrolled in the VA SCI/D System of Care, Veterans' family, VA SCI/D Center/Hub and Spoke staff, other VACO program offices, Department of Defense, Military hospitals and Veterans Service Organization), a new public SCI/D mail group was created, "VHA NATIONAL SCI/D INTERFACILITY REQUEST," to help facilitate and coordinate transfers and admissions of Veterans with SCI/D within the VA, as well as with non-VA community hospitals. All transfers and admissions are tracked and monitored by the National SCI/D Office.
- VA began identifying measures and benchmarks to measure and improve efficiency and effectiveness of care across the twenty-four Spinal Cord Injury Centers. Work was begun with VHA based resource groups to finalize and implement the measures and needed supporting structure and process.
- We provided individualized consultation and guidance in resolving nursing care and staffing deficiencies and gaps identified through site visits on environmental care issues and surveys conducted by the Paralyzed Veterans of America.

Future Goals (2016-2018)

- Develop a methodology to measure wait times for elective admissions to the SCI/D Centers. This is an important measure for the SCI/D System of Care, because at this time, there is no objective measure of the demand for inpatient SCI/D services.
- Continue to improve care coordination and increase access to VHA SCI/D specialty care throughout the country for Veterans with SCI/D by strengthening the hub and spokes system of care and the SCI PACT care delivery model, and by expanding the SCI/D Telehealth program.

- Develop a benchmarking system for the VA SCI/D centers, utilizing existing administrative and clinical data available in Corporate Data Warehouse (CDW), as a preliminary step to objectively measure quality of care provided at the SCI/D Centers.
- In collaboration with the Office of Nursing Services (ONS), develop a new and effective nurse staffing methodology for SCI/D to ensure safe, quality inpatient care for Veterans admitted to SCI/D inpatient units, and to provide SCI/D nursing support and expertise to the field to facilitate recruitment and retention of high quality SCI/D nurses.
- Utilizing the Geographic Information System (GIS) intern program, GIS technology will be used for outreach, to determine the penetration rate of clinical services for each SCI/D Center, and to quantify unique geographical access issues for Veterans with SCI/D.
- Continue to improve the relationship and partnership with the Paralyzed Veterans of America and improve processes and timeliness of the VA response to PVA Site Visit Reports.
- Establish standard operating procedures for the evaluation, training, and issuance of exoskeleton technologies utilized by Veterans with SCI/D.
- Successfully shutdown the SCI outcomes system, called SCIDO, and develop a new and improved SCI/D outcomes management system that will interface with the CDW and the new medical records system to facilitate quality improvement projects and outreach activities for both the field and the SCI/D national office. Of note, the reason for the shutdown of the SCIDO include non-compliance with ICD 10, privacy and security issues, and the inability to obtain meaningful aggregate data as the result of the system being on 22 different servers.
- Develop solutions for non-institutional care delivery through comprehensive analysis of existing programs, exploration of opportunities to standardize practices, and coordination for consistent Veteran care in the home setting, including the SCI bowel and bladder non VA care program.
- Develop a user-friendly internet website for the VA SCI/D System of Care that focuses on developing content that is relevant to both Veterans with SCI/D who are currently enrolled in the system, as well as those are new to the VA. The internet website is anticipated to be one of the key means of outreach to Veterans with SCI/D who may not know about the SCI/D services that they are eligible to receive.
- Ensure continual improvement and excellence of the VA SCID Centers by maintaining accreditation status with the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission (TJC) for acute care beds in SCI/D regional centers.
- Revise and implement the organizational structure to provide enhanced support and services to the SCI/D Veterans and SCI Centers by updating and developing Positions Descriptions and to recruit appropriately qualified personnel to enhance

the support and consultation from the national office to improve care and services to the SCI/D Veterans.

- Plan, Design, Integrate, Implement, and Evaluate a Comprehensive Performance Improvement (PI) Program for the SCI/D System of Care, by identifying performance measures and benchmarks and to improve efficiency and effectiveness of care across the twenty-four Spinal Cord Injury Centers.
- Establish standard operating procedures for the evaluation, training, and issuance of exoskeleton technologies utilized by Veterans with SCI/D.

Mental Health Care

Mental Health
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$6,851,643	$7,455,017	$7,484,555	$7,715,357	$7,831,890	$7,997,054	$347,335	$165,164

Mental health services and operations ensure timely access to a range of services, from treatment of a variety of common mental health conditions in primary care, to more intensive interventions in specialty mental health programs for more severe and persisting mental health conditions. Specialty services such as evidence-based psychotherapies, intensive outpatient programs, residential rehabilitation treatment, and inpatient care, are available to meet the range of Veterans' needs. It is critical for Veterans to get timely access to mental health services and this is further discussed in the Performance Plan Chapter.

2015 Accomplishments

- VA provided specialized mental health treatment to more than 1.4 million Veterans.
- VA began implementing peer support into primary care through the initiation of pilots at seven sites.
- VA developed a predictive model for suicide that identifies Veterans who are at increased risk for suicide. In collaboration with VA’s Center for Innovation, a contract was awarded to develop practical applications of this model across the VA.
- Related to suicide prevention efforts, gun safety initiatives continued to increase, including a gun safety toolkit that was disseminated to help educate providers and Veterans on the importance of gun safety.
- A mental health staffing model was implemented, incorporating team-based concepts. Teams may be configured as considered by the facility appropriate to meet access and clinical care needs, and accommodate local conditions and sustainability.

- VA's Primary Care-Mental Health Integration (PC-MHI) program, which provides mental health care as a routine component of primary care, is now established in 98.8 percent of VHA divisions, 98.5 percent of the very large and 81.2 percent of large community based outpatient clinics. VHA provided over 1 million PC-MHI encounters in 2015, an increase of 8 percent from 2014 and an increase of 28 percent from 2013.
- Each VA Medical Center hosted a Community Mental Health Summit. This generated mutually-beneficial relationships enhancing mental health care for Veterans and their family members through collaboration between VA and the community.
- Mental Health Mobile—VA Mental Health remains on the leading edge of mobile health with a broad array of mobile apps available in the public and VA app stores to provide self-help and therapy adjunct tools to Veterans working on mental health concerns. New apps in 2015 include Mood Coach and PTSD Family Coach. The original PTSD Coach has now been downloaded more than 200,000 times in more than 90 countries, and during 2015, Israel began working on their country version of the PTSD Coach.
- During 2015, the VA online portal for self-help web-based resources, (http://www.veterantraining.va.gov/), was recognized with several awards, most notably the Federal Government Distance Learning Association 5-Star Award, which recognizes outstanding work in the area of distance learning in the Federal Government. The following courses are available:
    - Moving Forward (www.veterantraining.va.gov/movingforward): an educational and life coaching program that teaches Problem Solving skills to help Veterans better handle life's challenges. It is an interactive program based on the principles of Problem Solving Therapy which allows for anonymous, self-paced, 24-hour-a-day access that can be used independently or in conjunction with mental health treatment.
    - Veteran Parenting (www.veterantraining.va.gov/parenting): a course to help parents learn how to address everyday parenting challenges as well as family issues unique to military families.
    - PTSD Coach Online

      (http://www.ptsd.va.gov/apps/ptsdcoachonline/default.htm): a web-based version of the award winning PTSD Coach, this course is for trauma survivors, their families or anyone coping with stress. It includes tools to help manage anxiety, anger, sleep problems and more.
    - Anger & Irritability Management Skills, an educational interactive course on managing anger effectively was launched during the 2nd quarter of fiscal year 2015.
- Over 1,600 VHA and Vet Center mental health clinicians were trained in one or more evidence-based psychotherapies during 2015.

- In 2015, VHA continued to establish new Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) by opening a new 7-bed PTSD Domiciliary program in Boise, Idaho and a new 65-bed Compensated Work Therapy/Transitional Residence (CWT/TR) in Greater Los Angeles. There also are several programs under current development including SUD residential programs in Atlanta, Anchorage, and Huntington (WV); Domiciliary Care for Homeless Veteran (DCHV) programs in San Juan and West Palm Beach; and general residential programs in Cheyenne and Alexandria. The Pacific Islands Health Care System in Honolulu also has broken ground for a new residential unit for their PTSD residential program. VHA also established a Low Demand/Bridge Housing track within the DCHV program in Greater Los Angeles. At the end of 2015, VHA operated 244 MH RRTP programs with 8,148 beds at 113 VA sites of care.
- The PTSD Consultation Program, launched in 2011 to support VA providers, expanded to make its services available to community providers who treat Veterans with PTSD (http://www.ptsd.va.gov/professional/consult/index.asp). Any provider treating Veterans with PTSD can now request a consultation with experts from the National Center for PTSD on topics such as assessment, evidence-based treatment, medications, clinical management, resources, referrals, education and training opportunities, improving care, and transitioning Veterans to VA care. The expansion specifically helps to support the Veterans Access, Choice, and Accountability Act by enhancing the skills and knowledge of community providers who are treating Veterans with PTSD. The program responded to a total of 1,114 consults in 2015, 192 of them from community providers treating Veterans.
- The Women's Mental Health section developed and implemented an entirely web-based, train-the-trainer workshop in Skills Training in Affective and Interpersonal Regulation (STAIR) therapy. The use of web-cameras allowed for inclusion of elements previously limited to face-to-face trainings, such as live demonstrations, role-playing, training in the non-verbal aspects therapy, and greater cohesion among participants.
- Expansion of the PTSD 101 online electronic training series curriculum to support clinicians treating Veterans with PTSD via ongoing development of courses. In addition, our popular PTSD 101 courses on Practical Assessment of PTSD and functioning were updated to be consistent with DSM-5 and we developed a course on the dissociative subtype of PTSD to reflect the addition of this subtype in DSM-5.
- "Assessment and Treatment of Sleep Problems in PTSD", an online five-module course for VA and community providers was released. The course offers information on both pharmacological and cognitive behavioral interventions for Veterans and active duty Servicemembers with PTSD who are seeking help for sleep problems. The course helps providers learn about the most effective strategies for treating sleep problems and discourages use of ineffective treatments and potentially dangerous use of medications.

- The annual PTSD Awareness campaign expanded in 2015, with the National Center for PTSD collaborating with over 100 organizations and departments to implement a national online and networking campaign to promote raising PTSD awareness centered on the theme of "PTSD Awareness - Learn. Connect. Share.", with social media outreach as a main focus.
- In May 2015 the National PTSD Brain Bank began enrollment of potential post-mortem donors (http://www.research.va.gov/programs/tissue_banking/PTSD/default.cfm). As of September 2015, 8 Veterans had volunteered to be followed over their lifetime, another 25 were in process, and an additional 40 had indicated interest. The bank's inventory included 50 PTSD and comparison tissue specimens. This brain bank will enable VA to lead the nation in unique research that will facilitate deeper understanding of the causes and consequences of PTSD as well as assessment and treatment. These efforts are a key aspect of VA's response to National Research Action Plan, which was created in response to the President's 2012 Executive Order on Service member and Veterans' mental health.

2016 –2018 Future goals

- Incorporate innovations in mental health care by providing a clear menu of evidence-based treatment choices, enhancing Primary Care Mental Health Integration in Patient Aligned Care Teams, providing self-care and self-management resources, and fully implementing a patient-centered, recovery-oriented model of care.
- Continue full implementation of the VA/DoD Clinical Practice Guideline for Suicide Prevention across VA. The VA/DoD Clinical Practice Guideline will help those within VA best provide care to Veterans who may be at risk for suicide.
- Advance further gun safety initiatives in collaboration with Veterans Service Organizations (VSOs) and firearm associations by developing training on firearm safety for Veterans and the public.
- Complete and disseminate a dashboard of Veterans who have been found to be at heightened risk for suicide through predictive modeling. Engage all appropriate VA providers in following up with these Veterans through targeted interventions.
- Increase training of Operation SAVE, VA's gatekeeper training for suicide prevention, to include all of VHA, VBA, NCA, and VACO. Provide yearly Operation SAVE training.
- Launch the second generation of Mental Health Outcome Oriented Quality Metrics to include measures of patient satisfaction, function, and symptom monitoring as part of the overall strategy to develop a measurement-based system of mental health care.
- Support measurement-based care in mental health by completing development and release of the MH PRO mobile app, currently a joint project with the Connected Health Office, for the purpose of assigning Patient Reported Outcome Measures

(PROM) to Veterans engaged in mental health, to be completed via a mobile web or smart phone.

- Complete development and release of phase I of the MH Quality and Clinical Outcomes Reporting System, a comprehensive tracking system that will allow providers to track the flow of their patients through mental health care and monitor their outcomes with standardized PROM's. Continue the expansion of peer support services into Primary Care beyond the initial seven pilot sites, as per the President's August 2014 Executive Order.
- Expand the use of Telemental Health services and support the VISNs in their implementation of the Telemental Health Strategic Plan.
- Work with VA medical centers as they complete all of the items in their After Action Reports from the 2015 Community Mental Health Summits and provide technical support for additional local summits that are planned.
- Improve the understanding of military culture among healthcare professionals through the continued dissemination of the VA/DoD web-based training curriculum, Military Culture: Core Competencies for Healthcare Professionals. Nearly 3000 providers completed at least one module of the course during 2015.
- Work with VISNs and VA Medical Centers to ensure appropriate geographic distribution and availability of residential treatment in order to ensure timely access for men and women Veterans presenting with mental health and substance use disorders. These efforts will incorporate information from new projection models developed in collaboration with the Office of Policy and Planning.
- Launch the first publically available online treatment decision aid for Veterans with PTSD. This tool is designed to help patients learn about effective PTSD treatments and engage in shared decision-making with their provider. The decision aid features interactive media that allow users to create a customizable grid to compare treatment options and to generate an individualized summary of their symptoms, goals, and treatment preferences to share with their provider.
- Release self-help web-based programs for Veterans with PTSD, one on STAIR (Skills Training in Affective and Interpersonal Regulation) Therapy.
- Launch an online course to train providers in the use of the Clinician Administered PTSD Scale for DSM-5 (CAPS-5), the "gold standard" for PTSD assessment and diagnosis. The course will include branching video vignettes that will help learners develop a comprehensive understanding of CAPS-5 administration and scoring.
- Continue interagency efforts to improve mental health care for Servicemembers and Veterans. In 2014, Administration announced a Cross-Agency Priority Goal (CAPG) and 19 new executive actions that the Departments of Veterans Affairs (VA) and Defense (DoD) are taking to improve the mental health of Servicemembers, Veterans and their families. These initiatives build on the actions the Departments have taken in response to the President's 2012 Executive Order on Servicemembers, Veterans and their families' mental health. They are focused

on reducing barriers to mental health care, improving access to high quality care, supporting innovative research and promoting safety.

- Pursue collaborative partnerships with the private sector that will enhance and complement VA's efforts to improve Veterans' mental health
- Continue outreach efforts to increase awareness of mental health services and resources, reduce negative perceptions about seeking mental health care, and improve mental health literacy among Veterans and their loved ones.

Overview of Mental Health Services in VHA

		2016		2017		2018		
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Treatment Modality ($000):								
VA Inpatient Hospital	$1,405,817	$1,386,655	$1,421,492	$1,320,305	$1,343,666	$1,219,397	($77,826)	($124,269)
Contract Inpatient Hospital	$372,830	$480,948	$426,062	$527,189	$481,387	$523,041	$55,325	$41,654
Psychiatric Res. Rehab. Trmt	$296,479	$337,424	$310,219	$339,523	$311,001	$302,106	$782	($8,895)
VA Dom. Residential Rehab. Trmt	$475,769	$550,877	$498,698	$557,807	$493,061	$470,844	($5,637)	($22,217)
VA Outpatient Clinics	$3,945,981	$4,515,445	$4,431,850	$4,768,326	$4,779,243	$5,025,573	$347,393	$246,330
Non-VA Outpatient	$44,421	$39,988	$52,345	$42,961	$61,324	$69,617	$8,979	$8,293
Suicide Prevention Outreach	$117,181	$143,680	$148,380	$159,246	$164,305	$186,128	$15,925	$21,823
VA - Mental Health in non MH Setting	$193,165	$235,248	$195,510	$250,085	$197,903	$200,348	$2,393	$2,445
Total	$6,851,643	$7,690,265	$7,484,556	$7,965,442	$7,831,890	$7,997,054	$347,334	$165,164
Major Characteristics of Program ($000):								
SMI - PTSD	$351,270	$381,182	$359,671	$392,898	$368,755	$378,809	$9,084	$10,054
SMI - Substance Abuse	$550,811	$612,277	$557,925	$623,840	$566,506	$576,784	$8,581	$10,278
SMI - Other Than PTSD & SA	$4,397,786	$4,798,907	$4,698,302	$5,144,143	$5,022,207	$5,363,078	$323,905	$340,871
Subtotal, SMI	$5,299,867	$5,792,366	$5,615,898	$6,160,881	$5,957,468	$6,318,671	$341,570	$361,203
Suicide Prevention Outreach	$117,181	$143,680	$148,380	$159,246	$164,305	$186,128	$15,925	$21,823
Other Mental Health (Non-SMI)	$1,434,595	$1,754,219	$1,720,277	$1,645,315	$1,710,117	$1,492,255	($10,160)	($217,862)
Total Mental Health	$6,851,643	$7,690,265	$7,484,555	$7,965,442	$7,831,890	$7,997,054	$347,335	$165,164
Included Above:								
OEF/OIF/OND POPULATION *ONLY*:								
SMI - PTSD	$137,073	$161,339	$149,018	$173,578	$158,918	$167,691	$9,900	$8,773
SMI - Substance Abuse	$107,658	$134,959	$120,936	$148,438	$131,744	$141,074	$10,808	$9,330
SMI - Other Than PTSD & SA	$718,861	$796,929	$802,715	$881,641	$890,318	$975,899	$87,603	$85,581
Subtotal, SMI	$963,592	$1,093,227	$1,072,669	$1,203,657	$1,180,980	$1,284,664	$108,311	$103,684
Other Mental Health (Non-SMI)	$232,899	$262,396	$257,507	$286,902	$279,067	$299,945	$21,560	$20,878
Total OEF/OIF/OND	$1,196,491	$1,355,623	$1,330,176	$1,490,559	$1,460,047	$1,584,609	$129,871	$124,562
Average Daily Census:								
Acute Psychiatry	2,513	2,474	2,428	2,435	2,356	2,281	(72)	(75)
Contract Hospital (Psych)	462	421	533	437	598	665	65	67
Psy Residential Rehab	1,926	2,123	1,915	2,181	1,900	1,892	(15)	(8)
Dom Residential Rehab	4,410	4,469	4,385	4,489	4,350	4,331	(35)	(19)
Total	9,311	9,487	9,261	9,542	9,204	9,169	(57)	(35)
Outpatient Visits / Encounters:								
VA Care - Mental Health	12,918,336	12,713,687	13,487,534	13,049,600	13,979,398	14,491,899	491,864	512,501
Non-VA Care - Mental Health	353,609	281,779	375,628	292,131	438,538	399,948	62,910	(38,590)
Not Included Above:								
VA - Mental Health in non MH Setting	883,660	1,056,979	1,005,598	1,157,848	1,118,621	1,223,719	113,023	105,098

Mental Health in VA Central Office has two components:

- Mental Health Services (MHS) resides in the Office of Patient Care Services, is responsible for providing clinical policies and national guidance for mental health programs, and defines the vision of mental health care for VA.
- Office of Mental Health Operations (OMHO) in Operations and Management is responsible for ensuring that these policies developed by and with MHS are implemented in order to guide the development, enhancement, and sustainment of mental health programs throughout the VA health care system.

MHS and OMHO collaborate to ensure the availability of a range of services, from treatment of a variety of common mental health conditions in primary care to treatment in specialty mental health programs for conditions requiring more specialized intensive intervention, including the most severe and persisting mental health conditions. A continuum of primary and specialty care services including evidence-based psychotherapies, intensive outpatient programs, residential rehabilitation treatment, and inpatient care is available to meet the range of needs that Veterans have.

MHS developed the recommendations of the VHA Comprehensive Mental Health Strategic Plan (MHSP), implemented beginning in 2005 and completed in 2009. MHS then designed national requirements for mental health programs, reflected in VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (UMHSH), published in September 2008. Further, and more recently, in support of broad VHA, Patient Care Service and VISN Network Operation initiatives, MHS has been actively involved in the development of PACT and has been working collaboratively with the National Center for Prevention to improve and maintain the health of populations of Veterans treated in VA primary and specialty care. All of this work was further enhanced and facilitated by the Department's major initiative to *Improve Veterans Mental Health (IVMH)* as outlined in VA's 2011-2015 Strategic Plan Refresh. VA's commitment to IVMH was tracked through the Major Initiative monthly reporting process during 2011 and 2012, and through the routine reporting processes in MHS beginning in 2013.

OMHO is the operational partner to MHS, with particular responsibility to work directly with the VISNs and medical facilities to monitor and support full implementation of policies defining required mental health services in VA. OMHO provides consultation and support regarding clinical care, program evaluation, and technical assistance. Clinical care components include the Veterans Crisis Line, the Therapeutic and Supported Employment program, and the National Clozapine Center. Two core responsibilities for OMHO include responsibility for the ongoing monitoring of mental health programs and services throughout VA (evaluation), and working with VISNs and facilities to ensure that relevant policy requirements are met and that unnecessary variability between programs is minimized (technical assistance). These two components often overlap and are carefully coordinated within the office. For example, the Technical Assistance component helps to monitor programs through site visits, and the Program Evaluation component provides

technical assistance to help VISNs and facilities respond to analytic findings. These two components are described in greater detail later in this section.

The guiding principles/goals of VA mental health services are:

- Veteran-centric care
- A recovery/rehabilitation orientation to health care
- Evidence-based practices in the delivery of care
- Maximizing access to care across clinical sites of care
- Decrease stigma associated with mental health treatment
- Improve the health of Veterans through the PACT
- Increase use of technology to facilitate care
- Expand partnerships with other government agencies and communities

These concepts are consistent with VA's Core Values: Integrity, Commitment, Advocacy, Respect and Excellence ("I CARE") and with the Blueprint for Excellence, and they are operationalized in the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook.

VA continues to work closely with the Department of Defense (DoD) and the Department of Health and Human Services (HHS) to implement the President's Executive Order (E.O.) 13625, "Improve Access to Mental Health Services for Veterans, Service Members, and Military Families," signed on August 31, 2012. The executive order reaffirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The Executive Order strengthens suicide prevention efforts, supports recovery-oriented mental health services through peer counseling, and supports VA in using a variety of recruitment strategies to assist in hiring qualified mental health personnel. In addition, VA is partnering with DoD and HHS to carry out the 2014 Cross Agency Priority Goal (CAP Goal) on Servicemember and Veteran mental health, and 19 new Executive Actions announced by the President in August 2014. The CAP Goal focuses on improving access and reducing barriers to mental health care and on supporting innovative research on posttraumatic stress disorder and suicide prevention. The new Executive Actions include activities that will: (1) improve Servicemembers' transition from DoD to VA and civilian health care providers; (2) improve access and quality of mental health care at DoD and VA; (3) improve treatments for mental health conditions; (4) raise awareness about mental health and encouraging individuals to seek help; (5) improve patient safety and suicide prevention; and (6) strengthen community resources for Servicemembers, Veterans and their families.

VHA has developed and implemented an aggressive recruiting and marketing effort to fill vacancies in mental health care occupations. This effort includes the following actions: working directly with mental health provider associations and training programs, conducting numerous media advertising efforts, developing a professional recruitment contract, and using incentives such as pay flexibilities and loan repayment to promote hiring of mental health professionals. Additionally, VA partners with the National Rural

Recruitment and Retention Network for outreach to difficult-to-recruit areas and is partnering with HHS to collaborate on pilots that increase access to underserved areas.

More specific information is provided on the following pages about a number of VHA's key programs in mental health. The first section below describes programs that are based in specific clinical settings, the second focuses on the needs of specific Veteran patient sub-populations, and the third section provides information on programs that cut across clinical settings and populations to enhance the health and mental health of all Veterans:

Mental Health Care Provided in Specific Clinical Settings

Mental Health Integrated in Patient Alignment Care Teams (PACTs): The UMHSH requires that integrated mental health services operate in PACTs in primary care clinics in VA medical centers and large CBOCs. Integrated mental health services utilize evidence-based practices that blend together both co-located collaborative care and care management components. The co-located collaborative care component involves one or more mental health professionals who are integral members of the primary care team, providing assessment and psychosocial treatment as needed for a variety of mental health problems, including depression, PTSD, problem drinking, anxiety, and other mental disorders. The care management component is based on the Behavioral Health Laboratory, the Translating Initiatives for Depression into Effective Solutions (TIDES) program, or other evidence-based strategies; it includes monitoring adherence to treatment, ongoing evaluations of treatment outcomes and medication side effects, decision support, patient education and activation, and assistance in referral to specialty mental health services when needed. Integrated mental health services are core components of the PACT model, alongside Health Behavior Coordinators to support Health Promotion/Disease Prevention activities.

General Mental Health Services: VA supports the availability of general outpatient mental health services for the broad range of conditions Veterans may experience (such as depression, anxiety, PTSD, psychosis, and other disorders). General mental health outpatient services are available on-site in every medical center and all CBOCs with greater than 1,500 unique Veterans. Smaller CBOCs must develop strategies to ensure such services can be delivered to all eligible Veterans in their patient case load who need such care. VA Telemental Health services are available to supplement services provided by the CBOC staff. For those Veterans whose mental health problems cannot be adequately managed in primary care clinics and general outpatient mental health clinics, an array of specialized programs are available, as detailed below.

Intensive, Recovery-Oriented Programs: Day Treatment and Day Hospital programs, which historically provided few rehabilitative services, have been replaced by recovery-oriented Psychosocial Rehabilitation and Recovery Centers (PRRC), which provide individual and group treatments designed to help Veterans learn the life skills, coping skills, and interpersonal skills required for meaningful community integration. Additionally, VA facilities with more than 1,500 Veterans on the National Psychosis Registry must develop a PRRC to meet the needs of these Veterans. As of the end of December 2015, there were 102 VA Central Office-funded, formally designated PRRCs,

and others are under development. PRRCs must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Currently, all PRRCs are CARF-accredited, and all received full three-year accreditation. Program evaluation efforts in collaboration with the Northeast Program Evaluation Center (NEPEC) have commenced.

With the expansion of peer support positions nationwide in 2013 and 2014, in accordance with E.O. 13625, the VA Mental Health program requires the use of certified peer specialists in the provision of treatment services. Veterans who are currently confronting a serious mental illness may be more willing to seek treatment and to share their experiences when they share a common bond of duty, honor, and service with the provider. Peers can be found in a wide variety of mental health programs, including inpatient mental health units, PRRCs, Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs), and substance use disorder programs. With at least two certified Peer Specialists at each medical center and at each very large CBOC, this hiring initiative not only improves existing services to Veterans but is a positive employment opportunity for Veterans who have mental health conditions to become successfully employed in meaningful and well-paying jobs. Many newly hired peer support staff began in apprentice roles and attended certification training paid for by VHA under a contract with the Depression and Bipolar Support Alliance (DBSA) or Recovery Innovations (RI). In 2015, peer support expanded into Primary Care through the development of pilot sites authorized by an August 2014 Executive Action.

Mental Health Intensive Case Management (MHICM) and Rural Access Network for Growth Enhancement (RANGE): MHICM and RANGE programs have been established to provide treatment to Veterans who have a diagnosis of a serious mental illness and need intensive support to avoid or decrease utilization of inpatient mental health services and to support an effective community-based life for these Veterans. These programs are based on the successful, evidence-based Assertive Community Treatment programs. Increasing the incorporation of psychosocial rehabilitation and recovery-oriented values and practices on these teams is a major priority in the coming year. MHICM teams primarily serve urban and suburban Veterans in larger market areas, and RANGE serves Veterans in rural and small market areas. There are 112 MHICM teams serving over 8,000 Veterans with serious mental illness. A newer program, RANGE has expanded MHICM level care to rural areas and areas where the population density has been too sparse to be served by conventional MHICM programs. There are now 37 RANGE programs serving over 900 Veterans.

Inpatient Care: Inpatient mental health services are available for Veterans who need this level of care for safety, such as in the case of suicidal or homicidal patients, or stabilization for patients with acute episodes of psychosis or other severe conditions. The Inpatient Mental Health Handbook (1160.06) was published at the end of 2013 and was designed to fully incorporate recovery-oriented principles and practices into this setting and level of care. Facilities are developing recovery-oriented programming into their inpatient care programs to facilitate seamless programming as patients move through levels of care. This initiative is part of ongoing efforts to improve the care provided in the inpatient mental health setting; reduce lengths of stay, particularly for longer-term

hospitalizations; reduce admissions and readmissions; and improve patient engagement in outpatient care. A continuum of care upon discharge is offered to include transition from inpatient to residential care, MHICM, general or specialty ambulatory services, and other care modalities as appropriate to support safety, stabilization, and recovery. Additionally, facilities are being encouraged to incorporate design elements within their inpatient units to create warm, healing, and safe environments of care that promote patient and staff engagement and interaction. In 2015, VA provided over 924,000 inpatient mental health Bed Days of Care (BDOC) to over 59,000 Veterans and had an average daily census (ADC) of over 2,500 Veterans.

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP): The mission of MH RRTP is to provide state-of-the-art, high-quality 24-hours-per-day, 7 days-per-week (24/7) structured and supervised residential rehabilitation and treatment services for Veterans with complex mental health and substance use disorder treatment needs as well as co-occurring medical conditions and other psychosocial needs including homelessness. MH RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration while providing specific treatment and services for mental health and substance use disorders and homelessness. Currently, VHA operates 244 MH RRTPs at 113 VA sites of care with a total of 8,148 operational beds located across all VISNs. This includes programs providing specialized treatment for PTSD (42 programs), substance use disorders (63 programs), and for Veterans who are homeless (47 programs). As an organization, VHA is working diligently to provide a consistently high level of residential rehabilitation and treatment for all Veterans, including those classified as special populations, by continuously aiming to improve and enhance services.

Population-Specific Approaches to Care

Specialized PTSD: PTSD is a mental disorder that can occur following potentially life-threatening trauma, including combat or Military Sexual Trauma (MST). Symptoms can include reliving the experience through nightmares and flashbacks; increased arousal and difficulty sleeping; and feeling numb, detached, or estranged. These symptoms can be severe and persistent enough to impair daily life, with difficulties that include marital problems, divorce, difficulties in parenting, and occupational instability. PTSD frequently occurs in conjunction with related problems such as depression, substance use disorder, problems with memory and cognition, and other physical and mental health challenges. Although it can be an acute condition, it is often episodic, recurrent, or chronic.

Of those who have sought VA health care, slightly more than half of returning OEF/OIF/OND Veterans with a mental health condition have been diagnosed with PTSD, either by itself or in association with another problem. PTSD represents the most common, but by no means the only, mental health condition among returning OEF/OIF/OND Veterans. To address the needs of returning Veterans, VA has established post deployment services in most medical centers that provide mental health assessment and treatment services as well as other components of care. Serving Returning Veterans – Mental Health (SeRV-MH) Teams are specifically designed to meet the unique needs of returning combat Veterans and work in collaboration with Primary Care Post Deployment

Health Clinics to provide care in a setting that minimizes the potential stigma that may be associated with treatment in an identified mental health clinic.

To provide a continuum of care to match the needs of Veterans with PTSD, VA maintains an array of treatment sites and services to help Veterans gain mastery over their PTSD symptoms and to improve their social and occupational functioning. VA operates specialized programs for the treatment of PTSD in each of its medical centers. These programs provide a continuum of care, from outpatient PTSD Clinical Teams and specialists through specialized inpatient units, brief-treatment units, and residential rehabilitation treatment programs around the country. Every VA medical center possesses outpatient PTSD specialty capability and Addictions Specialists are associated with these PTSD services. In accordance with the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook, PTSD services are also provided in CBOCs. VA's programs are designed to deliver evidence-based treatments including specific forms of behavioral and cognitive-behavioral psychotherapy and pharmacotherapy. For those who experience recurring or persistent symptoms in spite of evidence-based therapies, VA offers a range of recovery-oriented services that focus on improving day-to-day functioning. VA is addressing the need for concurrent and integrated treatment for disorders that commonly co-occur with PTSD, such as substance use disorders and traumatic brain injury. VA consensus conferences based on thorough literature reviews support the efficacy of concurrent treatment of PTSD and these co-occurring disorders, following the guidance of the VA/DoD Clinical Practice Guideline. VA also supports research on new treatments including Complementary and Alternative Medicine approaches and innovative strategies for delivering care.

<u>Substance Use Disorders (SUD)</u>: Misuse of substances is associated with a variety of adverse effects across the various dimensions of life functioning, including physical health and mental health along with occupational and social functioning. Despite their potential for causing grave harm to individuals with the condition and those near them, substance use disorders are generally treatable with evidence-based psychosocial and pharmacological interventions.

Within the Veteran population, unhealthy drinking and other forms of substance misuse occur in forms that vary in frequency and severity. The most common and uncomplicated cases are best identified and treated in primary care and other general medical settings through programs that include screening, brief interventions, collaborative care within those settings and referral to specialty programs as needed. When these problems occur in the presence of other mental health conditions, they can be treated in various mental health clinic settings that provide integrated care for the co-occurring conditions. In recognition of this principle, VA has incorporated substance use disorder treatment specialists into the PTSD treatment teams in each medical center to facilitate integrated care for both disorders. More severe problems with substance misuse are typically treated in residential or outpatient specialty care programs. Services in the programs vary from intensive residential care or multiple sessions of outpatient treatment several times per week, to less frequent ambulatory care visits. Monitoring response to treatment and

sustaining patient improvement following initial stabilization are important components of the continuum of care.

Treatment for alcohol and other substance use disorders recognizes the principle that these are often chronic or recurring conditions. For some Veterans, treatment begins with medically-supervised detoxification provided in ambulatory or inpatient settings. However, for care to be effective over the long term, detoxification and initial stabilization must be followed by continuing care using evidence-based psychosocial and/or pharmacological treatments. Evidence-based medication-assisted treatment for opioid dependence, including buprenorphine, has expanded to 167 locations that served at least 10 patients and an additional 139 CBOCs or other locations that had at least some active buprenorphine treatment.

Other components of effective treatment for alcohol and other substance use disorders include rehabilitative services focusing on day-to-day functioning and maintenance treatments focusing on preventing relapse. Relapse prevention involves ongoing monitoring for any substance use or emerging relapse risk factors using standardized brief assessments that are available as part of the electronic health record and being implemented in substance use disorder specialty care programs.

Services for Veterans with Serious Mental Illness (SMI): VA Mental Health is committed to transforming mental health services to follow a recovery orientation, providing services that will help Veterans with serious mental illness fulfill their personal goals and live meaningful lives in a community of their choice. To that end, Local Recovery Coordinators (LRC) have been deployed at VA facilities throughout the country. They have been instrumental in facilitating the transition of mental health services to a recovery orientation through education of staff and Veterans, the development of peer support programs and through involvement in facility- and VISN-level committees and task forces. LRCs have broadened their reach to include inpatient settings, in order to promote the expansion of recovery-oriented services along the entire continuum of care. In addition, LRCs are the Points of Contact (POC) for a new program designed to re-engage Veterans with serious mental illness in treatment (described below).

The transformation to a recovery orientation cannot be accomplished without the involvement of Veterans, their family members, and stakeholder groups. VA Mental Health encourages the development of Veterans Mental Health Councils, operated independently from VHA, to provide input into mental health programming from the Veterans' perspective and maintain contact with outside mental health and Veteran constituency groups (e.g., National Alliance on Mental Illness (NAMI), Depression and Bipolar Support Alliance (DBSA), Veterans Service Organizations (VSOs), professional organizations) to both solicit and provide information about mental health services for Veterans.

Work is a fundamental component of recovery; therefore, VA has significantly expanded its Compensated Work Therapy (CWT) programs. In particular, Supported Employment has been deployed throughout VA facilities and focuses on helping Veterans with serious

mental illness find meaningful, competitive work. In addition, partnering with families is an essential component of VA mental health services. Consistent with a recovery philosophy, flexibility is a key principle when involving families in care. Services must be tailored to the Veteran's phase of illness, symptom level, self-sufficiency, family constellation, and preferences. When family services are a necessary part of the Veteran's treatment plan, VA offers a continuum of family services to meet varying needs including family education/training, consultation, and marriage and family counseling. National training programs in several evidence-based practices for marital and family counseling are available for clinicians.

In support of Veterans with SMI, the UMHSH requires that clozapine be available to all eligible Veterans. Clozapine is the most efficacious medication available for the treatment of schizophrenia, and it is the only medication proven to reduce the suicidality of patients with schizophrenia. However, there is a one-to-two percent risk of clozapine-induced agranulocytosis that is fatal, if not treated. The FDA has mandated that all patients receiving clozapine enroll in a national clozapine registry to monitor Absolute Granulocyte Counts. The VA National Clozapine Coordinating Center (NCCC) fulfills this FDA mandate in a manner that is safe, provider- and patient-friendly, and cost effective. NCCC also serves as a nationally accessible medical consulting resource for all VA clozapine providers.

Women's Mental Health: VHA offers a full continuum of mental health services to women Veterans, including general outpatient, specialty, inpatient and residential treatment options. Evidence suggests that women Veterans may differ from men in the prevalence and expression of certain mental health disorders, and their responses to treatment. VA policy requires that mental health services be provided in a manner that recognizes that gender-specific issues can be important components of care. For example, all VHA facilities must ensure that outpatient and residential programs have environments that can accommodate and support women with safety, privacy, dignity, and respect. Some specialty care programs that target problems such as PTSD, substance use, depression, and homelessness, include women-only services (e.g., women-only groups). Many facilities provide this care through specialized women-only outpatient treatment teams. For those in need of more intense treatment, many facilities offer MH RRTPs and nationally there are women-only programs that specialize in women's care and MST-specific treatment.

Mental Health Services has developed targeted educational resources for VA providers who care for women Veterans. For example: Women's Mental Health maintains an active collaboration with the author of an evidence-based therapy for women with emotional dysregulation and interpersonal problems, which are common in chronic and complicated forms of PTSD. This partnership has yielded two, entirely web-based advanced clinical training programs: The advanced Didactic and Case Consultation Workshop in Skills Training in Affective and Interpersonal Regulation (STAIR) and train-the-trainer workshop that uses web cameras to facilitate live demonstrations, role playing exercises, and real time feedback as participants practice new skills and techniques. The Women's Mental Health monthly teleconference training series offers didactic seminars on key topics and best practices in the provision of women's mental health services. These calls

are attended, on average, by over 200 VA providers. The Women's Mental Health SharePoint makes up-to-date information and treatment resources readily available to VA providers. Finally, in collaboration with Women's Health Services, a clinical training curriculum on reproductive mental health has been developed and disseminated to the field.

Mental Health Programs for Older Veterans: VHA has implemented several programs designed to promote mental health care access and treatment for older Veterans. These initiatives incorporate innovative and evidence-based mental health care practices, as well as person- and family-centered care approaches. A full-time mental health provider is an integrated member of every VA Home Based Primary Care (HBPC) team, to promote access to integrated mental health services for mostly older, homebound Veterans. HBPC mental health providers collaborate with the interdisciplinary team to meet behavioral and mental health needs of the population, by providing mental health and cognitive/capacity evaluation services; individual and family psychotherapy; behavioral interventions for problems such as sleep disturbance, chronic pain, and disability; caregiver interventions; team consultation and training; and prevention-oriented services. VHA has also integrated mental health providers in VA Community Living Centers (CLCs) to provide a full range of assessment and treatment services, with specific focus on promoting the delivery of evidence-based psychosocial services to manage challenging behaviors associated with dementia and mental illness. VHA has expanded the implementation of STAR-VA, adapted from the evidence-based Staff Training in Assisted Living Residences (STAR) protocol. STAR-VA is a psychosocial intervention for managing challenging behaviors associated with dementia in CLC residents. Beginning with the pilot program in 2010, and expanded implementation in 2013, 2014, and 2015, a total 68 CLCs have participated in STAR-VA training to date. Evaluation results indicate significant reductions in the frequency and severity of challenging dementia-related behaviors, as well as reductions in symptoms of depression and anxiety.

Programs that Cut Across Settings and Populations

Mental Health Outreach: VA Mental Health programs engage in numerous, widespread outreach efforts to improve access to care and to reduce the stigma associated with seeking mental health care, as documented in an October 2011, Government Accountability Office's (GAO) report titled "*VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*". These efforts are too numerous to list here, but they include some specific programs deserving special attention: two specific public messaging campaigns, a program to re-engage Veterans with SMI in treatment, and a college campus outreach initiative.

- **The Veterans Crisis Line** is a toll-free, confidential resource that connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs (VA) responders. Veterans and their loved ones can call 800-273-8255 and Press 1, text to 838255, or chat online at www.VeteransCrisisLine.net to receive free, confidential support 24 hours a day, 7 days a week, throughout the year, even if they are not registered with VA or enrolled in VA health care. The online chat function and a new texting option reflect efforts to

improve access to care for Veterans of all eras of service through alternative modes of communication. In 2015, VA continued its national public information campaign to help promote the Veterans Crisis Line and suicide prevention. The campaign, entitled “The Power of One”, focuses on the idea that one small act (one conversation, one call, one person) can make a significant difference in a Veteran’s life. The Suicide Prevention Coordinators at each VA medical center also engage in significant outreach efforts within their local communities.

- **Make the Connection** is an award-winning, national mental health public awareness campaign that launched in November 2011. The goals of the campaign are to reduce the stigma that Veterans and their families associate with seeking mental health care, to educate Veterans and their families about signs and symptoms of mental health issues, to increase awareness of and trust in VA’s advances in mental health services, and to promote a positive view of Veterans’ unique strengths to the American public. Make the Connection utilizes traditional media (radio and television), internet, and social media (e.g. Facebook and YouTube) to reach as many Veterans as possible. At the heart of the campaign is a comprehensive, interactive website (www.maketheconnection.net) where Veterans and their friends and families can confidentially and easily connect with information and services that are most relevant to their own experiences and needs. The website features extensive videos of dozens of Veterans who share their personal stories of facing life events, experiences, physical injuries or psychological symptoms, and overcoming a wide variety of challenges. To reach as many Veterans as possible with the Veterans Crisis Line (Power of One) and Make the Connection public outreach campaigns, VA is coordinating with communities and partner groups nationwide, including community-based organizations, Veteran Service Organizations, and local health care providers, to let Veterans and their loved ones know that support is available whenever, if ever, they need it. A specific effort focused on increasing awareness of PTSD, “About Face” (http://www.ptsd.va.gov/apps/AboutFace/) has also been developed by the National Center for PTSD and fully complements the messages and strategies of Make the Connection.

- **The SMI Re-engagement Program** is designed to re-engage in-treatment Veterans with serious mental illness who at one time received care from VHA but who have been lost to follow-up care. Based on findings from a project by the Office of the Medical Inspector (OMI), this program utilizes the resources of the Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) to identify such Veterans with SMI who have been lost to follow-up care. The OMI project documented that such Veterans are at a markedly increased risk of mortality unless reconnected with care. The lists of these Veterans are disseminated to the Local Recovery Coordinators (LRC) at the facility where the Veteran was last seen, and the LRC attempts to locate the Veterans and re-engage them in treatment. This program was implemented nationally in 2012, with initial efforts targeting those Veterans most at risk for mortality. Subsequent efforts are focusing on re-engaging all Veterans with serious mental illness who have been

lost to follow-up care since the end of the OMI project and will expand to identify such Veterans in as close to real time as possible. To date, over 500 Veterans have been successfully returned to care.

- **The Veterans Integration to Academic Leadership (VITAL) Initiative** is an outreach partnership between VA and community colleges, colleges, and universities. Veterans bring unique resources to these settings, as well as face a variety of challenges. The purpose of this initiative is to build resilience and leadership in Veterans on campus, facilitate adjustment to and success in academic life, and increase access to high quality health and mental health resources for those Veterans who need them. The goal of the VITAL initiative is to provide support for projects that increase access to Veteran-centric, results-oriented, forward-looking services for Veterans on college and university campuses.

Suicide Prevention: VA's suicide prevention activities are built upon the principle that prevention requires ready access to high-quality mental health care and other services. This requires outreach, educational, and assessment programs designed to help individuals seek care when needed, and programs designed to address the specific needs of those at high-risk for suicide.

The suicide prevention program includes specific outreach activities and clinical programs for addressing high-risk and potentially high-risk patients, including the Veterans Crisis Line (discussed above) and Veterans Chat and Text service; Suicide Prevention Coordinators and their teams in each medical center and large community-based outpatient clinic; the VA National Suicide Prevention Office; the Center of Excellence for Suicide Prevention in Canandaigua, NY; the Mental Illness Research Education and Clinical Center in Denver, CO; the Serious Mental Illness Treatment Resource and Evaluation Center in Ann Arbor, MI; demonstration projects; and national public information campaigns. Enhanced care packages have been developed for those Veterans who have been identified as being high-risk for suicide. In addition, a wide range of tracking and reporting mechanisms have been established, including the joint VA/DoD Suicide Data Repository. Also, the VA/DoD Clinical Practice Guidelines on the Assessment and Management of Patients at Risk for Suicide have been disseminated throughout the VA system to help inform how to best manage Veterans who may be at high risk for suicidal behavior.

Evidence-Based Psychotherapies (EBPs): VA is working intensively to make a broad array of EBPs for PTSD, depression, SMI, relationship distress, substance use, and behavioral health conditions (e.g., insomnia and pain) widely available to Veterans who can benefit from them. Many of these EBPs are considered to be first line treatments in VA/DOD and other respected clinical practice guidelines. UMHSH requires that all facilities have the capacity to provide a variety of EBPs. VA is nationally implementing training to ensure an adequate workforce able to deliver the following EBPs with full competence: Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE) for PTSD, and Cognitive Behavioral Conjoint Therapy for PTSD; Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy, and Interpersonal Psychotherapy

for depression; Behavioral Family Therapy (BFT) and Social Skills Training for SMI; Integrative Behavioral Couples Therapy (IBCT) for relationship distress; Motivational Enhancement Therapy, and Contingency Management for substance use disorders; Motivational Interviewing (MI) for promoting behavioral change and treatment adherence; CBT for insomnia; and CBT for chronic pain. VA's EBP Training Programs were recently lauded as an example for the nation in an Institute of Medicine (IOM) report (Institute of Medicine. 2015. *Psychosocial interventions for mental and substance use disorders: A framework for establishing evidence-based standards.* Washington, DC: The National Academies Press).

To promote the availability and effective implementation of these therapies, VA has established national competency-based staff training programs that have provided training to more than 10,500 VA staff (VHA and Vet Center) in the delivery of one or more EBPs. Beginning in 15, the EBP training programs began to utilize innovative technologies for training staff in these treatments. Use of these technologies has helped VA maintain the quality of the training while reducing costs. Program evaluation components that have been incorporated into each of these programs show that, the training in and implementation of these therapies, have resulted in significant, positive outcomes for therapists and patients. Furthermore, VA has designated a Local EBP Coordinator at each medical center to promote local systems and administrative infrastructures to facilitate the implementation of these therapies. The Local EBP Coordinator Program has been implemented throughout the system and has helped to increase the availability of evidence-based psychotherapies at the local level. VA sees significant potential to extend the reach of these therapies, especially to Veterans residing in rural and frontier communities, by utilizing telehealth modalities (such as clinical video teleconferencing) so that providers and Veterans can meet synchronously across distances. In 2011 – 2014, VA placed more than 100 evidence-based PTSD psychotherapy providers at targeted sites to deliver CPT and PE Telemental health services, where needed. In 2016, VHA will continue to expand its efforts to implement EBPs and to evaluate the impact of the training in and delivery of these therapies and new training methods. In addition, VHA is now closely monitoring the availability and delivery of these services throughout the system through specialized EBP documentation templates that have been nationally incorporated into VA's electronic health record system. Furthermore, VHA will implement mechanisms and resources for sustaining and expanding providers' EBP skills.

Military Sexual Trauma: VA defines MST in accordance with U.S. law as sexual assault or repeated, threatening sexual harassment experienced by a Veteran while on active duty, active duty for training, or inactive duty training. Among Veterans receiving VA health care, approximately one in four women and one in a hundred men report experiences of sexual trauma during their military service. A broad range of mental health diagnoses exists among Veteran users of VA health care services who screened positive for MST including PTSD and other anxiety disorders, depressive disorders, bipolar disorders, drug and alcohol disorders and schizophrenia and psychoses. MST survivors may also struggle with chronic physical health problems, difficulties in relationships, and increased risk of unemployment or homelessness.

VHA has policies and services in place to assist the recovery of Veterans who experienced MST. All Veterans seen in VHA must be screened for MST, and all health care for mental and physical health conditions related to MST is provided free of charge. Receipt of free MST-related services is entirely separate from the disability compensation process through VBA; service connection (VA disability compensation) is not required. Veterans may be able to receive this free MST-related care even if they are not eligible for other VA care. Every VHA facility provides outpatient care for conditions related to MST. For Veterans who need more intensive treatment and support, there are also programs that offer specialized sexual trauma treatment in VA residential or inpatient settings. In July 2015, VA implemented a major upgrade to the national clinical reminder used by all VA providers when conducting MST screens. Enhancements include: increasing the sensitivity of the screening questions to be more inclusive of the range of possible MST experiences; enhancing the opportunity for patient education by including informational materials in the reminder; and adding a mental health services referral question, which will standardize the automatic referral process system-wide and streamline access to care for Veterans who express interest in MST-related treatment.

VHA has established an organizational structure that provides oversight of MST-related services at the facility, regional, and national level. Every facility must have a designated MST Coordinator who serves as the point of contact for MST-related issues, including staff education and training, monitoring of MST-related screening, referral, and treatment, and outreach to Veterans. Each VISN has an MST POC to monitor and ensure national and VISN-level policies related to MST are implemented within the VISN. At the national level, MHS created the MST Support Team to monitor screening and treatment related to MST, oversee and expand MST-related education and training, promote best practices in the field, and develop policy recommendations.

VA has implemented a number of education and training initiatives to prepare VA staff to work skillfully and sensitively with Veteran MST survivors. Nationally, all VA mental health and primary care providers are required to complete a one-time mandatory training on MST. This training requirement complements pre-existing and ongoing training opportunities provided by the MST Support Team, including webinar trainings on MST-related topics that are available to all interested VA staff, and an annual conference focused on MST-related clinical care and program development. To continue to improve VHA's MST-related services, VA launched a number of new educational initiatives in fiscal year 2015, including: a new MST Consultation Program, which offers any VA staff member the opportunity for one-on-one, personalized consultation with MST experts; a new web-based training on MST for Compensation & Pension examiners focused on familiarizing examiners with the impact of MST, unique issues involved in MST-related disability claims, and how to conduct exams in a trauma-sensitive manner; and a new sensitivity training video targeted to frontline staff (e.g., telephone operators, clinic clerks), focusing on the variety of steps these staff members can take to be sensitive to the unique needs of MST survivors and improve their experience while visiting a VA health care facility.

Family Services: Substance Abuse and Mental Health Services Administration (SAMHSA) in HHS, has defined one of its mental health recovery principles as "*Recovery is supported through relationship and social networks."* In accordance with this principle, partnering with families is an essential component of VA mental health services. Consistent with a recovery philosophy, flexibility is a key principle when involving families in care. Services must be tailored to the Veteran's phase of illness, symptom level, self-sufficiency, family constellation, and preferences. When family services are a necessary part of the Veteran's treatment plan, VA offers a continuum of family services to meet varying needs including family education/training, family consultation, and marriage and family counseling. National training programs in several evidence-based practices for marital and family counseling are available for clinicians. While some of these are specific to diagnosis (for example, Cognitive Behavioral Conjoint Therapy for PTSD) others are cross-diagnostic (for example, Integrative Behavioral Couples Therapy for relationship distress). Couples therapy trainings are augmented with instruction on supporting Veterans' successful parenting, identifying and managing interpersonal violence, and working with same sex couples. Additionally an online Veteran parenting website (www.veteranparenting.org) is now available to help Veterans (re)connect with their children and provide strategies and tools for effective parenting. VA has collaborated with the National Alliance on Mental Illness (NAMI) through a Memorandum of Understanding (MOU) to offer the family peer-led Family-to-Family Education Program at VAs throughout the country. VA also has an active monthly training program for clinicians on family issues and interventions of particular relevance to Veterans and has developed a family services website as a resource for VA providers. We have also recently developed a mentor program so that facilities seeking to expand and enhance their family services can access guidance from sites with expertise in this area.

Specialized Mental Health Centers of Excellence: Specialized Mental Health Centers of Excellence (MH CoEs), which include the National Center for PTSD (NCPTSD); ten Mental Illness Research, Education and Clinical Centers (MIRECCs); three specialized Centers created to address the mental health needs of Veterans returning from the wars in Iraq and Afghanistan; and the Center for Integrated Healthcare are essential components of VA's response to meeting the mental health needs of Veterans. All of the MH CoEs have a singular mission: to improve the health and well-being of Veterans through world class, cutting-edge science, education and support of clinical care. Because mental illness is not a single disorder and includes multiple complex conditions that differ considerably in terms of symptoms, causes, prevalence, course, prognosis, and treatment, each Center focuses on a specific mental illness or illnesses across the spectrum of Veteran mental health. The centers are designed to be incubators for new investigators, new clinicians, new methods of treatment, new ways of educating staff and patients, and new ways of delivering care. The MH CoEs not only leverage regional and local VA expertise but also pull in clinical, research and educational expertise from academic affiliates and across other centers, making it possible for a single site to conduct research and educational activities across the spectrum of basic and clinical domains that is necessary to fully address a given disorder. Research by the MH CoEs has had a profound effect on enhancing the understanding and treatment of mental illness in Veterans. The

concentrated expertise at each center informs and strengthens clinical care, research, and education tools that are essential to improving Veteran mental health. Because of its particular prominence, additional information specifically on the NCPTSD follows.

Program Evaluation Centers: OMHO includes three Program Evaluation Centers that serve its needs as well as those of MHS: the Northeast Program Evaluation Center (NEPEC) in West Haven, CT; Program Evaluation Resource Center (PERC) in Palo Alto, CA; and the Serious Mental Illness Treatment Resource and Education Center (SMITREC) in Ann Arbor, MI. The three centers provide data and analysis needed to implement policy, facilitate quality improvement, manage programs, evaluate mental health care innovations, and improve accessibility, effectiveness and efficiency of mental health care delivery. Each of the Centers additionally represents a source of expertise in specific subspecialties of mental health. Briefly, NEPEC has expertise in areas such as inpatient and residential care, mental health rehabilitation, mental health services for homeless Veterans, and ambulatory care in mental health specialty services. PERC has expertise in substance use and behavioral health disorders, including treatment provided in inpatient, residential, intensive outpatient, and general ambulatory settings. SMITREC has expertise in psychosis and depression, suicide prevention, services for the elderly, and the integration of mental health with primary care. Among the Centers, PERC is leading efforts to monitor the implementation of current policies and requirements to enhance measurement-based program management; NEPEC, to develop periodic evaluations of the extent to which current policies and requirements need revision; and SMITREC, to organize longitudinal strategies for monitoring specific patient populations over time.

The three Centers collaborated extensively to develop a set of tools to guide implementation of mental health policy and mental health program management. These include a comprehensive Mental Health Information System, developed in 2011 to provide detailed information on the performance of each VISN and medical center on key measures of the populations receiving mental health services, their access to services, the continuity of care, and the intensity of their treatment. The Mental Health Information System has been used to inform and tailor a program of comprehensive site visits and action-planning to address gaps or challenges in mental health services at every VHA facility. More recently, the three Centers worked together to develop and launch a Mental Health Domain to the Strategic Analytics for Improvement and Learning (SAIL) program, a VHA-wide mechanism for monitoring performance and supporting accountability across the full range of clinical programs provided at each Medical Center. Finally, in parallel with implementation of the Mental Health component of SAIL, the Centers developed a Mental Health Management System that combines the summary Mental Health Domain composite measures with key operational data, such as staffing, growth rate, provider productivity, timely access measures, and use of innovative programming, and presents them in the form of a user-friendly dashboard. The Mental Health Management System dashboard is used as a focus of communication between the Office of Mental Health Operations and the Mental Health leads and Chief Medical Officers in each of the VISNs. Patterns of strengths and weaknesses as evaluated on the dashboard serve to guide quarterly discussions between VACO Mental Health and the VISN leads on the status of Mental Health services in each facility, and strategies for addressing challenges. As part of

these efforts, the Program Evaluation Centers conduct phone and mail-based surveys of Veterans to understand their experience of VA mental health services and the effectiveness of care received, as the Veterans Outcomes Assessment and the Veterans Satisfaction Survey programs.

In addition to these comprehensive tools, the Program Evaluation Centers also provide data, implementation support, and formative and summative evaluation for targeted initiatives and innovations. Recent programs lead or supported by the Program Evaluation Centers include the Psychotropic Drug Safety Initiative (PDSI) to improve quality of mental health prescribing, the Overdose Education and Naloxone Distribution program (OEND) to reduce mortality and morbidity related to opioid overdose, the Behavioral Health Improvement Program to facilitate team-based general mental health care to improve care coordination and access, the Stratification Tool for Opioid Risk Management (STORM) to allow targeted review and intervention on patients at high risk of opioid-related adverse events, Executive Ordered Community Partnership pilots to expand collaboration with community programs to improve mental health treatment access, the Strong Practices program to facilitate sharing of innovative and effective solutions to mental health service delivery, the SMI Re-Engage Program to identify and reach out to patients with serious mental illness who have dropped out of care, and predictive modeling to identify patients at risk for suicide and related adverse outcomes.

Lastly, the Program Evaluation Centers maintain core datasets, tracking Mental Health programs and populations, providing patient-level data to support program planning in both central office and the field; maintaining registries of mental health patient (sub)/populations and directories of specialized mental health programs; and providing recurring reports on specific programs and periodic issue briefs. Through these activities and products, contributions to technical assistance, and their availability for consultation and the conduct of analyses whenever requested, the Program Evaluation Centers are key resources for VA's mental health programs, both in VA Central Office and the field.

Informatics: The Mental Health Informatics group within VHA Mental Health Services works closely with the Office of Information and Technology (OI&T), VHA Office of Informatics and Analytics (OIA), and other VHA program offices to design and implement technology tools that support the transformation of mental health services. Particular emphasis is placed on providing tools for clinicians to support the delivery of evidence-based services; development of patient facing tools to support patient-centered care and preventative interventions; and on improving the monitoring of patient outcomes to support continuous improvement in care delivery.

Technical Assistance: OMHO also provides technical assistance to facilities and VISNs regarding the delivery of quality mental health care to Veterans. Its role is to assist the VHA system with strategic action planning and implementation of policies to improve access to clinical services, integrate and execute new/revised clinical services with other components of the health care organization, and monitor the integrity, quality and value of mental health services. Technical assistance is provided as a collaborative consultative service when facilities or VISNs request or require assistance in specific areas identified

as being in need of improvement (e.g., review of SAIL, Mental Health Management System, and other national dashboards). This includes quarterly reviews of facility developed plans for mental health in areas of need of improvement, with targeting of specific action steps, milestones, deliverables, and measured targets. The OMHO technical assistance team members are professionally trained consultants and facilitators who work with internal and external experts in mental health services across the spectrum.

Examples of technical assistance include data analysis and interpretation, consultation, mentoring, connection with Subject Matter Experts (SMEs) and/or relevant program materials, and training. Technical Assistance can be accomplished through telephone calls, video-teleconference, and/or site visits. OMHO provides technical assistance in conjunction with the OMHO Program Evaluation Centers, MHS, National PC-MHI Office, National PC-MHI Program Evaluation Office, Office of Geriatric and Extended Care, and other PCS offices.

National Center for Posttraumatic Stress Disorder

(Amounts included in total Mental Health)

National Center for PTSD
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Total Medical Care.....	$17,029	$19,000	$19,000	$19,000	$19,107	$19,680	$107	$573

National Center for Post-Traumatic Stress Disorder (PTSD) is dedicated to the advancement of the clinical care and social welfare of America's Veterans through research, education and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. The Center was created in response to a Congressional mandate (P.L. 98-528, 98 Stat. 2686 (1984)) to address the needs of Veterans with military-related posttraumatic stress disorder. The mandate called for a center of excellence that would set the agenda for research and education on PTSD without direct responsibility for patient care. The Center also was mandated to serve as a resource center for information about PTSD research and education for VA and other Federal and non-Federal organizations. The Center currently consists of seven divisions located at VA facilities, with headquarters in White River Junction, VT. Other divisions are located in Boston, MA; West Haven, CT; Palo Alto, CA; and Honolulu, HI. The National Center for PTSD is an integral component of Mental Health Services within Patient Care Services in VHA.

Research: The National Center for PTSD helps improve patient care through its strong commitment to research into the prevention, causes, assessment, and treatment of traumatic stress disorders. Each of the Center's divisions has its own area of specialization, giving researchers access to different types of expertise across many geographical areas of the country. Besides its own staff, the Center has built strong collaborative relationships with institutions and agencies from VA, other branches of government, the health care community, and academia, giving researchers a vast array of affiliates and partners for research activities. These activities are enriched by constant contact with clinicians who are directly involved in patient care, giving the research activities a uniquely real-world perspective. As a result, the Center specializes in translating basic findings into clinically relevant techniques and studying how best to implement evidence-based practices into care.

A leader in basic neurobiological research on PTSD, the Center coordinates the VA National PTSD Brain Bank, the nation's first brain tissue repository dedicated to researching the physical impact of stress, trauma and PTSD on brain tissue. The National Center, in partnership with the STRONG STAR Consortium at the University of Texas Health Science Center at San Antonio, continues to administer the $45 million five year Consortium to Alleviate PTSD (CAP) to advance PTSD care for service members and Veterans. CAP will provide an array of cutting-edge clinical treatment trials and biological studies, including efforts to learn more about the biology/physiology of PTSD development and treatment response to inform diagnosis, prediction of disease outcome, and new or improved treatment methods. In 2015, the Center initiated a CAP-funded trial on ketamine—a medication that is typically used for sedation but also has rapid

antidepressant effects—for treating PTSD in active duty military personnel and Veterans who do not respond to antidepressant treatment.

The Center leads the field in the development of state-of-the art assessment measures for PTSD. These include the Clinician Administered PTSD Scale (CAPS; the gold standard for assessing PTSD), the Primary Care-PTSD screen (used in VA and DoD to screen for PTSD), and the PTSD Checklist (the most widely-used measure of PTSD symptom severity). The Center updated these instruments to align with newly developed PTSD diagnostic criteria (*DSM-5*).

Center research has also led to innovations in PTSD treatment, including the VA national rollouts of Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), validation of telehealth delivered care, and the 2010 revision of the VA/DoD PTSD Practice Guideline for PTSD. The Center is currently leading a $10 million groundbreaking study that will compare PE and CPT. The study, which will involve 900 Veterans at 17 sites across the country will help VA leadership, clinicians, and Veterans in making informed choices about the delivery of PTSD care in VA, and will also be broadly relevant to the scientific and clinical communities outside VA.

The Center also conducts research on new delivery methods for PTSD treatment to give patients a range of choices. One recent project builds on the Center's work in telehealth by comparing three ways to provide Prolonged Exposure to Veterans with PTSD: in-home in-person, in-home teleconferencing, and in-clinic teleconferencing. A second trial compares written exposure therapy (WET), a brief treatment that requires minimal therapist involvement, with Cognitive Processing Therapy; if results are positive, WET could be an alternative trauma-focused treatment for patients who prefer to write, rather than talk, about their trauma.

Education and Training: The National Center for PTSD brings current research and clinical knowledge from the field to Veterans, their families, the general public, VA and community clinicians, military leaders, and others. Information is efficiently disseminated through the Center's award-winning website (www.ptsd.va.gov), publications, online resources, as well as nationwide trainings. The website expanded to better serve Veterans, the public, and professionals and upgraded to a responsive design template in 2015, providing optimal viewing for users across a wide range of devices. Web usage increased 10 percent over last year, with 6.9 million unique page views (average of 575,000 per month) in 2015. Examples of specific initiatives include:

- The *VA PTSD Mentoring Program*, established in 2008, provides support to PTSD Program Directors and PTSD Specialists via a network of PTSD Mentors who help to disseminate best administrative and clinical practices to improve the delivery of evidence based PTSD treatment in VA. A primary focus of the program is determining optimal clinic designs to improve the delivery of evidence-based PTSD care in VA. Much of the work of 2015 focused on establishing best practices in the coordinated treatment of Veterans with PTSD by the Behavioral Health Interdisciplinary Program (BHIP) teams and the PTSD Clinical Teams (PCTs).

- The *PTSD Consultation Program*, launched in 2011 to support VA providers through expert resources and consultation about the assessment and treatment of Veterans with PTSD, expanded this past year to providers outside of VA who treat Veterans with PTSD (http://www.ptsd.va.gov/professional/consult/index.asp). The expansion specifically helps to support the Veterans Access, Choice, and Accountability Act by enhancing the skills and knowledge of community providers who are treating Veterans with PTSD. The Consultation Program also hosts a monthly PTSD clinical lecture series, now available to any VA or community-based provider.
- The *PTSD Resource Center* is the world's largest collection of literature on traumatic stress, with more than 3,000 book volumes and 42,000 journal articles. The Resource Center's Published International Literature on Traumatic Stress (PILOTS) Database now includes 54,000 records with materials in 30 languages.
- Continuing online education for providers includes *PTSD 101,* a web-based curriculum of expert lectures on timely and relevant issues related to PTSD and trauma in an on-demand format. Our section on online education offerings had nearly 281,000 visitors in 2015 and now also includes longer advanced courses (e.g., Skills Training in Affective and Interpersonal Regulation, anger management). The Center also produced *the Iraq War Clinician Guide* to help providers treat returning Service members, and, with the National Child Traumatic Stress Network, developed *Psychological First Aid*, to help with mental health needs in the immediate aftermath of a disaster.
- The *Clinician's Trauma Update-Online,* an electronic newsletter published 6 times a year and distributed to over 37,000 subscribers, provides summaries of articles from professional journals that have relevance for clinicians, with emphasis on articles on the assessment and treatment of Veterans. A second regular publication intended primarily for researchers and scientists, the *PTSD Research Quarterly,* is distrusted to over 42,000 subscribers and provides expert reviews of the scientific literature on specific topics.
- A brief *PTSD Awareness* video for VA staff, released in 2014, helps non-clinical VA medical center employees—especially those who are in frontline positions such as appointment schedulers and desk clerks—to understand what PTSD is and respond appropriately to Veterans' behavior that may reflect PTSD symptoms. A version of the video for use by staff in non-VA healthcare settings and facilitators' guides for both videos were developed in 2015.
- Online educational courses for Veterans, their families, and the public, include *Understanding PTSD, Understanding PTSD Treatment*, and the *Returning from the War Zone Guides.* A web-based self-help version STAIR (Skills Training in Affective and Interpersonal Regulation) Therapy is in development.
- *AboutFace*, an online video collection of Veterans talking about living with PTSD and how getting into treatment turned their lives around. Family members describe the impact of PTSD on their relationships and clinicians discuss PTSD treatment. A new "Therapies" section where Veterans describe their experiences

with CPT and PE is coming soon.

- *PTSD Coach,* VA's first mobile phone application, was developed by the Center with DoD's National Center for Telehealth and Technology and released in 2011. The app, which has been downloaded nearly 212,000 times, offers users self-assessment, coping skills, and resources. Other apps include *PTSD Family Coach* (and apps that support the delivery of PE, CPT, and CBT for Insomnia. Mobile phone applications provide a way to assist individuals wherever they are, whenever they need support.
- *PTSD Coach Online,* released in 2013, extends the reach of the PTSD Coach app to desktop users and consists of a suite of 17 tools designed to help people cope with sleep problems, trauma reminders, anxiety and other symptoms that can develop after trauma. In 2015, the desktop app had over 116,000 visitors.
- In 2014, the Center developed a series of six *Whiteboards*, short animated videos that combine narration with hand-drawn images, to encourage recognition of PTSD and increase engagement in and provision of evidence-based treatment. The Whiteboards webpage had nearly 9,000 visitors in 2015.
- The Center utilizes diverse web-based communication strategies to disseminate information and its resources. One vehicle is the *PTSD Monthly Update*, an electronic newsletter sent to over 143,000 subscribers highlighting Center fact web pages and products on a particular topic. The Center also maintains a strong social media presence, with nearly 23,000 *Twitter* followers and a *Facebook* page with over 115,000 fans.

Prosthetics

Prosthetics
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$2,727,077	$2,841,942	$2,851,000	$3,039,353	$3,645,677	$3,376,159	$794,677	($269,518)

Prosthetic and Sensory Aids Service (PSAS) is an integrated delivery system designed to provide medically prescribed prosthetic and sensory aids, medical devices, assistive aids, repairs and services to eligible Veterans to maximize their independence and enhance their quality of life. Although the term "prosthetic device" may suggest images of artificial limbs, it actually refers to any device that supports or replaces loss of a body part or function and includes a full range of equipment and services for Veterans. This includes, but is not limited to, artificial limbs, hearing aids, speech communication aids, home oxygen, orthopedic footwear, orthopedic braces and supports, cosmetic restorations, breast prostheses, wigs; items that improve accessibility such as ramps and vehicle modifications, wheelchairs and mobility aids; and devices surgically placed in the Veteran, such as stents, joint replacements, and pacemakers. These items are provided from prescription through procurement, delivery, training, replacement, and when necessary, repair.

2015 Accomplishments

- VHA PSAS provided 19.1 million medical items and services to 3.2 million Veterans.
- Collaborated with VHA Office of Enrollment and Forecasting to build model for projecting/right-sizing resources for the procurement of Glasses/Contacts, Hearing Aids, Surgical Implants , Cardiothoracic Surgical Implants, Medical Equipment & Supplies, Home Telehealth Devices, Oxygen, Respiratory Equipment, Wheelchairs, Orthotics, Prosthetics – Artificial Limbs, Blind Aids and VA Specialized Products and Services.
- Improved the interactive analytic tool (Variance Report) and effectively monitored expenditures (for prosthetic devices) within a 4 percent variance.
- PSAS Clinical Team spearheaded the development of a user-friendly process for procurement of Apple Applications (Apps) prescribed by clinicians.
- The Procurement Acquisition Lead Time Tool developed and implemented to provide real-time tracking of critical patient specific prosthetic devices from prescription to acquisition, resulted in significantly improved timeliness in providing such devices to Veterans.
- PSAS supported VA's implementation of the Choice Act and Patient-Centered Community Care (PC3) program through development of prosthetic implementation strategies for the Choice Program. This included developing an executive-level options paper, conducting cost analysis, deployed an analytic tool to monitor prosthetic items and spending associated with the Choice Act, and developed guidance and processes for expanding provision of rehabilitation services through community care (e.g., PC3/Choice referral guidance, quality standards, etc.).
- Worked collaboratively with the Strategic Acquisition Center (SAC) to transition procurement requests from VA's National Acquisition Center to the SAC. This collaboration included developing a Source Selection Evaluation Plan for a Technical Evaluation Facility that will provide for the streamlining of acquisition processes, hands-on commodity evaluation, inspection, and short-term storage of products in support of pre-contract award processes.
- Successful development of a PSAS Dashboard displaying Key Performance Indicators in the areas of: Timeliness, Policy/Operational Audits, Staffing Levels, Contract Utilization, Purchasing Agent Efficiencies and Inventory Management.
- Increased the percentage of prosthetic procurements below the micro-purchase level completed in five days or less by 3.3 percent in 2015 over 2014.
- Collaborations with the Workforce Management and Consulting Policy and Programs, VISN Prosthetic Representatives, and Procurement and Logistics to conduct a comprehensive review of the 1105 Purchasing Series Classification Standards which will allow VHA to provide an updated account of the current

work environment, and contemporize classification of the position to include the title, series, and grade.

Future Goals (2016-2018)

- Support the Strategic Analytics for Improvement and Learning (SAIL) Value model by developing a measure under the Access domain related to the timeliness of providing prosthetic devices below the micro-purchase level. Increase the percentage of prosthetic procurements below the micro-purchase level completed in five days or less by one percent in 2016 based on end-of-fiscal-year 2015 actuals.
- Continue to refine and develop processes, policies and guidance that produce more accurate analyses and modeling to project resource requirements, and provide stringent fiscal accountability for the PSAS budget.
- Continue to stay abreast of emerging technologies and prosthetic devices, and incorporate into VA provision of devices and services in support of clinical plans that enable Veterans to function independently.
- Continue to measure the timeliness of prosthetic micro-purchases in 2016 and increase the number of micro-purchases completed in five days or less by another one percent in 2016 based on 2015 actuals.
- Under the Choice, PSAS continues to work with the Chief Business Office Purchase Care program to develop the next generation of Care in the Community contracts to ensure that the provision of prosthetic devices is managed in an efficient, cost effective and patient centered way.
- Continue to partner with the Veterans Benefits Administration (VBA) to administer the Clothing Allowance and Automobile Adaptive Equipment programs.
- Continue to improve the relationship and partnership with VBA's Adaptive Housing programs and improve processes and timeliness for VHA's Home Improvements and Structural Alterations program.

Dental Care

Dental
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$1,005,107	$1,072,544	$1,035,391	$1,148,797	$1,433,385	$1,277,378	$397,994	($156,007)

The mission of VA Dentistry is to improve the oral health of eligible Veterans. Eligibility for dental care is defined by statute and is provided in accordance with the provisions of existing law and VA regulations. The scope of care provided for every Veteran is determined by the Veteran's eligibility. VA Dentistry strives to be the benchmark of

excellence and value in oral health care by providing exemplary services that are both patient centered and evidence based.

2015 Accomplishments

- Provided dental care for over 495,000 Veterans, most of who are now eligible for lifelong comprehensive dental care due to their service-connected medical conditions.
- Over 93 percent of comprehensive care dental patients have been teamed with a primary dental care provider to oversee and coordinate their care needs.
- Updated the Dental Resource Modeling tool to assess forecasted demand, planning implications for freestanding dental facilities and the impact of increased Community dental care.
- Awarded a contract to conduct patient satisfaction surveys through 2020 that are specific to the dental care provided to Veterans and benchmarked against VA Survey of Healthcare Experience of Patients (SHEP) and private dental care.
- Introduced Virtual Care strategies in VA Dentistry including Secure Messaging and TeleDentistry.

Future Goals (2016-2018)

- Continue to right-size physical plant infrastructure to efficiently meet the forecasted demand for Veteran dental care utilizing a contemporary dental clinic design guide and data driven space planning criteria.
- Fully integrate VA Dentistry into the Veterans Choice Program to expand access to dental care consistent with other medical specialties.
- Improve the Veteran’s access to regular dental care by maintaining national dental quality indicators that focus on population health management metrics promoting timely preventive services.
- Expand the use of digital dental laboratory technologies and cost sharing strategies to provide prostheses in a more expedient manner to restore Veteran oral health and function.
- Consistently provide patient centered care by leveraging the results of the Dental Patient Satisfaction Survey to optimize dental service processes based on the needs and preferences of Veterans.
- Ensure an engaged, skilled dental workforce valuing individual accountability, recognition and educational opportunities that promote state of the art, evidence-based dental care.

Ending Veterans Homelessness

Ending Veterans Homelessness
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
Description	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Request	Advance Approp.	Increase/Decrease 2016-2017	2017-2018
Total Medical Care.....	$1,506,781	$1,393,000	$1,476,644	$1,393,000	$1,591,365	$1,122,398	$114,721	($468,967)

The Department of Veterans Affairs' (VA) is committed to preventing and ending Veteran homelessness and is poised to assist homeless and at-risk Veterans through the provision of a comprehensive continuum of care. VA's continuum of homeless services is designed to address the needs associated with both preventing first time homelessness as well as those who return to homelessness while building the capacity of available residential, rehabilitative, transitional, and permanent housing. It focuses on the root causes associated with poverty, addiction, mental health, and disability so that homeless and at-risk Veterans can achieve their optimal level of functioning and quality of life. These services include, but are not limited to, primary and specialty medical care; mental health and substance use disorder treatment; case management; outreach; vocational rehabilitation/employment services; housing support; and coordination of related services with VBA and NCA. This continuum includes VA Medical Centers (VAMCs), Public Housing Authorities, and Continuums of Care, as well as community partners. The intent is a systematic end to homelessness, meaning that there are no Veterans sleeping on streets and every Veteran has access to permanent housing. Should Veterans become or be at-risk of becoming homeless, there will be the capacity to quickly connect them to the help they need to achieve housing stability

Between 2010 and 2015, VA and its partners have reduced the estimated number of homeless Veterans by 36 percent. Data collected during the annual Point in Time (PIT) Count, conducted on a single night in January 2015 - estimates that there were fewer than 48,000 homeless Veterans in America, a decline of more than 26,360 Veterans since 2010 (~74,100). This includes a nearly 50 percent drop in the number of unsheltered Veterans sleeping on the street.

The PIT Count results are a snapshot of Veteran homelessness on a specific date. The PIT count provides an important national measure of annual progress and the overall direction of homelessness from year to year, but it does not depict the full scope of the effort and the number of Veterans prevented from becoming homeless or who have exited homelessness into permanent housing. Since 2010, more than 365,000 Veterans and their family members have been permanently housed, rapidly rehoused, or prevented from falling into homelessness as a result of VA's homeless continuum of services and targeted community resources. The ability to partner with HUD, the U.S. Interagency Council on Homelessness (USICH), other Federal agencies, state and local governments, and volunteer organizations contributed to this significant accomplishment. In 2015 alone, nearly 65,000 Veterans obtained permanent housing through VA Homeless Programs, including moves into HUD-VASH, rapid re-housing through SSVF and moves into permanent housing from VA's residential treatment programs, (2014: 50,730) and more

than 36,000 Veterans and their family members were prevented from becoming homeless through the SSVF program, including 6,555 children.

VA greatly expanded the services available to permanently house homeless Veterans [Department of Housing and Urban Development Department of Veterans Affairs Supportive Housing (HUD-VASH)] and implemented programs aimed at prevention [Supportive Services for Veterans Families (SSVF)], treatment [Homeless Patient Aligned Care Teams (PACTs)], low-threshold care/engagement strategies (Community Resource and Referral Centers, Safe Havens), and the capacity to track and monitor homeless outcomes (HOMES, Homeless Registry).

VA has not only expanded existing programs and developed new programs, but has increased efforts to: develop partnerships with Federal and state agencies, Veterans Service Organizations (VSOs), national advocacy groups, and community-based providers; enhance outreach efforts to agencies, as well as to individual Veterans; increase data collection and reporting methods by working closely with Federal agencies and local continuums of care; and develop new methods to explore evidence-based research and test best practice models. Additionally, VA has made unprecedented efforts to promote the services available to Veterans who are homeless or might become homeless through its comprehensive approach to outreach (media and ‘boots on the ground’), the implementation of an at-risk clinical reminder in VAMC outpatient settings, and continued interaction and collaboration with public and private sector partners.

VA understands that it cannot end Veteran homelessness alone. The ambitious goal of ending Veteran homelessness with the urgency that the problem requires has galvanized the federal government and local communities to work together to solve this important national issue. These strong federal and local partnerships along with strategies that work, such as Housing First and common assessment tools, have allowed communities to align resources and implement systems locally that focus on delivering housing solutions and re-orient the crisis response system to solve homelessness for Veterans. As a result, many communities across the country from - New Orleans to Mobile to Troy, New York - have effectively ended Veteran homelessness, demonstrating that it can be achieved. With the support of the federal government, this trend continues community by community across the country.

Program Descriptions and Highlights

This budget will support VA’s goal to eliminate Veteran homelessness by emphasizing rescue and prevention –- rescue for those who are on the streets or in shelters today, and prevention for those at risk of homelessness from starting that downward spiral.

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Total Medical Care Obligations ($000)	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Homeless Veterans Treatment Costs	$5,153,060	$5,269,667	$5,402,164	$5,496,909	$5,643,053	$5,881,071	$240,889	$238,018
Programs to Assist Homeless Veterans:								
Permanent Housing/Supportive Services								
HUD-VASH case management - Initiative 1/	$295,400	$321,000	$322,994	$321,000	$369,994	$265,091	$47,000	($104,903)
HUD-VASH - Sustainment 2/	$80,019	$52,668	$92,538	$52,668	$126,105	$154,024	$33,567	$27,919
Subtotal	**$375,419**	**$373,668**	**$415,532**	**$373,668**	**$496,099**	**$419,115**	**$80,567**	**($76,984)**
Transitional Housing							$0	$0
Grant & Per Diem 1/	$218,621	$171,094	$174,776	$171,094	$216,068	$108,034	$41,292	($108,034)
Grant & Per Diem Liaisons 1/	$30,028	$30,000	$31,093	$30,000	$31,409	$15,705	$316	($15,704)
Other - Sustainment 2/	$52,361	$35,561	$57,064	$35,561	$61,141	$64,546	$4,077	$3,405
Health Care for Homeless Vets (HCHV) 1/	$155,334	$155,000	$155,000	$155,000	$160,864	$80,432	$5,864	($80,432)
Subtotal	**$456,344**	**$391,655**	**$417,933**	**$391,655**	**$469,482**	**$268,717**	**$51,549**	**($200,765)**
Prevention Services							$0	$0
Supportive Services Low Income Vets & Families 1/	$299,997	$300,000	$300,000	$300,000	$300,000	$150,000	$0	($150,000)
National Call Center for Homeless Veterans (NCCHV) 1/	$3,917	$5,568	$4,023	$5,568	$0	$0	($4,023)	$0
Justice Outreach Homelessness Prevention - Initiative 1/	$28,147	$35,224	$31,022	$35,224	$31,403	$15,702	$381	($15,701)
Justice Outreach Homelessness Prevention - Sustainment 2/	$4,810	$3,155	$5,642	$3,155	$8,760	$11,380	$3,118	$2,620
Subtotal	**$336,871**	**$343,947**	**$340,687**	**$343,947**	**$340,163**	**$177,082**	**($524)**	**($163,081)**
Treatment							$0	$0
Domiciliary Care for Homeless Vets - Sustainment 2/	$202,815	$183,362	$193,778	$183,362	$179,867	$168,004	($13,911)	($11,863)
Domiciliary Care for Homeless Vets - Initiative 1/	$5,266	$0		$0	$0	$0	$0	$0
Telephone/Homeless Chronicallly Mentally Ill - Sustainment 2/	$19,155	$13,194	$20,825	$13,194	$22,098	$23,130	$1,273	$1,032
Expansion of Homeless Dental Initiative 1/	$841	$0		$0	$0	$0	$0	$0
Subtotal	**$228,077**	**$196,556**	**$214,603**	**$196,556**	**$201,965**	**$191,134**	**($12,638)**	**($10,831)**
Employment/Job Training							$0	$0
Homeless Veterans Supported Employment Program 1/	$12,403	$0	$0	$0	$0	$0	$0	$0
Homeless Veterans Community Employment Program 1/	$12,358	$15,000	$15,000	$15,000	$15,182	$7,591	$182	($7,591)
Homeless Ther. Empl, CWT & CWT/TR - Sustainment 2/	$70,299	$60,565	$62,302	$60,565	$57,369	$53,207	($4,933)	($4,162)
Subtotal	**$95,060**	**$75,565**	**$77,302**	**$75,565**	**$72,551**	**$60,798**	**($4,751)**	**($11,753)**
Administrative							$0	$0
Getting to Zero	$998	$532	$532	$532	$0	$0	($532)	$0
Supportive Services Low Income Vets & Families Admin	$10,806	$8,619	$8,403	$8,619	$8,647	$4,324	$244	($4,323)
National Homeless Registry	$3,206	$2,458	$1,652	$2,458	$2,458	$1,229	$806	($1,229)
Subtotal	**$15,010**	**$11,609**	**$10,587**	**$11,609**	**$11,105**	**$5,553**	**$518**	**($5,552)**
VA Require Total							$0	$0
Obligations (Grand Total)	**$1,506,781**	**$1,393,000**	**$1,476,644**	**$1,393,000**	**$1,591,365**	**$1,122,399**	**$114,721**	**($468,966)**
Specific Purpose total	**$1,077,322**	**$1,044,495**	**$1,044,495**	**$1,044,495**	**$1,136,025**	**$648,108**	**$91,530**	**($487,917)**
General Purpose total	**$429,459**	**$348,505**	**$432,149**	**$348,505**	**$455,340**	**$474,291**	**$23,191**	**$18,951**

1/ Initiative funding reflects Specific Purpose funds allocated to the program by VA Central Office.
2/ Sustainment funding reflects General Purpose funds distributed through the Veterans Equitable Resource Allocation (VERA) process and allocated to the program.

Housing and Urban Development-VA Supportive Housing (HUD-VASH) case management: HUD-VASH is the Nation’s largest supportive permanent housing program. HUD-VASH funding will provide resources for HUD-VASH case management and Homeless Veteran Patient Aligned Care Teams (H-PACTs) in 2016.

HUD-VASH is a collaborative effort, combining HUD Section 8 “Housing Choice” rental assistance vouchers with VA’s provision of case management and supportive services. HUD-VASH targets the most vulnerable and chronically homeless Veterans who require intensive case management and supportive services to maintain housing. These Veterans often have severe, persistent physical and mental health conditions as well as substance use disorders. This program ends homelessness for Veterans by providing permanent supportive housing through HUD’s vouchers with VA case management and supportive services that promote and maintain recovery and housing stability. The

primary goal of HUD-VASH is to move Veterans and their families out of homelessness and into stable permanent supportive housing, and then to provide the supports needed to maintain the Veteran and their family in housing.

During 2015, the HUD-VASH program continued to implement a multi-disciplinary team approach to meet the complex case management needs of participating Veterans through provision of a full range of medical, mental health and employment services to Veterans within their communities and, most frequently, in their homes. This ensures access to care in community settings, where Veterans are most likely to engage in services, and provides the support needed to ensure housing stability. In 2015, the HUD-VASH program funded 433 additional positions in various disciplines, including Peer Support Specialists, Employment Specialists, Occupational Therapists, Psychiatrists, Nurses, and Housing Specialists. At the end of 2015, 63,039 unique Veterans were housed in HUD-VASH, a 21.4 percent increase from the 51,913 reported in 2014. At the end of 2016, VA projects that more than 75,136 total Veterans will be housed through the HUD-VASH program.

H-PACTs: In 2015, this initiative is being implemented in 60 facilities, including all of the 25 cities targeted by the United States Interagency Council on Homelessness (USICH) as high priority cities, with the goal of providing integrated, coordinated, and comprehensive clinical and primary care in conjunction with homeless services. These 25 cities, and the VA facilities within them, serve approximately 70 percent of all homeless Veterans nationally. During 2015, the HPACT initiative had over 18,000 Veterans enrolled in the program. This was a 24.7 percent increase over 2014's 14,600 enrolled Veterans. This initiative has substantially reduced emergency (-28%) and inpatient levels (-30%) of care while facilitating earlier exits from homelessness.

Grant and Per Diem (GPD) Program: Under authority of the Veterans Benefits, Health Care, and Information Technology Act, P.L. 109-461, through the Homeless Providers GPD Program, VA awards grants to community-based agencies to create transitional housing programs and offer per diem payments to GPD funded organizations. These per diem payments help offset the operational costs of the program. These grants promote the development and provision of supportive housing and/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and realize greater self-determination. The GPD Program has more than 650 funded projects and over 14,500 beds nationwide; the average length of stay for a homeless Veteran in the GPD program is 6 months.

In 2015, 43,971unique Veterans were served in GPD programs. The GPD program projects that approximately 41,000 homeless Veterans will receive services in GPD in 2016. The projected reduction is based upon the continued drop in the number of homeless Veterans and reduction of underutilized beds based on reduced demand for these services. However, overall per diem costs for the program are anticipated to gradually rise overall for operational programs as the nightly cost for per diem increases in the community. Even though the demand for GPD transitional housing beds is expected to decrease over time, the program still plays a vital role in the continuum of homeless services; providing supportive services to those Veterans who would otherwise be among

the unsheltered homeless population, and ultimately transitioning to permanent housing. During 2015, 15,507 Veterans exited GPD programs with permanent housing placements and it is estimated that approximately 12,500 Veterans would exit GPD programs with permanent housing with the proposed budget of $199 million in 2017.

Health Care for Homeless Veterans (HCHV): HCHV provides outreach and case management, as well as contract residential services (CRS), which target homeless Veterans transitioning from literal street homelessness, those being discharged from institutions, and Veterans who recently became homeless and require safe and stable living arrangements while they seek permanent housing. Each of the program elements has been impacted by an increased demand for services and program expansion. In 2015, 185,405 unique Veterans were served through HCHV, an almost 8.8% percent increase from the 170,253 reported in 2014. Based on increased demand for services, there has been an expansion in both size and scope of service delivery across programs and initiatives supported through the HCHV program. It is anticipated that HCHV core programs (outreach, case management, and CRS) will provide services to an estimated 201,905 homeless and at-risk Veterans in 2016.

Community Resource and Referral Centers (CRRCs): Established in strategically selected locations to provide services in a "one-stop" environment, CRRCs enable enhanced access to services, especially for chronic homeless, newly homeless, women, women with children, and other hard to reach populations. CRRCs are a model development program administered through the National Center on Homelessness among Veterans with funding support made available through HCHV. There are a total of 30 CRRCs nationwide.

In 2015, over 32,000 homeless, or at risk Veterans received services in the CRRCs. This was a 60% increase as compared to 20,000 Veterans receiving services in 2014. It is expected that CRRCs will record at least 32,000 Veteran visits in these facilities in 2016. CRRC programs partner with SSVF grantees, HPACTS, and other VA and non-VA service providers in their area and are considered a link to community permanency and a pathway out of homelessness for Veterans.

Contract Residential Services (CRS): VA contracts with community partners to provide emergency housing and residential treatment beds. The demand for this residential bed capacity has grown steadily since the start of the Eliminate Veterans Homeless (EVH) initiative, with 4,245 beds currently operational, representing a 473 percent increase in bed capacity since 2009, and a more than 4.5 percent increase from 2014 levels. Funding has been prioritized to ensure that every VAMC has the capacity to offer "bridge housing" services targeted to and prioritized for homeless Veterans who are transitioning from literal street homelessness. A "no wrong door" approach to ending Veteran homelessness includes availability of these community-based, emergency housing options as an entry point for Veterans in need, and supports VA's commitment to house all unsheltered, homeless Veterans.

The average length of stay for a homeless Veteran receiving CRS services is 61.4 days. In 2015, 16,771 unique Veterans were served, a 6.1 percent increase from the 15,739 reported in 2014. In 2015, 7,617 Veterans exited HCHV CRS programs to permanent housing, and 27 percent experienced an increase in income. At discharge, 37 percent of Veterans were receiving or had pending application for VA benefits, and 32 percent for non-VA benefits. Service linkages with VA and non-VA providers were established for the majority of Veterans following discharge: 75 percent for alcohol treatment, 76 percent for drug treatment, 89 percent for mental health treatment, and 97 percent for medical treatment.

Low Demand/Safe Havens (LDSH): LDSH is a 24-hour per day/7-days per week, community-based early recovery model of supportive housing that serves hard-to-reach homeless Veterans with severe mental illness whom have been unable to participate in traditional treatment and supportive services. Four LDSH sites were funded as pilot program development projects in 2012 under the National Center on Homelessness among Veterans (NCHAV), with funding support made available through HCHV. Outcomes of fidelity reviews conducted by NCHAV warranted expansion of the model program, to include an additional 18 sites in 2013 for chronically homeless Veterans with concurrent mental illness and substance use disorders. In 2015, LDSH programs served 1,379 Veterans, including both males and females. Forty-seven percent of homeless Veterans left the Safe Haven to move into permanent housing, and 50 percent experienced an increase in income during their time in the program. At discharge, 40 percent of Veterans were receiving or had a pending application for VA benefits, and 40 percent for non-VA benefits. Service linkages with VA and non-VA providers were established for the majority of Veterans following discharge: 63 percent for alcohol treatment, 64 percent for drug treatment, 84 percent for mental health treatment, and 94 percent for medical treatment.

Supportive Services for Veteran Families (SSVF): At-risk Veterans benefit from early interventions to avoid homelessness for themselves and their families. VA used the authority mandated in the Veterans Mental Health and Other Care Improvements Act of 2008, P.L. 110-387, and authority provided in other legislation to establish the SSVF program. VA provides resources through the SSVF program for supportive services to very low-income Veteran families. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veterans and their families by providing a range of supportive services designed to promote housing stability. Services provided to these Veteran families were highly effective, with 79 percent of those discharged from SSVF in 2015 exiting into permanent housing. In a review of services provided to those exiting SSVF to permanent housing, the VA's National Center on Homelessness found that 85 percent of all families, and 76 percent of all individuals, did not return to homelessness two years after their discharge from SSVF. Furthermore, SSVF is a cost-effective program, providing the lowest cost per permanent housing placement of any homeless intervention program. In 2015, the cost of serving a Veteran household averaged approximately $3,000. SSVF provides services to all 50 states, Puerto Rico, the District of Columbia, Guam, and the Virgin Islands. In 2015, SSVF served 157,416 participants. Of those served, 34,636 were dependent children, 13,944

were women Veterans (14 percent of Veterans served), and 14,561 Veteran participants were OEF/OIF/OND Veterans (15 percent of Veterans served).

National Call Center for Homeless Veterans (NCCHV): NCCHV began full operation in March 2010. The purpose of NCCHV is to provide homeless Veterans, and Veterans at-risk of homelessness, with timely and coordinated access to VA and community services. NCCHV also disseminates information to concerned family members and non-VA providers about all the programs and services available to assist these Veterans. In 2015, NCCHV addressed 112,363 callers, and provided information and referral to approximately 71,110 Veterans and other interested parties. VA uses NCCHV as a national vehicle for responding to Veterans and community providers, assisting them in connecting to local VA and community resources that provide prevention services to Veterans or assist Veterans in exiting homelessness. In 2016, the NCCHV expects to address over 115,000 callers, and funding is now fully managed by the Chief Business Office (CBO).

Justice Outreach Homelessness Prevention Initiative/Veterans Justice Outreach (VJO) Program: The VJO program, formally launched in 2009, aims to prevent homelessness by providing outreach and linkage to VA services for Veterans at early stages of the justice system, including Veterans' courts, drug courts, and mental health courts, and Veterans in local, county, and city jails. At least one VJO Specialist is located at each VAMC, and works with local justice system partners to facilitate access and adherence to treatment for justice-involved Veterans. The number of Veteran-focused court programs (including Veterans Treatment Courts), community-based entities, and one of the three functions of the VJO outreach, increased nationally from 266 in 2013 to 351 in 2014, an increase of 32 percent. Due to increased community demand for VA outreach services to Veterans in jails and courts not yet served, VA added 13 VJO Specialist positions in 2015. VJO Specialists served 46,534 justice-involved Veterans in 2015, and are expected to serve 55,000 in 2016.

VJO funding will also provide limited support for the Health Care for Reentry Veterans (HCRV) program, which is designed to address the community reentry needs of incarcerated Veterans. HCRV's goals are to prevent homelessness; reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment; and decrease the likelihood of re-incarceration for those leaving prison. In 2015, 15,580 reentry Veterans were provided services through HCRV.

Homeless Veteran Community Employment Services (HVCES): Homeless and at-risk Veterans need access to employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts. Beginning in 2014, funding was provided to hire approximately 160 Community Employment Coordinators (CECs). CECs are dedicated to improving competitive employment outcomes for homeless Veterans. In addition to providing direct employment services, the CECs function as community liaisons to all providers of employment placement; support services both within medical centers and in the community; and provide training and guidance to homeless program staff on resources

that enhance and result in competitive employment outcomes for Veterans who are homeless. In 2015, the number of Veterans exiting homeless residential programs with employment (GPD, Compensated Work Therapy/ Transitional Residences (CWT/TR), and Domiciliary Care for Homeless Veterans (DCHV)) increased by 9 percent. For 2016, VA has a $15 million budget to support 160 CECs. HVCES is the only employment program within VHA specifically targeting homeless Veterans.

New Hepatitis C Treatment

New Hepatitis C Treatment
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Total Medical Care.....	$1,218,398	$690,000	$1,500,000	$660,000	$1,500,000	$600,000	$0	($900,000)

VA places a high priority on ensuring that all enrolled Veterans who require Hepatitis C treatment have access to the necessary therapies. Hepatitis C is an infectious disease primarily affecting the liver, caused by the Hepatitis C virus (HCV). The infection is often asymptomatic, but chronic infection can lead to scarring of the liver and ultimately to cirrhosis, which is generally apparent after many years. In many cases, those with cirrhosis will go on to develop liver failure, or liver cancer. Approximately 175,000 enrollees are diagnosed with HCV, with at least 30,000 having cirrhosis; the proportion of enrollees with HCV who have cirrhosis has doubled over the last decade. There are approximately 130,000 Veterans currently in VA care that are awaiting treatment. It is estimated that as many as 38,000 enrollees may be infected with the virus but have not yet had this condition diagnosed.

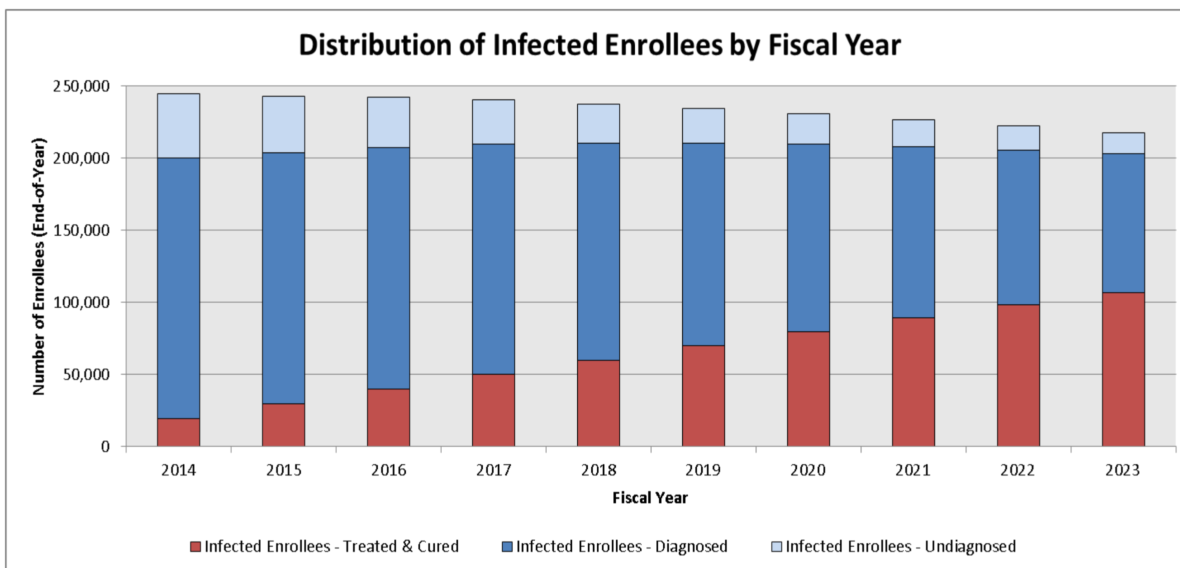
Over the last two years, the U.S. Food and Drug Administration has approved multiple new highly effective drugs for treatment of HCV, with many fewer side effects. These new treatments will change the lives of Veterans infected with Hepatitis C. Prior to the introduction of the new high-cost treatment therapies in January 2014 in the VA system, the treatments for Hepatitis C were often ineffective and subjected patients to considerable side effects. In contrast, the new treatment options are considerably more effective at treating patients with HCV, with cure rates in VA of over 90 percent, present significantly fewer side-effects than earlier options, and are considerably simpler to administer. The primary treatments in use in VA during 2015 were sofosbuvir/ledipasvir for 8 weeks, sofsobuvir/ledipasvir for 12 weeks, sofosbuvir for 12 weeks, and ombitasvir/paritaprevir/ ritonavir/dasabuvir for 12 weeks. Daclatasvir, a new drug used in combination with sofosbuvir, became available in the fourth quarter of 2015, and two new combination medication regimens are expected in the second and fourth quarters of 2016. Cure of HCV significantly decreases the risk of progression of disease to cirrhosis, liver failure, liver cancer, and death. As a result, there has been a large increase in demand for the new treatments and subsequent increases in the number of prescribed treatments. Furthermore, given the availability of new anti-viral therapies as well as increases in HCV testing to identify previously undiagnosed enrollees with HCV, VHA may experience an increase in Hepatitis C diagnoses within the enrolled Veteran population. These increased treatments

and diagnoses may reduce the number of cases of cirrhosis or liver cancer for enrollees infected with HCV.

VA has developed a Hepatitis C projection model to supplement the VA Enrollee Health Care Projection Model. The Hepatitis C model projects both the prevalence of HCV infections in the enrolled Veteran population, as well as the number of newly available treatment therapies prescribed for 2014 through 2023. Each modeled treatment is assigned a national average cost per treatment. The cost per treatment, along with the number of projected treatments in each projection year, has been used to develop projected total treatment drug costs for 2015 through 2017.

The following chart (see Figure A) shows the projected number of enrollees infected with HCV, broken into the following categories: undiagnosed, diagnosed, or cured in 2014 through 2023. The actual number of undiagnosed enrollees is not known; in this chart, the maximum estimated number of undiagnosed enrollees, 38,000, is used. The effectiveness of the new HCV treatments is evident in the considerable increase in the projected number of infected enrollees who are treated and cured.

Figure A



The number of total national Hepatitis C treatments per year increased from approximately 2,800 per year in 2011 through 2013, to approximately 5,400 in 2014. This growth reflects the additional demand for HCV treatment with the newly available drugs, beginning in the second quarter of fiscal year 2014. The total number of treatments was over 30,000 during 2015 and beyond.

The total cost of Hepatitis C treatment increased significantly from 2013 to 2015, due to both the increased treatment rate described above, as well as the significant increase in the average cost per treatment under the new regimens.

Long-Term Services and Supports

Long Term Services and Supports
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$7,702,251	$7,460,513	$8,222,678	$7,875,662	$8,587,920	$9,124,465	$365,242	$536,545

Background

Veterans receive nursing home and domiciliary care through one of four venues: VA Community Living Centers (CLCs), Community Nursing Homes (CNH), State Veterans Nursing Homes, and State Veterans Home Domiciliary. Aging and the changes in the Priority Level 1a population are significant drivers of projected expenditure increases for Long Term Services and Supports (LTSS). VA is mandated by law to provide continuing care nursing home services to Priority 1a enrollees. Additionally, World War II enrollees are in the age bands (greater than age 75) that are the highest users of LTSS and are driving the recent and near-term annual growth in LTSS expenditure requirements. For more details about LTSS, please see the Enrollee Healthcare Projection and CHAMPVA Models chapter.

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Total Medical Care Obligations	Actual	Estimate 1/	Estimate	Approp. 1/	Request	Approp.	2016-2017	2017-2018
Institutional:								
Obligations ($000)								
VA Community Living Centers..........	$3,377,088	$3,453,246	$3,512,886	$3,621,640	$3,613,461	$3,861,735	$100,575	$248,274
Community Nursing Home..........	$861,464	$844,863	$969,603	$907,986	$1,012,378	$1,064,090	$42,775	$51,712
State Home Nursing..........	$1,049,756	$1,169,306	$1,166,253	$1,257,334	$1,268,888	$1,388,354	$102,635	$119,466
Subtotal (VA CLC, CNH, SNH)..........	$5,288,308	$5,467,415	$5,648,742	$5,786,960	$5,894,727	$6,314,179	$245,985	$419,452
State Home Domiciliary..........	$58,298	$59,543	$62,855	$61,537	$66,361	$70,583	$3,506	$4,222
Total Institutional..........	$5,346,606	$5,526,958	$5,711,597	$5,848,497	$5,961,088	$6,384,762	$249,491	$423,674
Average Daily Census								
VA Community Living Centers..........	9,226	8,944	8,975	8,759	8,711	8,514	(264)	(197)
Community Nursing Home..........	8,311	8,417	8,750	8,776	9,145	9,590	395	445
State Home Nursing..........	20,328	20,070	20,371	20,292	20,987	21,454	616	467
Subtotal..........	37,865	37,431	38,096	37,827	38,843	39,558	747	715
State Home Domiciliary..........	3,565	3,539	3,676	3,527	3,753	3,846	77	93
Total Institutional..........	41,430	40,970	41,772	41,354	42,596	43,404	824	808
Per Diem Costs								
VA Community Living Centers..........	$1,002.85	$1,054.91	$1,069.42	$1,132.81	$1,136.48	$1,242.67	$67.06	$106.19
Community Nursing Home..........	$283.99	$274.25	$302.76	$283.46	$303.28	$303.99	$0.53	$0.71
State Home Nursing..........	$141.48	$159.18	$156.42	$169.76	$165.65	$177.30	$9.22	$11.65
State Home Domiciliary..........	$44.80	$45.97	$46.72	$47.80	$48.44	$50.28	$1.73	$1.84
Denominator								
VA Community Living Centers..........	365	366	366	365	365	365	(1)	0
Community Nursing Home..........	365	366	366	365	365	365	(1)	0
State Home Nursing..........	365	366	366	365	365	365	(1)	0
State Home Domiciliary..........	365	366	366	365	365	365	(1)	0

Total Medical Care Obligations	2015 Actual	2016 Budget Estimate 1/	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Non-Institutional:								
Obligations ($000)								
VA Adult Day Health Care	$14,905	$14,769	$15,114	$15,283	$15,462	$15,845	$348	$383
Home-Based Primary Care	$750,575	$766,653	$816,102	$799,753	$849,798	$882,423	$33,696	$32,625
Spinal Cord Injury Home Care	$10,354	$9,407	$10,526	$9,685	$10,905	$11,271	$379	$366
Home Telehealth	$218,208	$227,529	$227,630	$239,104	$239,414	$247,528	$11,784	$8,114
Subtotal VA provide Non-Institutional	$994,042	$1,018,358	$1,069,372	$1,063,825	$1,115,579	$1,157,067	$46,207	$41,488
State Adult Day Health Care	$1,031	$1,203	$892	$1,312	$1,029	$1,195	$137	$166
Community Adult Day Health Care	$119,692	$78,853	$123,711	$84,693	$132,625	$135,496	$8,914	$2,871
Other Home Based Prgs:								
Home Respite Care	$35,399	$32,812	$37,457	$35,092	$40,062	$43,102	$2,605	$3,040
Purchased Skilled Home Care	$319,249	$228,929	$333,502	$239,481	$348,986	$365,392	$15,484	$16,406
Hospice Care	$90,817	$78,283	$93,464	$80,987	$96,329	$99,223	$2,865	$2,894
Homemaker/Hm. Hlth. Aide Prgs	$721,119	$473,469	$778,602	$499,695	$817,723	$864,082	$39,121	$46,359
Community Residential Care	$74,296	$21,648	$74,081	$22,080	$74,499	$74,146	$418	($353)
Subtotal Community Non-Institutional (excluding State)	$1,360,572	$913,994	$1,440,817	$962,028	$1,510,224	$1,581,441	$69,407	$71,217
Total Non-Institutional	$2,355,645	$1,933,555	$2,511,081	$2,027,165	$2,626,832	$2,739,703	$115,751	$112,871
Clinic Stops (VA Care)/Procedures (Purchased LTC)								
VA Adult Day Health Care	123,661	131,446	122,510	132,427	122,486	122,450	(24)	(36)
Home-Based Primary Care	1,275,258	1,391,421	1,345,456	1,413,182	1,364,090	1,393,741	18,634	29,651
Spinal Cord Injury Home Care	19,835	19,916	19,704	19,964	19,873	20,177	169	304
Home Telehealth (Participation Months)	1,112,225	1,227,005	1,191,454	1,255,389	1,220,264	1,247,934	28,810	27,670
Subtotal VA provide Non-Institutional	2,602,003	2,769,788	2,750,302	2,820,962	2,795,947	2,784,302	45,645	(11,645)
State Adult Day Health Care (ADC)	38	39	42	41	47	53	5	6
Community Adult Day Health Care	904,028	903,506	909,907	914,130	922,330	937,907	12,423	15,577
Other Home Based Prgs:								
Home Respite Care	326,284	319,698	332,549	331,666	346,251	362,654	13,702	16,403
Purchased Skilled Home Care	1,825,750	1,754,413	1,907,049	1,780,289	1,941,237	1,977,144	34,188	35,907
Hospice Care	462,663	390,070	416,708	391,456	417,780	418,611	1,072	831
Homemaker/Hm. Hlth. Aide Prgs	10,020,422	8,013,269	10,103,187	8,203,731	10,300,770	10,581,392	197,583	280,623
Community Residential Care	71,024	67,867	71,178	66,606	69,634	68,209	(1,544)	(1,425)
Subtotal Community Non-Institutional (excluding State)	11,636,862	11,448,823	12,311,786	11,687,878	15,655,725	13,754,767	3,343,939	(1,900,958)
Cost Per Clinic Stop/Procedure								
VA Adult Day Health Care	$120.53	$112.36	$123.37	$115.41	$126.23	$129.40	$2.87	$3.16
State Adult Day Health Care	$108.09	$122.41	$84.28	$127.49	$87.23	$89.83	$2.95	$2.60
Community Adult Day Health Care	$132.40	$87.27	$135.96	$92.65	$143.79	$144.47	$7.83	$0.67
Home-Based Primary Care	$588.57	$550.99	$606.56	$565.92	$622.98	$633.13	$16.42	$10.15
Other Home Based Prgs:								
Home Respite Care	$108.49	$102.63	$112.64	$105.81	$115.70	$118.85	$3.07	$3.15
Purchased Skilled Home Care	$174.86	$130.49	$174.88	$134.52	$179.78	$184.81	$4.90	$5.03
Hospice Care	$196.29	$200.69	$224.29	$206.89	$230.57	$237.03	$6.28	$6.46
Homemaker/Hm. Hlth. Aide Prgs	$71.96	$59.09	$77.06	$60.91	$79.38	$81.66	$2.32	$2.28
Spinal Cord Injury Home Care	$522.01	$472.33	$534.21	$485.12	$548.73	$558.61	$14.53	$9.87
Home Telehealth	$196.19	$185.43	$191.05	$190.46	$196.20	$198.35	$5.15	$2.15
Community Residential Care	$1,046.07	$318.98	$1,040.79	$331.50	$1,069.87	$1,087.04	$29.08	$17.18
Denominator								
State Adult Day Health Care	251	252	252	251	251	251	(1)	0

		2016		2017		2018		
	2015 Actual	Budget Estimate 1/	Current Estimate	Advance Approp. 1/	Revised Request	Advance Approp.	Increase/Decrease 2016-2017	2017-2018
Length of Stay								
Short Stay								
VA Community Living Centers	2,371	2,384	2,347	2,370	2,317	2,295	(30)	(22)
Community Nursing Home	1,599	1,577	1,725	1,664	1,840	1,974	115	134
State Home Nursing	755	1,035	773	1,162	812	784	39	(28)
Subtotal	4,725	4,996	4,845	5,196	4,969	5,053	124	84
Long Stay								
VA Community Living Centers	6,855	6,560	6,628	6,389	6,394	6,219	(234)	(175)
Community Nursing Home	6,712	6,840	7,025	7,112	7,305	7,616	280	311
State Home Nursing	19,573	19,035	19,598	19,130	20,175	20,670	577	495
Subtotal	33,140	32,435	33,251	32,631	33,874	34,505	623	631
Total	37,865	37,431	38,096	37,827	38,843	39,558	747	715
Age								
Age < 65								
VA Community Living Centers	1,883	1,556	1,630	1,297	1,383	1,158	(247)	(225)
Community Nursing Home	1,343	1,148	1,241	1,036	1,140	1,053	(101)	(87)
State Home Nursing	1,272	1,115	1,173	1,022	1,110	1,041	(63)	(69)
Subtotal	4,498	3,819	4,044	3,355	3,633	3,252	(411)	(381)
Age 65-84								
VA Community Living Centers	5,262	5,488	5,369	5,666	5,456	5,573	87	117
Community Nursing Home	4,652	5,006	5,100	5,429	5,514	5,949	414	435
State Home Nursing	9,509	9,189	9,561	9,235	9,881	10,130	320	249
Subtotal	19,423	19,683	20,030	20,330	20,851	21,652	821	801
Age > 84								
VA Community Living Centers	2,081	1,900	1,976	1,796	1,872	1,783	(104)	(89)
Community Nursing Home	2,316	2,263	2,409	2,311	2,491	2,588	82	97
State Home Nursing	9,547	9,766	9,637	10,035	9,996	10,283	359	287
Subtotal	13,944	13,929	14,022	14,142	14,359	14,654	337	295
Total	37,865	37,431	38,096	37,827	38,843	39,558	747	715
Eligibility								
Priority 1A								
VA Community Living Centers	4,602	4,622	4,284	4,634	3,969	3,695	(315)	(274)
Community Nursing Home	5,855	6,237	6,118	6,579	6,346	6,606	228	260
State Home Nursing	2,682	2,854	2,930	3,172	3,251	3,543	321	292
Subtotal	13,139	13,713	13,332	14,385	13,566	13,844	234	278
Service-connected								
VA Community Living Centers	1,890	1,841	2,079	1,788	2,253	2,432	174	179
Community Nursing Home	1,529	1,287	1,537	1,236	1,533	1,534	(4)	1
State Home Nursing	3,984	3,996	4,155	4,072	4,437	4,684	282	247
Subtotal	7,403	7,124	7,771	7,096	8,223	8,650	452	427
Non-service-connected								
VA Community Living Centers	2,734	2,481	2,612	2,337	2,489	2,387	(123)	(102)
Community Nursing Home	927	893	1,095	961	1,266	1,450	171	184
State Home Nursing	13,662	13,220	13,286	13,048	13,299	13,227	13	(72)
Subtotal	17,323	16,594	16,993	16,346	17,054	17,064	61	10
Total	37,865	37,431	38,096	37,827	38,843	39,558	747	715
	37,865		38,096		38,843	39,558		

	2015 Actual	2016 Budget Estimate 1/	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Institutional Long-Term Care Obligations:								
Length of Stay								
Short Stay								
VA Community Living Centers	$1,024,662	$1,086,793	$1,083,266	$1,156,264	$1,132,320	$1,225,248	$49,054	$92,928
Community Nursing Home	$180,795	$170,208	$208,344	$185,159	$221,924	$238,510	$13,580	$16,586
State Home Nursing	$40,073	$63,494	$45,441	$75,796	$50,371	$52,042	$4,930	$1,671
Subtotal	$1,245,530	$1,320,495	$1,337,051	$1,417,219	$1,404,615	$1,515,800	$67,564	$111,185
Long Stay								
VA Community Living Centers	$2,352,426	$2,366,453	$2,429,620	$2,465,376	$2,481,141	$2,636,487	$51,521	$155,346
Community Nursing Home	$680,669	$674,655	$761,259	$722,827	$790,454	$825,580	$29,195	$35,126
State Home Nursing	$1,009,683	$1,105,812	$1,120,812	$1,181,538	$1,218,517	$1,336,312	$97,705	$117,795
Subtotal	$4,042,778	$4,146,920	$4,311,691	$4,369,741	$4,490,112	$4,798,379	$178,421	$308,267
Total	$5,288,308	$5,467,415	$5,648,742	$5,786,960	$5,894,727	$6,314,179	$245,985	$419,452
Age								
Age < 65								
VA Community Living Centers	$715,838	$869,277	$671,191	$939,433	$622,586	$600,403	($48,605)	($22,183)
Community Nursing Home	$146,436	$179,335	$162,659	$200,201	$167,606	$173,903	$4,947	$6,297
State Home Nursing	$68,476	$100,859	$81,974	$119,009	$95,032	$109,781	$13,058	$14,749
Subtotal	$930,750	$1,149,471	$915,824	$1,258,643	$885,224	$884,087	($30,600)	($1,137)
Age 65-84								
VA Community Living Centers	$1,935,109	$1,885,929	$2,143,068	$1,973,789	$2,324,627	$2,599,478	$181,559	$274,851
Community Nursing Home	$485,762	$407,767	$518,954	$414,371	$514,141	$512,711	($4,813)	($1,430)
State Home Nursing	$498,311	$549,821	$569,581	$594,844	$635,526	$711,070	$65,945	$75,544
Subtotal	$2,919,182	$2,843,517	$3,231,603	$2,983,004	$3,474,294	$3,823,259	$242,691	$348,965
Age > 84								
VA Community Living Centers	$726,141	$698,040	$698,626	$708,418	$666,247	$661,854	($32,379)	($4,393)
Community Nursing Home	$229,266	$257,761	$287,991	$293,414	$330,631	$377,476	$42,640	$46,845
State Home Nursing	$482,969	$518,626	$514,698	$543,481	$538,331	$567,503	$23,633	$29,172
Subtotal	$1,438,376	$1,474,427	$1,501,315	$1,545,313	$1,535,209	$1,606,833	$33,894	$71,624
Total	$5,288,308	$5,467,415	$5,648,742	$5,786,960	$5,894,727	$6,314,179	$245,985	$419,452
Eligibility								
Priority 1A								
VA Community Living Centers	$1,614,407	$1,998,130	$1,857,161	$2,302,457	$2,104,643	$2,468,492	$247,482	$363,849
Community Nursing Home	$611,430	$640,598	$707,509	$701,350	$755,842	$809,819	$48,333	$53,977
State Home Nursing	$150,173	$196,317	$198,926	$237,999	$249,176	$306,053	$50,250	$56,877
Subtotal	$2,376,010	$2,835,045	$2,763,596	$3,241,806	$3,109,661	$3,584,364	$346,065	$474,703
Service-connected								
VA Community Living Centers	$698,761	$420,766	$578,908	$267,983	$433,826	$281,234	($145,082)	($152,592)
Community Nursing Home	$155,854	$118,913	$156,313	$115,115	$146,297	$138,594	($10,016)	($7,703)
State Home Nursing	$205,835	$215,699	$220,331	$224,940	$231,204	$244,280	$10,873	$13,076
Subtotal	$1,060,450	$755,378	$955,552	$608,038	$811,327	$664,108	($144,225)	($147,219)
Non-service-connected								
VA Community Living Centers	$1,063,920	$1,034,350	$1,076,817	$1,051,200	$1,074,992	$1,112,009	($1,825)	$37,017
Community Nursing Home	$94,180	$85,352	$105,781	$91,521	$110,239	$115,677	$4,458	$5,438
State Home Nursing	$693,748	$757,290	$746,996	$794,395	$788,508	$838,021	$41,512	$49,513
Subtotal	$1,851,848	$1,876,992	$1,929,594	$1,937,116	$1,973,739	$2,065,707	$44,145	$91,968
Total	$5,288,308	$5,467,415	$5,648,742	$5,786,960	$5,894,727	$6,314,179	$245,985	$419,452

	2015	2016		2017		2018	Increase/Decrease	
	Actual	Budget Estimate 1/	Current Estimate	Advance Approp. 1/	Revised Request	Advance Approp.	2016-2017	2017-2018
Institutional Long-Term Care Per Diems:								
Length of Stay								
Short Stay								
VA Community Living Centers	$1,184.01	$1,245.55	$1,261.08	$1,336.64	$1,338.91	$1,462.68	$77.83	$123.77
Community Nursing Home	$309.77	$294.89	$330.00	$304.86	$330.44	$331.03	$0.44	$0.59
State Home Nursing	$145.42	$167.61	$160.62	$178.71	$169.95	$181.86	$9.34	$11.91
							$0.00	$0.00
Long Stay								
VA Community Living Centers	$940.19	$985.63	$1,001.55	$1,057.20	$1,063.13	$1,161.48	$61.57	$98.35
Community Nursing Home	$277.84	$269.49	$296.08	$278.45	$296.44	$296.99	$0.37	$0.54
State Home Nursing	$141.33	$158.73	$156.26	$169.22	$165.47	$177.12	$9.22	$11.65
Age								
Age < 65								
VA Community Living Centers	$1,041.53	$1,526.40	$1,125.06	$1,984.42	$1,233.34	$1,420.50	$108.28	$187.16
Community Nursing Home	$298.73	$426.82	$358.12	$529.44	$402.80	$452.47	$44.68	$49.66
State Home Nursing	$147.49	$247.15	$190.94	$319.03	$234.56	$288.92	$43.62	$54.36
Age 65-84								
VA Community Living Centers	$1,007.54	$938.92	$1,090.59	$954.40	$1,167.31	$1,277.92	$76.72	$110.61
Community Nursing Home	$286.08	$222.56	$278.02	$209.11	$255.44	$236.12	($22.58)	($19.32)
State Home Nursing	$143.57	$163.48	$162.77	$176.47	$176.21	$192.31	$13.44	$16.10
Age > 84								
VA Community Living Centers	$956.00	$1,003.80	$966.00	$1,080.66	$975.07	$1,016.99	$9.07	$41.92
Community Nursing Home	$271.21	$311.21	$326.63	$347.85	$363.64	$399.61	$37.01	$35.96
State Home Nursing	$138.60	$145.10	$145.92	$148.38	$147.55	$151.20	$1.62	$3.65
Eligibility								
Priority 1A								
VA Community Living Centers	$961.11	$1,181.17	$1,184.46	$1,361.26	$1,452.80	$1,830.31	$268.34	$377.51
Community Nursing Home	$286.11	$280.63	$315.97	$292.07	$326.30	$335.86	$10.33	$9.56
State Home Nursing	$153.41	$187.94	$185.50	$205.56	$209.99	$236.66	$24.49	$26.68
Service-connected								
VA Community Living Centers	$1,012.92	$624.46	$760.81	$410.63	$527.55	$316.82	($233.26)	($210.73)
Community Nursing Home	$279.27	$252.45	$277.87	$255.16	$261.46	$247.53	($16.41)	($13.93)
State Home Nursing	$141.55	$147.48	$144.89	$151.34	$142.76	$142.88	($2.12)	$0.12
Non-service-connected								
VA Community Living Centers	$1,066.15	$1,139.09	$1,126.39	$1,232.35	$1,183.28	$1,276.33	$56.89	$93.05
Community Nursing Home	$278.35	$261.14	$263.94	$260.92	$238.57	$218.57	($25.38)	($20.00)
State Home Nursing	$139.12	$156.51	$153.62	$166.80	$162.44	$173.58	$8.82	$11.14

Institutional and Non-Institutional LTSS

VA offers a spectrum of Long Term Services and Supports LTSS and a specialty in geriatric services to Veterans enrolled in its health care system. The spectrum of long term services and supports includes home and community based services (HCBS); hospice and palliative care; nursing home and domiciliary care; and programs of geriatric innovations, ambulatory and inpatient geriatrics, and dementia management. All VA medical centers provide HCBS for Veterans of all ages. This patient-focused approach supports Veterans who wish to live safely at home in their own communities for as long as possible.

<u>Nursing Home and Domiciliary Care</u>

Institutional LTSS are provided for Veterans whose health care needs cannot be met in the home or on an outpatient basis because they require a level of skilled treatment or assessment which can best be provided in an institutional setting. Institutional services may be long term, (i.e., for life), or may be short term for rehabilitation or recovery from an acute condition. Short-term institutional respite care is also available to temporarily relieve caregivers who look after Veterans in the home.

VA's nursing home and domiciliary care programs include VA operated CLCs, CNHs, and State Veterans Home programs. While all three programs provide nursing home care, each program has its own particular features. VA re-structured its own program to reflect the Department's commitment to the culture change movement in nursing homes and to enhance Veteran choice. VA CLCs are hospital-based and provide an extensive level of nursing home care supported by an array of clinical specialties at the host hospital. VA purchases care through the CNH program. These homes provide a broad range of nursing home care and have the advantage of being offered in many local communities throughout the Nation, enabling a Veteran to receive care near his/her home and family. VA's CLCs and selected CNHs specialize in treating Veterans with post-acute needs, thus reducing hospital days. The State Veterans Nursing Home program provides a broad range of nursing home care and is characterized by a joint cost-sharing agreement between VA, the Veteran, and the state.

Home and Community Based Services (HCBS):
HCBS programs have grown out of the philosophy that: (1) a home or community setting is the desired location to deliver LTSS; and (2) placement in a nursing home should be reserved for situations in which Veterans cannot receive the care they need or can no longer safely be cared for at home. Veterans prefer HCBS care because it enables them to live at home with a higher quality of life than is normally possible in an institution. Within VA, HCBS programs include home-based primary care, purchased skilled home health care, spinal cord injury home care, adult day health care, homemaker and home health aide services, Veteran-directed home- and community-based services, home respite care, home hospice care, community residential care, medical foster home and home Telehealth.

Hospice and Palliative Care (HPC):
HPC represents a continuum of comfort-oriented and supportive services provided in the home, community, outpatient, or inpatient settings for persons with advanced life-limiting disease. The mission of the VA HPC program is to honor Veterans' preferences for care at the end of life. VA must offer to provide or purchase hospice and palliative care that VA determines an enrolled Veteran needs (38 Code of Federal Regulations 17.36 and 17.38). These services include, but are not limited to: advance care planning, symptom management, inpatient palliative care, collaboration with community hospice providers, and access to home hospice care at VA expense. To effectively deliver these services, VA has embarked on a Comprehensive End of Life Care Initiative to ensure reliable access to quality end of life care through enhanced palliative care staffing and leadership, expansion of the number of HPC inpatient units, specialized Veteran-specific training, promotion of Hospice-Veteran Partnerships, and implementation of a quality program that links quality indicators to care interventions.

Geriatric Programming:
Older Veterans with multiple medical, functional or psychosocial problems and those with particular geriatric problems receive assessment and development of multidimensional plan of care from an interdisciplinary team of VA health professionals. A small percentage of the frail, elderly Veterans receive primary care in special Patient-Aligned

Care Teams, or PACTs, also called Geri PACT, (formerly termed Geriatric Primary Care) where their more complex cases and involved medical histories can receive in-depth attention. Care for Veterans with Alzheimer's or other dementia is provided throughout the full range of VA health care services, which includes, but is not limited to, geriatrics and extended care services. Caregiver support is an essential part of all of these services.

State Home Programs

The State Homes Per Diem program comprises four components or levels of payment: (1) Adult Day Health Care (ADHC), (2) State Home Domiciliary Care, and (3) State Home Nursing Care [Basic and P1A].

Adult Day Health Care:

ADHC provides support for individuals whom do not fully function independently, but do not need full-time nursing care. It is generally provided in a group environment, and is coordinated with health and social services designed to stabilize or improve a veteran's ability for self-care, or to prevent, postpone, or reduce the need for institutional placement.

State Home Domiciliary Care:

State Home Domiciliary Care provides shelter, food, and necessary medical care on an ambulatory self-care basis to assist eligible Veterans who are suffering from a disability, disease, or defect of such a degree that incapacitates the Veteran from earning a living. However, the Veteran, although not in need of hospitalization or nursing care services, needs to attain the physical, mental, and social well-being through special rehabilitative programs to restore the Veteran to the highest level of functioning.

State Home Nursing Care:

State Home Nursing Care provides accommodations for convalescents or other persons whom are not acutely ill and not in need of hospital care, but who require nursing care and related medical services, if such nursing care and medical services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such care. It does not include domiciliary care.

The cost of State Homes care is determined by a very detailed and strict budgetary process. The process begins with understanding, capturing, trending, and analyzing the variables that drive these costs.

State Home model uses three independent variables to arrive at a projection for future year requirements: Per Diem Rates, Average Daily Census (ADC), and the number of days available by component within the financial period.

Per Diem Rates

Data Sources: Centers for Medicaid and Medicare Services (CMS), and Federal Register, Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities.

Methodology: ADHC, Domiciliary Care, and Nursing Home Care (Basic) per diem rates are based on the rates published in the Federal Register, Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF). If for example, the published rate indicates that the SNF market basket percentage change between 2013 and 2014 is 2.2 percent, then we use this percentage to increase the basic ADC rates accordingly.

The per diem rate calculation for Nursing Home Care (P1A) comprises two components (1) physician expense, and (2) Resource Utilization Group (RUG) IV average.

The data for physician expense can be found at the CMS web-site:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

There are two parts to the physician expense component: (1) the geographic practice cost index (GPCI), and (2) the practice expense per hour (PE/HR) data - that is, total PE/HR for all physicians.

The RUG-IV data is found on the Federal Register - either in a final rule or a notice. The physician expense component is calculated by multiplying the PE/HR by the specific physician work (PW) GPCI for each State Home. The result is an adjusted PE/HR. The adjusted HR is then multiplied by 12 and divided by 365 in order to derive at a daily rate.

The RUG-IV average is calculated by taking the labor portion of each RUG and multiplying it by the wage index of the specific Core Based Statistical Area (CBSA) or State/Territory and then adding the non-labor component. This calculated is done for all 66 RUGS and 52 States/Territories (rural areas) and 440 CBSAs (urban areas) regardless of whether a State Home is located in the particular area.

The average RUG-IV rate is then added to the physician expense component to obtain a final per diem rate.

Average Daily Census (ADC)

Data Sources: Historical trends and Veteran Population Projection Model (VetPOP) 2011

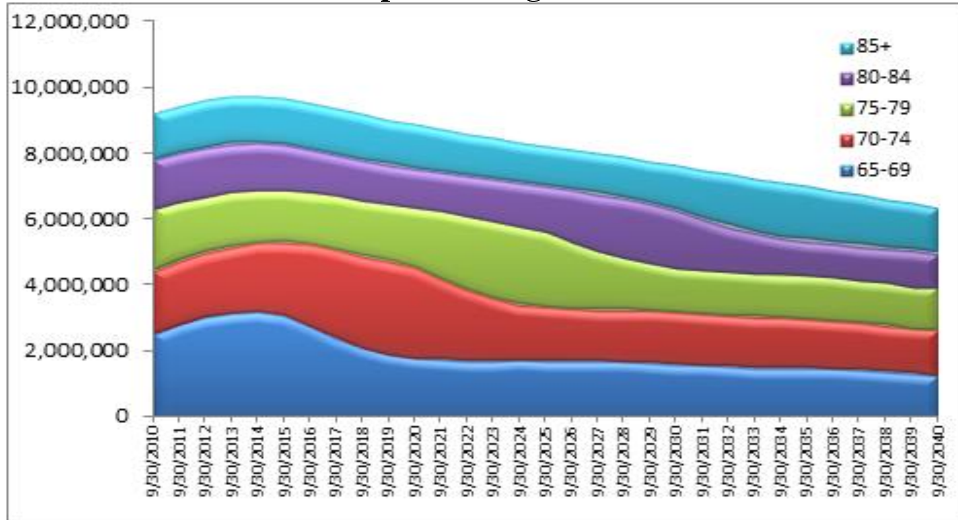
Methodology: For the State Nursing Home Care (NHC) Priority 1, and Adult Day Health Care projections, an Additive Winters Exponential Smoothing model was used. For State Home Domiciliary, the regular Winters Exponential Smoothing model was used. Originally, the Additive Winters Exponential Smoothing model was used for NHC Basic, but after consulting with the Program Office for State Home Per Diem, it was decided to use the model, but use the upper bound of the interval—rather than the

predicted path. The reasoning is that with the new beds and new state homes being added, it was unrealistic to see a meaningful drop in the NHC Basic. Stabilization is more likely (as Veterans transition to Priority 1 status from Basic). We will monitor the situation and be ready to update the forecast as more data is added in the coming months. Additionally, we used actual data through 2015 for the ADC and per diem, which contributes to the differences between last year's submission and this year's.

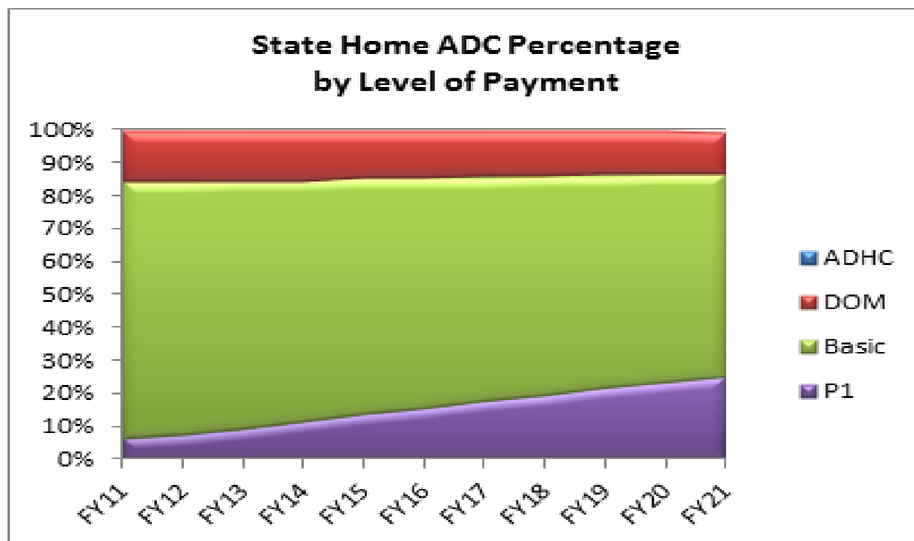
ADC projections incorporate a time series analysis of historical ADC figures going back to the beginning of 2008 as well as the VetPop 2011 projections for Veterans over the age of 65, and residing in counties with State Homes. ADC is projected on a month by month basis for all future years for each of the four population segments using four separate calculations to establish potential future trends: logarithmic regression, forecast, trend, and a change rate forward calculation.

Each of the four ADC forecasts is evaluated for accuracy on a monthly basis to determine which should be used in any final projections submitted forward. The forecast with the lowest residual, or variance between projected ADC to actual ADC, is then selected to project future fiscal years. The most dynamic change in ADC has been within the NHC segment, where the Basic NHC ADC has been steadily declining since 2011, while the NHC P1 group has been increasing significantly. Consistent with the VetPop 2011 projections, this level of growth is not expected to be sustainable, but will taper off in future years (see table below). National Center for Veterans Analysis and Statistics (NCVAS) Vetpop 2011 projections has been incorporated into the model for the overall NHC population. Based on VetPoP 2011, the Veteran population aged 65 and over is expected to peak in 2014 and then slowly decline in future years.

Veteran Population Age 65 and Above



Additionally, the chart below (ADC percentage) helps illustrate the dynamics in the different populations over time, as the overall NHC population remains fairly stagnant, the composition within it changes: NHC– Basic population slowly erodes while NHC – P1 continues to grow. As NHC – P1 is the costliest population, it accounts for more than 80 percent in the program's overall cost over time.



Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Other Dependent Programs

CHAMPVA, Spina Bifida, FMP, & CWVV
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Total Medical Care.....	$1,547,010	$1,883,882	$1,816,611	$2,061,930	$1,919,874	$2,063,652	$103,263	$143,778

The Veterans Health Care Expansion Act of 1973, P.L. 93-82, authorized VA to provide a health benefits program that shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001, P.L. 107-14, extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65. To be eligible for CHAMPVA benefits, the beneficiary must be the spouse or child of a Veteran who has a total and permanent service-connected disability, or the widowed spouse or child of a Veteran who: (a) died as a result of a service-connected disability; (b) had a total, permanent disability resulting from a service-connected condition at the time of death; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense (DOD) TRICARE Program. CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service, and State Victims of Crime Compensation Programs.

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Obligations ($000)								
CHAMPVA.......	$1,393,576	$1,714,390	$1,590,142	$1,878,900	$1,715,000	$1,850,000	$124,858	$135,000
Foreign Medical Program (includes Foreign C&P Exams)....	$27,051	$28,187	$64,644	$31,280	$31,280	$34,151	($33,364)	$2,871
Spina Bifida Program.......	$32,352	$38,232	$53,002	$42,216	$58,026	$57,601	$5,024	($425)
Children of Women Vietnam Veterans.......	$0	$200	$200	$200	$200	$200	$0	$0
Subtotal.......	$1,452,979	$1,781,009	$1,707,988	$1,952,596	$1,804,506	$1,941,952	$96,518	$137,446
Operating Expense:								
Administrative.......	$88,912	$97,123	$102,873	$103,300	$109,334	$115,367	$6,461	$6,033
Facilities.......	$5,119	$5,750	$5,750	$6,034	$6,034	$6,333	$284	$299
Total.......	$1,547,010	$1,883,882	$1,816,611	$2,061,930	$1,919,874	$2,063,652	$103,263	$143,778

The Veterans Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163, section 102, further expanded CHAMPVA to include primary family caregivers of certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through the existing CHAMPVA Program when the primary family caregiver has no other health care coverage (including Medicare and Medicaid).

In addition to CHAMPVA, other VA purchased care programs also include the Foreign Medical Program (FMP), Spina Bifida Health Care Benefits Program, and Children of Women Vietnam Veterans Health Care Benefits Program (CWVV).

Foreign Medical Program (FMP): The Foreign Medical Program is a health care benefits program for United States Veterans with VA-rated service-connected conditions that are residing or traveling abroad, excluding the Philippines where the VA Outpatient Clinic

has jurisdiction of the health care services. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions.

Spina Bifida Health Care Program: Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, P.L. 104-204, section 421, VA administers the Spina Bifida Health Care Benefits Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003, P.L. 108-183, section 102, authorized birth children with spina bifida of certain Veterans who served in Korea to be eligible for care under this program. Prior to October 10, 2008, the program provided reimbursement only for medical services associated with spina bifida; however, under the Veterans' Mental Health and Other Care Improvements Act of 2008, P.L. 110-387, the program provides reimbursement for comprehensive medical care.

Children of Women Vietnam Veterans Health Care Benefits Program (CWVV): Under the Veterans Benefits and Health Care Improvement Act of 2000, P.L. 106-419, section 401, VA administers the CWVV Program for children with certain birth defects born to women Vietnam Veterans. CWVV Program provides reimbursement only for covered birth defects.

Caregivers

Caregivers
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$453,623	$555,096	$622,466	$641,509	$724,628	$839,828	$102,162	$115,200

The Caregivers and Veterans Omnibus Health Services Act of 2010, signed into law by President Obama on May 5, 2010, allows VA to provide an unprecedented level of benefits to family caregivers of Veterans ("Family Caregivers"). The Caregiver Law (P.L. 111-163, Title 1, Caregiver Support) directly benefits Family Caregivers by establishing a comprehensive National Caregiver Support Program with a prevention and wellness focus that includes the use of evidence-based training and support services for Family Caregivers.

The 2017 estimated obligation increase from the advance appropriation level is primarily driven by an increase in the number of anticipated Caregivers, from 30,644 in 2016 to 36,644 in 2017. The increase is based on the most recent data trends within the Program of Comprehensive Assistance for Family Caregivers.

P.L. 111-163 establishes additional services and supports for Family Caregivers of eligible post 9/11 Veterans seriously injured in the line of duty under the Program of Comprehensive Assistance for Family Caregivers. Additional services and supports include a stipend paid directly to the Family Caregiver, enrollment in VA's Civilian

Health and Medical Program (CHAMPVA) if the Family Caregiver is not already eligible under a health care plan, an expanded respite benefit, and mental health treatment.

VA has partnered with Easter Seals Disability Services to provide comprehensive Family Caregiver training for eligible Family Caregivers. Training is available for Family Caregivers in traditional classroom settings, in a workbook format, and in an online format. More than 31,000 Caregivers have been trained since the program's inception in May 2011.

Caregiver Support Coordinators at each VA medical center serve as the clinical experts on Caregiver issues and are knowledgeable of both VA and non-VA support services and benefits available for Veterans of all eras and their Family Caregivers. Caregiver Support Coordinators can also assist eligible Post 9/11 Veterans and their Caregivers in applying for additional services.

VA established a National Caregiver Support Line (855-260-3274), on February 1, 2011, at the Medical Center located in Canandaigua, NY. This support line is available to respond to inquiries about the Caregiver services, as well as serve as a resource and referral center for Caregivers. The support line is also available to Veterans and others seeking Caregiver information, provide referrals to local VA Medical Center Caregiver Support Coordinators and VA/community resources, and provide emotional support. As of October 2015, VA's Caregiver Support Line, has received 206,772 calls, averaging over 150 calls per day. The calls received are from Family Caregivers of Veterans of all eras.

2015 Accomplishments

- VA's Caregiver Support Program has been accepting applications for the Program of Comprehensive Assistance for Family Caregiver since May 9, 2011. As of September 30, 2015, 24,771 Primary Family Caregivers are approved for the program with 5,772 Primary Family Caregivers who did not previously have health insurance covered under VA's Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- Caregiver Education and Training: Prior to approval for the Program of Comprehensive Assistance, Caregivers complete a Caregiver Core Curriculum developed in partnership with Easter Seals Disability Services which may be completed on-line, via workbook/DVD or in a classroom setting. In fiscal year 2014, additional optional training opportunities in collaboration with Easter Seals were developed and deployed in the form of 4 Caregiver Self-Care Courses. The courses were made available to Caregivers of all era Veterans participating in the Caregiver Support Program: Managing Stress, Effective Communications/ Problem Solving, Taking Care of Yourself and Utilizing Technology. As of September 30, 2015, approximately 34,000 Caregivers participated in education and training opportunities.

- Caregiver Support Coordinators: Caregiver Support Coordinators (CSCs) stationed at each VA medical center serve as the clinical experts on Caregiver issues and are knowledgeable of both VA and non-VA support services and benefits available for Veterans and their Family Caregivers. VA anticipates funding 328 CSC positions in 2016, allowing for expanded support to a growing number of Family Caregivers of Veterans from all eras across the nation.
- VA's Caregiver Support Line (855-260-3274): The Support Line, staffed by licensed social workers, has responded to more than 206,000 calls as of September 30, 2015 and continues to average 150+ calls per day.
- Building Better CaregiversTM (BBC): VA partnered with the National Council on Aging (NCoA) to offer BBC to Family Caregivers of Veterans of all eras beginning in January 2013. BBC is an evidence-based, interactive web-based workshop designed to provide Family Caregivers with support, teach problem solving, and provide Family Caregivers with additional skills. As of September 30, 2015, more than 4,718 Family Caregivers have been referred to BBC.

2016 – 2018 Future Goals

- Caregiver Education and Training: Provide additional opportunities to engage Caregivers of Veterans from all eras in live remote training opportunities around special topics of interest.
- Partnered Evaluation Center: Support the Partnership Evaluation Center, in collaboration with VA's Quality Enhancement Research Initiative (QUERI), to support the evaluation of program components under the Caregivers and Veterans Omnibus Health Services Act of 2010.
- Caregiver Support Line: Continue monthly telephonic educational calls offered for Family Caregivers nationwide. Expand the calls to include topics presented by Caregivers to provide a different forum for peer support.
- Caregiver Peer Support: Expand opportunities for Caregiver peer support through ongoing collaboration with Joining Forces, Department of Defense, the Elizabeth Dole Foundation, and other community partners through establishing both local and web-based opportunities to connect Caregivers of Veterans and Service members to one another.

Indian Health

Indian Health Services Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act (dollars in thousands)								
		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Total Medical Care.....	$14,999	$28,062	$15,000	$28,062	$28,062	$29,358	$13,062	$1,296

Consistent with the Administration's goal to increase access to care for Veterans and with the Affordable Care Act, VA and the Indian Health Service (IHS) signed the VA-IHS National Reimbursement Agreement in December 2012. This Agreement facilitates reimbursement by VA to IHS for direct health care services provided to eligible American Indian/Alaskan Native (AI/AN) Veterans in IHS facilities. The Agreement also paves the way for future agreements negotiated between VA and Tribal Health Programs (THP), in addition to those already in existence. This VA-IHS national agreement created the basis for individual agreements with interested and appropriate THPs. Each interested tribe can initiate contact with VHA and VHA Chief Business Office in turns will provide the necessary paper work and guidance for the tribe to pursue the agreement. Agreements with tribes will reimburse them for direct care provided to eligible AI/AN Veterans.

Phase 1 implementation was completed with Local Implementation Plans for 10 sites in April 2013. Phase 2 was completed with all remaining sites in 71 Local Implementation Plans in July 2013. Two additional sites were recently identified as qualifying IHS sites and were included in the program making the total IHS sites participating in the program 83.

VA Reimbursement Agreements with THPs are increasing as well. Currently, VA has 85 signed VA-THP Reimbursement Agreements with additional 59 agreements in progress. From September 2013 to December 2015, VA completed Over 100 program orientations providing program information to individual VA medical centers and tribes.
VA is facing the following challenge during implementation and onboarding Tribal facilities:

- THP Facilities Agreement: Some tribes are asking for more benefits than what the National Reimbursement Agreement allows for thus making negotiations with these tribes difficult and challenging.

2015 Accomplishments

- Number of THP Agreements increased to 85 (December 2015)
- Reimbursements to IHS and THP facilities for direct care services provided to eligible AI/AN Veterans totaled over $31 million covering over 6,200 Veterans.

2016 – 2018 Future Goals

- VA and IHS will continue to work closely to accomplish the goals set in the 2010 Memorandum of Understanding (MOU) to establish coordination, collaboration, and resource sharing.

- Support the MOU Workgroup six goals to increase availability of services, in accordance with law, by the development of payment and reimbursement policies and mechanisms to:
  - Support care delivered to eligible AI/AN Veterans served at VA and IHS.
  - Facilitate the sharing and coordination of services, training, contracts, and sharing agreements, sharing of staff, and development of health information technology and improved coordination of care as specified elsewhere in the agreement.
- Continue to coordinate with the VA Office of Tribal Government Relations and Office of Rural Health to conduct outreach and communication targeted to the THPs. This will increase the number of THP Reimbursement Agreements in 2016-2018.
- Continue developing awareness among AI/AN Veterans about the program and the choice of receiving care at participating IHS or THP facility thus potentially increasing the number of AI/AN Veteran Population benefitting from the program.

Camp Lejeune

Camp Lejeune Veterans & Family
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Veterans....................	$6,377	$7,220	$13,619	$7,120	$11,347	$11,794	($2,272)	$447
Family.......................	$3,556	$12,500	$10,273	$12,600	$9,840	$8,050	($433)	($1,790)
Total Medical Care.....	$9,933	$19,720	$23,892	$19,720	$21,187	$19,844	($2,705)	($1,343)

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services to certain Veterans who were stationed at Camp Lejeune, North Carolina, for at least 30 days between 1957 and 1987. Family members of such Veterans who resided, or were in utero, at Camp Lejeune for at least 30 days during that period are eligible for reimbursement of hospital care and medical services for 15 specified illnesses and conditions, and VA is the payer of last resort. Hospital care and medical services may only be furnished to family members to the extent and in the amount provided in advance in appropriations Acts for such purpose. In addition, VA may only provide reimbursement for such hospital care and medical services provided to a family member after all other claims and remedies against third parties for such care and services have been exhausted. The Consolidated and Further Continuing Appropriations Act of 2015 (Public Law 113-235), which was signed on December 16, 2014, increased the Camp Lejeune exposure period back from January 1, 1957 to August 1, 1953.

VA began providing care to Camp Lejeune Veterans on August 6, 2012, the day the initial law was enacted, and published regulations supporting implementation of this statutory requirement on September 11, 2013. VA began enrolling and reimbursing family

members for medical care related to treatment of the Camp Lejeune conditions on October 24, 2014, 30 days after the family member interim final rule was published in the Federal Register and became effective. Qualified family members with at least 30 days of Camp Lejeune residency from 1957-1987 may receive reimbursement for treatment received up to two years prior to the date on their eligibility determination. For family members with at least 30 days of Camp Lejeune residency from August 1, 1953 – December 31, 1956, VA may only provide claims reimbursement for covered treatment received on or after December 16, 2014. VA may not reimburse family members for Camp Lejeune related care prior to March 26, 2013, the date when Congress provided funding to Camp Lejeune Family Member Program.

The 2017 estimate reflects revised estimates for the Veteran population and cost per Veteran, based on actual 2014-2015 experience. This increased the overall cost for the Veterans portion of the program. The 2017 estimate for the Family Member population reflects a revision to the estimate for the Family Member population based on actual volume of applications and claims received in 2015. The medical cost methodology was also revised to account for costs by specific illness instead of one average cost for all illnesses. In addition, the Camp Lejeune law was amended in December of 2014 (i.e., P.L. 113-235) which expanded the Veteran and family member eligibility period back to August 1, 1953 and increased the Camp Lejeune eligible population. By 2017, all VA staff needed to support the Camp Lejeune Program is expected to be on board. This includes 10 administrative staff and 3 medical providers.

<u>2015 Accomplishments</u>

- Launched the Camp Lejeune Family Member Program on schedule (October 24, 2014).
- Deployed a web portal to make it easy for family members to apply to the Camp Lejeune.
- Deployed additional systems to process and track Camp Lejeune family member's Program enrollment, eligibility and claims processing.
- Conducted outreach to over 230,000 contacts that had expressed an interest in Camp Lejeune Program.
- Created clinical guidance and algorithm, which was reviewed by the Institute of Medicine, to assist VA clinicians in making clinical eligibility and claims reimbursement decisions.
- Designed and conducted numerous trainings to ensure VA employees involved in operation and administration of the Camp Lejeune Veteran and Family Member Programs were fully educated on the eligibility, enrollment and claims processing processes, systems and procedures.
- Initiated a legislative proposal to include Camp Lejeune reservists in the Camp Lejeune law.

- Coordination of clinical analysis of Camp Lejeune family member eligibility with War Related Illness and Injury Study Center (WRIISC) physicians.
- Planned outreach to over 100,000 retired United States Marine Corps (USMC) Veterans.
- Planned rollout of Pharmacy Benefits Manager for Camp Lejeune Family Members.
- Planned implementation of translation and interpretation for Camp Lejeune Family Members.
- **Veteran Care:** VA is making necessary process and system enhancements to enroll and provide health care for eligible Veterans. As of September 30, 2015, VA has provided health care to 16,466 Camp Lejeune Veterans, of which 2,292 have been treated specifically for a Camp Lejeune condition.
- **Family Member Care:** To support family members for medical care directly related to treatment of the 15 covered medical conditions listed in the law, VA published an interim final regulation and began reimbursing family members in 2015. As required by law, VA is the last payer of medical claims related to the 15 Camp Lejeune conditions, and family members must exhaust all other health insurance coverage (if any exists) prior to submitting a claim for coverage under this program.

  To implement care for Camp Lejeune family members, VA developed clinical guidelines for the fifteen medical conditions, created processes for reviewing applications and reimbursing family members, and implemented technology to support these processes. The Camp Lejeune Family Member Program launched on October 24, 2014. As of September 30, 2015, VA has provided reimbursement to 71 family members into the Camp Lejeune Family Member Program.
- **Program Outreach:** VA developed a comprehensive outreach strategy to identify and educate Veterans and their family members about the Camp Lejeune program. VA continues to use numerous communication channels to reach out to these key stakeholders, including websites, social media, handouts, stakeholder briefings, call centers, newsletters and traditional media. Briefings and information papers have been provided to members of the Camp Lejeune Community Action Panel, concerned Veterans and their family members, Veterans Service Organizations, congressional staff, and the media.
- **Interagency Collaboration:** VA has been working closely with DoD, specifically, USMC, to ensure the successful implementation of the Camp Lejeune Program. In May 2015, USMC will distribute a mailing to over 100,000 retired USMC Veterans which included information about the Camp Lejeune treatment authority along with a Camp Lejeune-specific Fact Sheet from VA. Veteran and family member Camp Lejeune inquiries increased as a result of the mailing. The USMC continues to assist VA in verifying Camp Lejeune residency for family members who apply for the program.

2016 –2018 Future Goals

- VA is making significant progress in providing Veteran care and implementing the Camp Lejeune family member program. VA's future goals include:
  - Reimburse family members for care related to the 15 conditions.
  - Expand outreach efforts to continue to educate Veterans and family members about the Camp Lejeune program.
  - Continue enhancements to VA systems to identify and provide care to Camp Lejeune Veterans.

Readjustment Counseling

Readjustment Counseling
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Total Medical Care.....	$221,158	$243,483	$258,000	$243,483	$243,483	$243,483	($14,517)	$0

Workload

Fiscal Year	Number of Visits	Number of Unique Patients (RCS Only)	Number of Total Patients	Number of Mobile Vet Centers	Number of Vet Centers
2015 Actual	1,661,145	22,721	219,509	80	300
2016 Estimate	1,710,979	23,403	226,094	80	300
2017 Estimate	1,762,309	24,105	232,877	80	300
2018 Estimate	1,815,178	24,828	239,863	80	300

Number of unique, Readjustment Counseling Services (RCS) only, clients has been trending downward as the outreach focus has encouraged enrollment in VHA and VN Veterans are seeking healthcare at higher rates.

Background

In the last nine years (2008-2015) RCS has:

- Increased the number of Vet Centers by 29 percent from 232 to 300.
- Increased the number of authorized Vet Center staff by 67 percent from 1,316 to 2,208.
- Provided over 10 million visits to over 822,114 unique Veterans, Service members, and their families. The number of Veterans, Service members, and families seen annually from 2008 to 2014 increased by 20 percent (from 167,034 to 201,415). The number of visits provided annually increased by over 45 percent from 1,113,419 to 1,661,145.
- Implemented the Mobile Vet Center Program (2009 - originally a fleet of 50 vehicles) that provide access to readjustment counseling to those distant from existing "brick and mortar" services. Since 2010, the number of Mobile Vet Centers has increased by 30 (60 percent).

- Implemented the Vet Center Combat Call Center to provide readjustment counseling on a 24-hour, 7-days a week basis. Since 2009, 1-866-WAR-VETS processed over 249,900 telephone calls and made referrals for nearly 150,000 Veterans, Service members, and their families.

Vet Centers are community-based counseling centers, within Readjustment Counseling Service (RCS) that provide a wide range of social and psychological services to include:

- Professional readjustment counseling to Veterans and Service members, regardless of discharge character, who served in a combat zone or area of hostility, were a member of a unmanned drone crew during combat operations, or provided direct support to the causalities of war;
    - Counseling to those who experienced a military sexual trauma; Bereavement counseling for families who experience an active duty death;
    - Substance abuse statements assessments and referral;
    - Medical referral;
    - Veterans Benefits Administration benefits explanation and referral; and
    - Employment counseling.

Services are extended to the family members of eligible individuals for issues related to military service when found to aid readjustment of the Veteran or Service member. Furthermore, this program facilitates community outreach and the brokering of services with community agencies that link Veterans with other needed VA and non-VA services. A core value of the Vet Center program is to promote access to care by helping Veterans, Service members, and their families overcome barriers that impede them from using those services. For example, all Vet Centers maintain scheduled non-traditional hours to provide services, such as on evenings and weekends.

Vet Centers are located in all 50 states, American Samoa, the District of Columbia, Guam, and Puerto Rico. Additionally, the Secretary authorized a qualified family counselor at every Vet Center. To extend the geographical reach of Vet Center services, RCS has implemented initiatives to ensure that Veterans have access to care including the placement of an outreach specialist position at each Vet Center, the Mobile Vet Center Program, and the Vet Center Call Center.

To facilitate access to services, RCS utilized 80 Mobile Vet Centers (MVC) across the country. The placement of the vehicles is designed to cover a national network of designated Veterans Service Areas (VSAs) that collectively cover every county in the continental United States, Hawaii, and Puerto Rico. MVCs are used to provide access to eligible individuals and their family via outreach and direct service provision to a variety of military and community events and are based within close proximity to major active duty military installations and demobilization sites. The vehicles are also extending Vet Center access to more rural communities that are isolated from existing VA services. MVCs are also an integral part of the VA response and relief effort

participation during states of emergency. The vehicles include private counseling space to be used at events where confidentiality is a challenge (i.e., Post Deployment Health Re-Assessment events). The vehicles also have been maximized for multi-use applications by adding portable exam tables and litters that can be configured within the existing private counseling areas to provide the aforementioned health care or disaster relief capabilities respectfully. Most MVCs are equipped with a state-of-the-art satellite communications package that includes access to all VA systems (Computerized Patient Record System, MyHealtheVet), video tele-conferencing/Telehealth (fully encrypted), and connectivity to emergency response systems (Emergency Management Strategic Health Care Group).

RCS has also established the Vet Center Call Center (877-WAR-Vets) where Veterans, Service members, and their family members can call at any time to talk confidentially to combat Veterans or family members of combat Veterans (trained Vet Center counselors) regarding any readjustment issues related to their military service or transition home. This also includes providing information and referral to other VA services and benefits. The Call Center is the product of VA leveraging technology to condense a national system of toll free numbers into a single modern center located in Denver, CO. The Call Center staff has the state of the art capability to provide warm handoffs to both the VA National Crisis Hotline and the VA Primary Care Triage Hotline (located in Dayton, OH) when medical care is needed. In 2015, the Vet Center Combat Call Center is on track to process over 100,000 calls from Veterans, their families, and concerned citizens.

2015 Accomplishments

- RCS provided over 219,509 Veterans and families with over 1.66 million visits at Vet Centers.
- The Vet Center Call Center received 113,022 calls from Veterans, Service members, their families, and concerned citizens. The call center made 67,813 referrals for services.
- According to Veteran and Service member Satisfaction Feedback Questionnaires, over 99 percent of Veterans and Service members who responded were satisfied with the services they received at a Vet Center and would recommend these services to a fellow Veteran. Additionally, over 98 percent of those who responded stated they received Vet Center services in a timely manner.
- Close collaboration with the White House “Joining Forces” initiative which included: a filmed site visit and media event by the First and Second ladies to the Silver Springs, MD Vet Center promoting Vet Center services, a “Late Night with David Letterman” segment about the Vet Center Program, and recruitment and selection for 291 newly authorized positions.

2016 – 2018 Future goals

- Continue expanding access to readjustment counseling and all other VA services to all eligible clients, especially those in underserved areas. Expanded access will continue as the program becomes fully staffed. There will be a greater leadership focus on efficient allocation of existing resources to ensure underserved areas with demonstrated need, receive increased service availability. Insure continued success of the Mobile Vet Center program including the appropriate replacement of aging equipment.
- Continue refinement of workload requirements to insure highest level of quality services to Veterans.
- Refine current analysis of Mortality & Morbidity Review of all client suicides.
- Continue and expand the brokering of services within the communities where Veterans live.
- Further develop existing relationships with a local VSO's at the Vet Center level.
- Refine current analysis of Mortality & Morbidity Review of all client suicides.

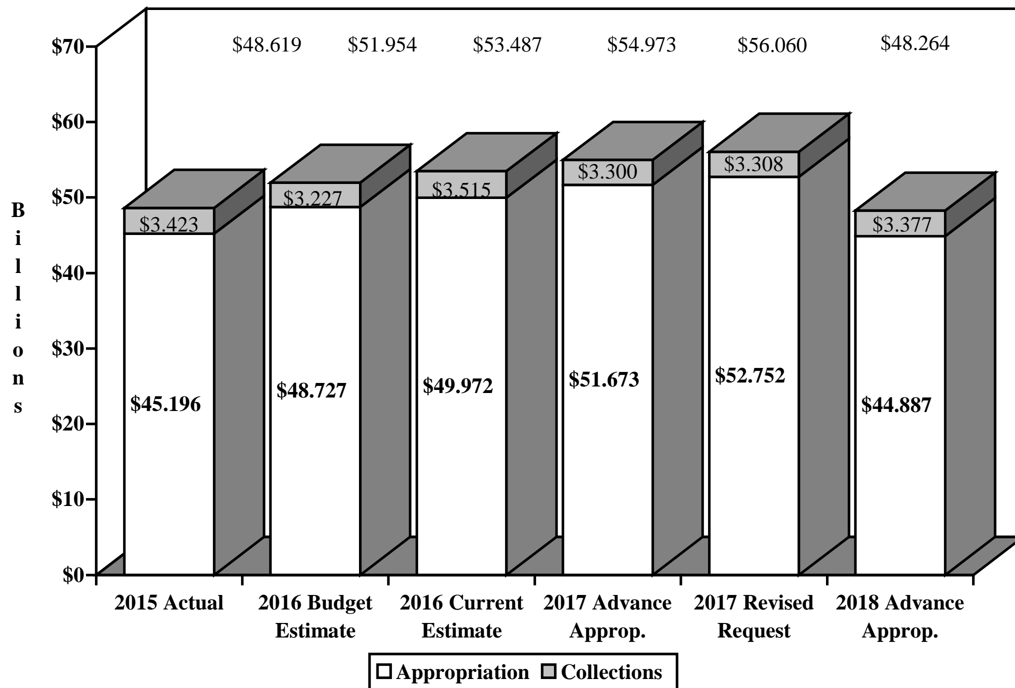
Legislative Proposals

VA Legislative Proposals
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

		2016		2017		2018	Increase/Decrease	
Description	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Request	Advance Approp.	2016-2017	2017-2018
Total Medical Care.....	$0	$49,375	$49,375	$49,390	$56,037	$57,997	$6,662	$1,960

See the Proposed Legislation chapter for a detailed description of these proposals

Medical Services



1/ Collections exclude the portion of Medical Care Collections Fund (MCCF) collections actually, or anticipated to be, transferred to Medical Community Care or the Joint DOD-VA Medical Facility Demonstration Fund, in support of the Captain James A. Lovell Federal Health Care Center (FHCC).

Medical Services
Net Appropriations & Collections
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Advance Appropriation	$45,015,527	$47,603,202	$47,603,202	$51,673,000	$51,673,000	$44,886,554	$4,069,798	($6,786,446)
Annual Appropriation Adjustment	$209,189	$1,124,197	$2,369,158	$0	$1,078,993	$0	($1,290,165)	($1,078,993)
Subtotal Appropriation Request	$45,224,716	$48,727,399	$49,972,360	$51,673,000	$52,751,993	$44,886,554	$2,779,633	($7,865,439)
Rescission, P.L. 113-235	($28,830)	$0	$0	$0	$0	$0	$0	$0
Net Appropriations	$45,195,886	$48,727,399	$49,972,360	$51,673,000	$52,751,993	$44,886,554	$2,779,633	($7,865,439)
Collections	$3,422,806	$3,226,548	$3,515,171	$3,299,954	$3,308,307	$3,377,255	($206,864)	$68,948
Total	$48,618,692	$51,953,947	$53,487,531	$54,972,954	$56,060,300	$48,263,809	$2,572,769	($7,796,491)

Appropriation Language

For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment

in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, bioengineering services, food services, and salaries and expenses of healthcare employees hired under title 38, United States Code, aid to State homes as authorized by section 1741 of title 38, United States Code, assistance and support services for caregivers as authorized by section 1720G of title 38, United States Code, loan repayments authorized by section 604 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163; 124 Stat. 1174; 38 U.S.C. 7681 note), and hospital care and medical services authorized by section 1787 of title 38, United States Code; [$2,369,158,000]*$1,078,993,000*, which shall be in addition to funds previously appropriated under this heading that became available on October 1, [2015]*2016*; and, in addition, [$51,673,000,000]*$44,886,554,000*, plus reimbursements, shall become available on October 1, [2016]*2017*, and shall remain available until September 30, [2017]*2018*: *Provided*, That, of the amount made available on October 1, [2016]*2017*, under this heading, $1,400,000,000 shall remain available until September 30, [2018]*2019*: *Provided further*, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: *Provided further*, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: *Provided further*, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: *Provided further*, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs[: *Provided further*, That, of the amount made available on October 1, 2016, under this heading, not less than $1,500,000,000 shall be available for Hepatitis C Virus (HCV) clinical treatments, including clinical treatments with modern medications that have significantly higher cure rates than older medications, are easier to prescribe, and have fewer and milder side effects: *Provided further*, That the Secretary of Veterans Affairs shall ensure that sufficient amounts appropriated under this heading for medical supplies and equipment are available for the acquisition of gender appropriate prosthetics]. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2016.)*

Appropriation Transfers

See "Appropriation Transfers & Supplementals" chapter for a detailed explanation of the appropriation transfers that affect the Medical Service appropriation.

Medical Community Care Appropriation Transfer

In 2017, Medical Services will transfer funds into the new Medical Community Care appropriation for purchased care components of care in the community. See "Medical Community Care" chapter for a detailed explanation of obligations in the Medical Community Care appropriation.

Summary of 2017 Revised Request

A 2017 advance appropriation of $51.7 billion for Medical Services was enacted in P.L. 114-113. The 2017 budget requests an additional $1.1 billion to ensure the delivery of high-quality and timely health care services to Veterans and other eligible beneficiaries. There are multiple factors contributing to the additional funding request for Medical Services:

- The cost of new Hepatitis C drug treatments is estimated to increase by $840 million over the initial advance appropriation estimate.
- Medical Equipment obligations increased $579.2 million over the advance appropriation to reflect a historic level of annual equipment purchases
- Prosthetics estimates were revised upward by $606.3 million to reflect the latest actuarial trends
- VA provided Long-Term Services and Supports costs are estimated to increase by $195.8 million, above the advance appropriation estimate, reflecting trends in the most recent actual data and the continued investment into non-institutional settings.
- Other VA provided health service programs not projected by the Enrollee Health Care Projection Model are expected to yield a net decrease of $60.4 million, driven largely by a decrease of $144.3 million in CHAMVPA Medical Service specific costs, VA provided Camp Lejeune Veteran costs of $7.1 million, and partially offset by a $91 million in increase in the Caregivers program due to revised projections of the number of Caregivers.
- Facility activation costs are estimated to increase by $183.6 million over the initial advance appropriation request; to account for the latest demand from new facilities.
- $7.246 billion of the 2017 Medical Services Appropriation request is expected to be transferred to the new Medical Community Appropriation. For more information about this new appropriation, please see the Medical Community Care appropriation Chapter

Update to the Medical Service 2017 Advance Appropriations Request Includes Veterans Choice Act (dollars in Thousands)			
	2017		
Description	Advance Approp.	Current Estimate	Increase/ Decrease
Health Care Services..	$45,436,303	$44,768,977	($667,326)
Non-Add included above:			
Medical Staffing Excluding (VACAA Sec. 801)........	*$27,586,047*	*$28,022,072*	$436,025
Activations..	*$442,649*	*$626,276*	$183,627
Pharmacy..	*$6,086,167*	*$7,672,411*	$1,586,244
Beneficiary Travel...	*$944,500*	*$923,700*	($20,800)
Prosthetics...	*$3,039,353*	*$3,645,677*	$606,324
Equipment...	*$438,800*	*$1,018,000*	$579,200
Care in the Community (excluding CHAMPVA & LT	*$4,214,883*	*$0*	($4,214,883)
Long-Term Services and Supports:			
VA..	$3,427,121	$3,622,873	$195,752
Community...	$3,168,117	$0	($3,168,117)
Long-Term Services and Supports [Total]......................	$6,595,238	$3,622,873	($2,972,365)
Other Health Care Programs:			
VA..	$1,268,019	$1,207,620	($60,399)
Community...	$1,580,812	$0	($1,580,812)
Other Health Care Programs [Subtotal]..........................	$2,848,831	$1,207,620	($1,641,211)
VA Legislative Proposals..	$48,516	$7,885	($40,631)
Prior Year Recoveries..	$721,190	$0	($721,190)
Obligations [Total]..	$55,650,078	$49,607,355	($6,042,723)
Funding Availability:			
Appropriation..	$51,673,000	$51,673,000	$0
Trns to Medical Community Care	$0	($7,246,181)	($7,246,181)
Trns to North Chicago Demo. Fund.............................	($200,172)	($201,604)	($1,432)
Trns to DoD-VA Health Care Sharing Incentive Fund...	($15,000)	($15,000)	$0
Medical Care Collections Fund....................................	$3,299,954	$3,308,307	$8,353
Reimbursements..	$171,106	$153,243	($17,863)
Change in Unobligated Balances.................................	$0	$35,000	$35,000
Veterans Choice Act Sec 801......................................	$0	$821,597	$821,597
Prior Year Recoveries..	$721,190	$0	($721,190)
Funding Availability [Total]..	$55,650,078	$48,528,362	($7,121,716)
Annual Appropriation Adjustment..................................			$1,078,993

Summary of the 2018 Advance Appropriations Request

The Medical Services Advance Appropriation Request is for $44.9 billion, a decrease of $7.9 billion from the 2017 Revised Request. The decrease is primarily driven by the transfer out of $7.2 billion to Medical Community Care in 2017 and the 2018 Advance Appropriation request excluding associated community care obligations. The 2018 request allows for $600 million in new Hepatitis C treatment, provides staffing levels above pre-Veterans Choice Act levels, and increases prosthetics obligations $337 million above the 2017 advance appropriation.

Medical Services Program Funding Requirements

The following table provides an itemized breakout of the obligations by program of the Medical Services appropriation.

VA Medical Services Obligations by Program
Includes Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate 1/	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Request 2/	2018 Advance Approp. 2/	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Health Care Services:								
Health Care Services [Total] 4/	$41,545,312	$43,189,496	$44,994,917	$45,436,303	$44,768,977	$43,021,042	($225,940)	($1,747,935)
Non-Add included above:								
Medical Staffing Excluding (VACAA Sec. 801)	*$24,313,280*	*$25,525,300*	*$25,589,722*	*$27,586,047*	*$28,022,072*	*$28,031,574*	*$2,432,350*	*$9,502*
Activations	*$417,934*	*$442,649*	*$447,955*	*$442,649*	*$626,276*	*$372,794*	*$178,321*	*($253,482)*
Pharmacy	*$6,097,079*	*$5,825,788*	*$6,975,634*	*$6,086,167*	*$7,672,411*	*$6,849,186*	*$696,777*	*($823,225)*
Beneficiary Travel	*$852,797*	*$908,200*	*$888,200*	*$944,500*	*$923,700*	*$960,700*	*$35,500*	*$37,000*
Prosthetics	*$2,727,077*	*$2,841,942*	*$2,851,000*	*$3,039,353*	*$3,645,677*	*$3,376,159*	*$794,677*	*($269,518)*
Equipment	*$872,880*	*$879,300*	*$926,700*	*$438,800*	*$1,018,000*	*$542,000*	*$91,300*	*($476,000)*
Care in the Community (excluding CHAMPVA & LTSS)	*$3,787,438*	*$4,365,739*	*$5,501,527*	*$4,214,883*	*$0*	*$0*	*($5,501,527)*	*$0*
Long-Term Services and Supports VA Care:								
VA Community Living Centers (VA CLC)	$2,471,096	$2,493,934	$2,673,307	$2,615,548	$2,749,844	$2,938,781	$76,537	$188,937
Non-Institutional VA Care	$803,618	$624,757	$836,868	$811,573	$873,029	$905,497	$36,161	$32,468
VA Long-Term Services and Supports [Total]	$3,274,714	$3,118,691	$3,510,175	$3,427,121	$3,622,873	$3,844,278	$36,161	$32,468
Long-Term Services and Supports Community Care:								
Community Nursing Home	$618,787	$844,863	$969,603	$907,986	$0	$0	($969,603)	$0
Community Non-Institutional Care	$814,085	$892,346	$1,440,817	$939,948	$0	$0	($1,440,817)	$0
State Nursing Home	$1,049,756	$1,169,306	$1,166,253	$1,257,334	$0	$0	($1,166,253)	$0
State Home Domiciliary	$58,298	$59,543	$62,855	$61,537	$0	$0	($62,855)	$0
State Adult Day Care	$1,031	$1,203	$892	$1,312	$0	$0	($892)	$0
Community Long-Term Services and Supports [Total]	$2,541,957	$2,967,261	$3,640,420	$3,168,117	$0	$0	($892)	$0
Other Health Care Programs VA Care:								
CHAMPVA Medical Staff, Pharmacy Costs	$272,576	$402,909	$377,876	$444,296	$300,000	$300,000	($77,876)	$0
Caregivers (Title 1)	$450,203	$522,282	$598,645	$605,552	$696,569	$814,847	$97,924	$118,278
Camp Lejeune - Veterans	$4,763	$7,220	$4,192	$7,120	$0	$0	($4,192)	$0
Readjustment Counseling	$188,428	$211,051	$221,118	$211,051	$211,051	$211,051	($10,067)	$0
Other Health Care Programs [Total]	$915,970	$1,143,462	$1,201,831	$1,268,019	$1,207,620	$1,325,898	$5,789	$118,278
Other Health Care Programs Community Care:								
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,121,000	$1,378,100	$1,330,112	$1,508,300	$0	$0	($1,330,112)	$0
Caregivers	$17,398	$28,776	$21,481	$31,850	$0	$0		
Indian Health Servcies	$14,999	$28,062	$15,000	$28,062	$0	$0	($15,000)	$0
Camp Lejeune - Veteran Purchased Care	$1,614	$0	$9,427	$0	$0	$0	($9,427)	$0
Camp Lejeune Family	$506	$12,500	$10,273	$12,600	$0	$0	($10,273)	$0
Other Health Care Programs community care [Total]	$1,155,517	$1,447,438	$1,386,293	$1,580,812	$0	$0	($1,364,812)	$0
VA Legislative Proposals:								
Total	$0	$48,347	$48,347	$48,516	$7,885	$7,469	($40,462)	($416)
Veterans Choice Act from 2016 PB (Medical Services Only) 1/								
Sec 801	*$0*	*$1,572,900*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
SubTotal Obligations	**$49,433,470**	**$53,487,595**	**$54,781,983**	**$54,928,888**	**$49,607,355**	**$48,198,687**	**($5,174,628)**	**($1,408,668)**
VA Prior-Year Recoveries	$574,411	$0	$0	$721,190	$0	$0	*$0*	*$0*
Financial Statement Audit Adjustment 5/	($149,222)	$0	$149,222	$0	$0	$0	*($149,222)*	*$0*
Total Obligations	$49,858,659	$53,487,595	$54,931,205	$55,650,078	$49,607,355	$48,198,687	($5,323,850)	($1,408,668)

Note: Dollars may not add due to rounding in this and subsequent charts.

1/ Obligations from Section 801 and 802 of the Veterans Choice Act were not included in 2016 Budget Estimate chart. Lines were in the table above to show comparable total Medical Care obligations, but the 801 and 802 funding in the 2016 Budget Estimate and 2017 Advance Appropriation columns remain undistributed into Health Care Services.

2/ In the 2016 Budget Estimate, Ambulatory Care removed funding for Ending Veterans Homelessness, VISTA Evolution, and Activations from this line and displayed them in their respective sections, below, so that the full amount of funding for these programs is displayed. This year's budget table does not reduce Ambulatory Care obligations to display full value and instead displays their full obligation values in the italicized non-add section. Ambulatory Care in the 2016 Budget Estimate and 2017 Advance Appropriation columns includes the Veterans Choice Program cost-shift.

3/ The cost of New Hepatitis C treatment is accounted for in Ambulatory Care

4/ In the 2016 Budget Estimate, the obligations for Non-Recurring Maintenance (NRM) were excluded from Health Care Services and displayed on their own row. This year, obligations for NRM are included within Health Care Services, and the full value is displayed in the italicized non-add section.

NRM includes Section 801 obligations.
5/ 2015 Financial Statement Audit Adjustment.
6/ Obligations include adjustments for Prior-Year Recoveries and Financial Statement Audit Adjustment.

Medical Services Staffing

VA Medical Services Staffing

(dollars in thousands)

		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Medical Services......	$24,313,280	$25,525,300	$25,589,722	$27,586,047	$28,022,072	$28,031,574	$2,432,350	$9,502
Sec 801....................	$562,567	$1,368,100	$1,330,896	$0	$775,026	$0	($555,870)	($775,026)
Total........................	$24,875,847	$26,893,400	$26,920,618	$27,586,047	$28,797,098	$28,031,574	$1,876,480	($765,524)

Medical Services FTE represent the largest share of VHA obligations by object. They include:

- Physicians;
- Dentists;
- Nurses;
- Non-physician providers such as podiatrists, physicians assistants, psychologists, nurse practitioners, chiropractors, and optometrists; and
- Health Technicians/Allied Health such as respiratory therapists, physical therapists, dietitians, social works, radiology technologists, pharmacists, audiologist and speech pathologists, nuclear medicine technologists, and laboratory aids and works

When including resources from Section 801 of the Veterans Choice Act, 2017 Medical Services will have 236,520 FTE in 2017, an increase of 9,035 FTE over the advance appropriation. They are expected to meet the large increase in demand for VA-provided health care in a post-Veterans Choice Act environment, as reflected in the workload table provided at the end of this chapter. The 2018 provider level of 223,016 FTE is above the 2015 actuals and reflects growth that would normally take place without the resources of the Veterans Choice Act. The 2018 FTE level will be reevaluated in the 2018 Congressional Budget Justification.

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
FTE by Type								
Medical Services								
Physicians	18,744	19,943	19,116	21,781	20,533	20,285	1,417	(248)
Dentists	1,016	1,108	1,056	1,111	1,159	1,070	103	(89)
Registered Nurses	51,432	52,800	52,843	54,323	56,877	54,244	4,034	(2,633)
LP Nurse/LV Nurse/Nurse Assistant	24,511	25,323	24,965	26,129	26,318	25,537	1,353	(781)
Non-Physician Providers	12,732	13,634	12,904	14,763	13,788	13,961	884	173
Health Technicians/Allied Health	64,132	65,643	65,570	68,427	69,474	66,533	3,904	(2,941)
Wage Board/Purchase & Hire	5,442	5,647	5,526	5,663	5,698	5,455	172	(243)
All Other 1/	33,183	33,107	33,793	35,288	36,215	35,931	2,422	(284)
SubTotal	211,192	217,205	215,773	227,485	230,062	223,016	14,289	(7,046)
Veterans Choice Act, Sec. 801, FTE	5,145	9,577	11,585	0	6,458	0	(5,127)	(6,458)
Total	216,337	226,782	227,358	227,485	236,520	223,016	9,162	(13,504)

Activations

Activations
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Medical Services	$417,934	$442,649	$447,955	$442,649	$626,276	$372,794	$178,321	($253,482)
Medical Care Total	$558,085	$598,174	$598,174	$598,174	$836,293	$497,808	$238,119	($338,485)

Facility activations provide non-recurring (equipment and supplies) and recurring (additional personnel) costs associated with the activation of completed construction of new or replacement medical care facilities. Resources include assumed rates for medical equipment and furniture reuse based on the facility type (renovation, replacement, or new). VA's activation plans are sensitive to delays in construction schedules and lease awards. VA has recently taken steps to identify and more closely monitor the activations of new facilities and leases to assure that projects stay on schedule, which will promote better synchronization of budgetary resources with program needs.

Health Care Services Remaining in Medical Services:

The following health care program activities will remain in the Medical Services appropriation, including cases prescribed or related to Non-VA providers funded out of the Medical Community Care appropriation.

Pharmacy

Pharmacy
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Medical Services	$6,097,079	$5,825,788	$6,975,634	$6,086,167	$7,672,411	$6,849,186	$696,777	($823,225)
Medical Care Total	$7,084,507	$6,526,315	$7,594,369	$6,818,003	$8,352,950	$7,456,705	$758,581	($896,245)

VA's use of medication therapies is a fundamental underpinning of how VA delivers health care today. VA's primary focus is on diagnosis and treatment in an ambulatory

environment and home environment basis with institutional care as the modality of last resort.

2015 Accomplishments

- Provided outpatient prescriptions to over 4.9 million Veterans.
- VA Consolidated Mail Outpatient Pharmacy (CMOP) ranked highest among mail-order pharmacies, including private sector companies, for customer satisfaction in J.D. Power and Associates 2015 National Pharmacy Study with a score of 876. This marks the sixth consecutive year that CMOP scored highest in this survey.
- On a daily basis, 3,000 to 4,000 Veterans track the delivery of their mail order prescriptions dispensed by CMOP via the MyHealtheVet website. As part of the service provided to Veterans, they have the ability to register for e-mail notification of pending delivery of their prescriptions to their address. This service has been well received by Veterans, with over 1 million e-mail notifications sent informing Veterans of their package delivery. This Veteran-centric service was the result of CMOP winning the 2013 Securing America's Value and Efficiency (SAVE) Award.
- When a Veteran's clinical needs require a specialty drug, they typically require special handling, administration, or monitoring. In order to meet our Veterans' needs, CMOP has recently expanded the Specialty Pharmacy operation. In 2015, CMOP's Specialty Pharmacy Program dispensed 37,038 specialty medications to Veterans.
- Providing Opioid Overdose Education and Naloxone Distribution (OEND) to Veterans at risk of an opioid overdose is a key objective of VHA safety initiatives. Pharmacy Benefits Management (PBM) has provided financial, education, and distribution support for the OEND program. In the less than two years since the program was implemented, over 12,000 Veterans have received a naloxone kit, and there have been 141 reported reversals as of December 13, 2015.
- Joint VA/Department of Defense (DoD) national pharmaceutical contracts provide a benefit to recently discharged Servicemembers by promoting product standardization used by both agencies. The number of joint national pharmaceutical contracts increased from 126 to 139 from the end of 2014 to the end of 2015, respectively.
- To meet the clinical needs of Veterans, PBM supports the VA National Formulary that contains national standardization items within selected therapeutic categories and ensures uniform availability of drug therapies across the nation.
- As part of promoting Veteran safety by helping preventing potential adverse drug events, PBM supported the deployment and implementation of the maximum single dose order check system.
- PBM provides comprehensive outpatient mail pharmacy services to 124,700 qualifying beneficiaries of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and dispensed 2,791,001 outpatient prescriptions to the beneficiaries through the CMOP.
- PBM Virtual Pharmacy Services (VPS) provides virtual outpatient pharmacy support to VA facility pharmacies to help ensure prescriptions are processed and

dispensed to Veterans in a timely manner. The VPS program processed 2,075,554 outpatient prescriptions for 18 VA Medical Centers and associated clinics.

- VA pharmacy has VA Learning Opportunities Residency (VALOR) positions nationwide that help VA Pharmacy recruit future pharmacists.
- The use of clinical pharmacists in the VA to expand access and improve the quality of medication management services continues to grow robustly. Since 2010, there has been a 63 percent increase in clinical pharmacists practicing as advanced practice providers with a scope of practice. There are now nearly 3,200 clinical pharmacists, many working full time, caring for Veterans with both chronic and acute diseases where they accumulated over 5 million patient care visits in 2015. They have assumed essential roles in the treatment and management of Anticoagulants, Hepatitis C and Anemia medications in the VA where they prescribe 69 percenct, 23.7 percent and 28.3 percent of all prescriptions for these disease states.
- Expansion of the Pharmacists Achieve Results with Medications Documentation (PhARMD) Project to 105 VA facilities, used by over 2,200 pharmacist users, who documented over 1,026,599 disease state interventions and an additional 399,655 interventions focused on their role in team-based care. These interventions demonstrated the clinical pharmacist's contribution to the use of medications in key chronic disease states such as diabetes, hypertension, hyperlipidemia, Hepatitis C, pain management, and mental health.
- Continual expansion of Mental Health pharmacist residency training in over 36 programs nationwide and over 70 pharmacist residents, the largest Mental Health pharmacist training programs in the country.
- PBM has provided financial, education, and implementation resources to support drug take-back programs that promote Veteran safety by reducing unwanted/unneeded medications in the home in an environmentally responsible manner. VA medical facilities implemented drug take back programs for Veterans in the form of mail-back envelopes and on-site receptacles at VA medical facilities. VA piloted the use of receptacles in six facilities in the beginning of 2015 and, based on the results of the pilot, quickly expanded receptacle use to 29 medical facilities and six community based outpatient clinics (CBOCs). Mail-back envelopes were provided to medical facilities for distribution to Veterans free of charge. Marketing for Veteran engagement on safe storage and disposal in the home and education of staff on the Drug Enforcement Agency (DEA) rule was conducted. Through the use of both options, Veterans returned approximately 7,000 pounds of unwanted/unneeded medications. Medications returned to the vendor are destroyed in an environmentally responsible manner that prevents the entry of hazardous waste into waterways or ground water.
- New Pharmacy Academic Detailing programs have been fully implemented in six VISNs, and partial implementation has occurred in an additional 14 VISNs, with a total of 3,443 Academic Detailing visits with 5,168 providers recorded in 2015.
- The PBM Academic Detailing Service has been working closely with VISN Academic Detailing programs to educate and support providers around the Opioid Safety Initiative (OSI). In 2015, academic detailers completed 1,913 visits with providers addressing pain management and opioid safety and 1,140

visits addressing Opioid Overdose Education and Naloxone Distribution (OEND), a complementary safety initiative to OSI.

- The PBM Academic Detailing Service has partnered with the Office of Mental Health Operations (OMHO) and Mental Health Services on the Psychotropic Drug Safety Initiative (PDSI) to target high risk drug classes, such as antipsychotics and benzodiazepines, through development of educational materials, programming, data tools, and standardized key messages covering related clinical initiatives.
- PBM implemented an easy-to-use National Drug Formulary search tool that can be accessed by Veterans and non-VA clinicians at http://www.pbm.va.gov/apps/VANationalFormulary/.
- State Retail Immunization Care Coordination Programs - VA is beginning its third flu season of data-sharing with retail partners such as Walgreens to incorporate immunization data directly into the VA electronic health record. Upcoming advancements with the program will allow sharing of any immunization type administered by retail health care partners. The program enhancements will provide improved clinician-facing functionality for the review of a Veteran's immunization history with additional details not previously available in electronic health record.
- PBM Patient Medication Information Management and Medication Reconciliation Initiative Office developed a "Medication Reconciliation Education Blitz' with many program offices, including a 4-hour Medication Use Crisis Virtual Conference, which provided accredited education to VA, DoD, and Indian Health Service, a Joint Commission-VHA MedRecon Town Meeting, VA Engineering Resource Center (VERC) Two Day MedRecon Train the Trainer Conference, numerous field and program offices, and community of practice presentations. This fueled the development of the MedRecon Toolkit and ongoing work to garner field and industry best practices.
- PBM Patient Medication Information Management and Medication Reconciliation Initiative Office VHA Essential Medication Information Standards Directive was published, which establishes policy that outlines the essential medication information elements necessary for review, management, and communication of medication information with Veterans and their health care teams.
- PBM Patient Medication Information Management and Medication Reconciliation Initiative Office completed development of the "Ask the Pharmacist Mobile App," which will enable Veterans to have a trusted resource for medication information, self-management, and pharmacy services.

Future Goals (2016-2018)

- VA Pharmacy will continue to promote initiatives and programs to improve the health status of Veterans by encouraging the appropriate use of medications in a comprehensive medical care setting.
- Continue Veteran engagement for safe disposal of medications and expansion of drug take-back options in alignment with the DEA rule.
- Develop a standardized and efficient method, supporting multiple workflows, for all facilities to respond to drug consults and timeliness of approval for prior authorization and non-formulary medications. The process will use standardized

health factors and consult titles to gather detailed information that allows for data analysis at the Facility, VISN, and National Level and eliminates the current manual tracking at each facility. This will enable in-depth analysis of drug requests and responses that can be used to enhance formulary decisions that provide for safety, efficacy, and value to our Veterans, allowing all sites to respond to Office of Inspector General (OIG) information requests with minimal effort.

- Upgrade equipment at MidSouth CMOP to increase quality and efficiency of prescription fulfillment operation by end of 2016.
- Integrate the newly approved naloxone nasal spray as an option for the CMOP-prepared naloxone rescue kits. This will offer two different pathways for administration with a Food and Drug Administration (FDA)-approved device in support of the OEND program.
- Integrate First Data Bank medication dosage images into the CMOP Medication Image Library to support the identification of non-VA medications for programs and services that use the CMOP Medication Image Library.
- Design and execute a data-driven process for tracking and trending the difficult-to-recruit pharmacy leadership vacancies.
- Implement VA's clinical decision support MOCHA Enhancements (Version 2) and MOCHA (Version 2.1). The versions will add Clinical Reminder Order Checks and Maximum Daily Dose order checks for providers and pharmacists. These enhancements will strengthen the Clinical Decision Support (CDS) infrastructure of Veterans Health Information Systems and Technology Architecture (VistA) and promote patient safety by preventing adverse drug events and drug overdoses.
- Develop a Pharmacy Graphic User Interface (GUI) to overlay onto the VistA Pharmacy order processing system. A Pharmacy GUI will be more responsive to changes in practice, pharmacy and patient needs, system priorities, and advances in technology in a VistA environment.
- Support VA facilities' ability to achieve better staffing in primary care and other specialty areas with Clinical Pharmacy Specialists.
- Continue to lead as business owner the enterprise-wide, "Medication Reconciliation System Integration Deployment Plan" with VA Engineering Resource Center and execute an overarching strategy across the VA entitled "Partnering with Veterans and their Medications." A task force entitled "Partnering with Veterans and their Medications Task Force" was also chartered to ensure Veterans and their Caregivers can expect safe, effective, team based, and patient driven medication reconciliation across the VA, as part of a larger goal to partner with health care teams and Veterans for their medication care.
- PBM Academic Detailing Service will support the full implementation of Academic Detailing programs within each VISN to enhance clinical staff practice change to include full adoption of evidence-based practice recommendations across VHA directed initiatives.
- Enhance the Pharmacy Product System/National Drug File. The planned enhancements will support VA's ability to share data with DoD and other health care partners.

- Define the requirements for the development of an e-prescribing system that will be implemented to allow non-VA prescribers to transmit prescriptions electronically to VA pharmacies for eligible Veterans.
- Support VA and PBM efforts on Pain Management, Ambulatory Care, Mental Health, Oncology, Pharmacy Administration and other specialties through specialty pharmacy residencies.
- PBM Patient Medication Information Management and Medication Reconciliation Initiative Office is the business owner for a multi-year effort for the enterprise-wide "Medication Reconciliation System Integration Deployment Plan" with VERC and multiple program offices, which will provide onsite support for every VA facility to implement standard process and promote success with three Medication Reconciliation Tools.

National Formulary - VA transitioned from individual medical center formularies to Veterans Integrated Service Networks (VISN) formularies in 1996 and established a VA National Formulary in 1997. VA abolished the use of individual medical center formularies in July 2001 and, in February 2009, abolished the use of VISN formularies, leaving only the VA National Formulary as the sole drug formulary authorized for use in VA. VA National Formulary contains national standardization items within selected therapeutic categories and ensures uniform availability of drug therapies across the nation.

Pharmacy Benefits Management (PBM) Services - VA established the PBM in the early 1990s to administer the drug benefit across the VA health care system. Where it is clinically feasible, national standardization contracts are awarded within therapeutic categories that represent the greatest opportunity for enhancing cost-effective drug therapy.

Pharmacy Recruitment and Retention Office (PRRO) - PBM established PRRO to provide guidance and support to VA facilities facing pharmacy recruitment and retention challenges. PRRO is responsible for authoring PBM-related sections of the annual VA National Workforce Succession Strategic Plan and the PCS Workforce Succession Strategic Plan. The office administers the national PBM Mentoring Program and provides subject matter experts for developing the My Career at VA website, which won a 2012 Bright Idea in Government award from Harvard University's Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government. This office provides tuition support for VA pharmacists enrolled in the Pharmacy Leadership Academy (PLA); contributes to recruiting a diverse workforce by posting vacancy announcements on the job board for Historically Black Colleges and Universities; offers support for recruitment events held in areas of Hispanic Association of Colleges and Universities (HACU), precepts Health-System Pharmacy Administration residents on retention and recruitment activities; and publishes the national monthly newsletter *Pharmacy News*. PRRO engages VA Learning Opportunities Residency (VALOR) positions nationwide and extends an outreach program to potential VA pharmacy candidates through VHA Placement Services.

Consolidated Mail Outpatient Pharmacies (CMOP) – VA automated and consolidated its prescription fulfillment processes for Veteran outpatients. Prescriptions are filled and mailed to the Veteran's home. CMOPs significantly improve customer service, reduce potential for errors, and improve efficiency by filling large volumes of prescriptions faster with continually improving technologies that require less staff than would be needed at individual VA medical centers. VA currently operates seven of these facilities across the nation and fills approximately 80 percent of all outpatient prescriptions via the CMOPs.

VA/DoD Pharmaceutical Procurement – When clinically appropriate, VA and DoD continue to convert existing unilateral contracts to joint contracts.

VA Adverse Drug Event Reporting (VA ADERS) / **VA** Center for Medication Safety (VAMedSAFE) – VA ADERS is a spontaneous web-based passive surveillance reporting system for adverse drug and vaccine events (ADEs). These reports are reported directly to the Food and Drug Administration (FDA) and are analyzed for overall trends and preventable ADEs. VAMedSAFE conducts passive surveillance (VA ADERS), active medication safety surveillance (integrated databases), and national medication safety Medication Use Evaluations and Risk Reduction efforts for certain classes of medication and vaccines. Staff works collaboratively with the FDA on surveillance with an emphasis on the safe use of medications and vaccines in the Veteran population.

VA Mobile Pharmacy – VA mobile pharmacies provide acute and chronic medications to Veterans and potentially other Americans affected by a natural disaster. VA mobile pharmacies are capable of connecting via satellite to a CMOP which can then dispense prescriptions for delivery to a central location within the disaster zone.

Pharmacy Clinical Informatics and Re-engineering – VA Pharmacy Informatics and Re-engineering program provides business owner oversight of pharmacy development activities to improve and transform health care through information technology. The primary initiative is to replace the Pharmacy VistA system component of VA's Electronic Health Record.

One component of this effort is the VA Medication Order Check Healthcare Application (MOCHA). This application provides customizable clinical decision support for drug interactions and excessive doses when medications are ordered. Maximum Single Dose order checks were fully deployed to all VA medical centers in July 2014. MOCHA generates over 4.5 million order checks nationwide per month to help prevent adverse drug events due to incorrect drug dosage, unnecessary therapeutic duplication and potential drug-drug interactions.

Pharmacy Product System (PPS)/National Drug File Project (PPS/NDF) is the largest open-source drug file in the United States. The Pharmacy Product System-National (PPS-N) is a Web-based application that provides the ability to manage pharmacy-specific data across the VA enterprise, ensuring that all facilities are using the same base data for the prescription ordering and fulfillment processes. The Drug File contains over 128,000

medications and product terms, and the system contains medication information that is provided to patients.

Clinical Pharmacy Program Office – The Clinical Pharmacy Program Office was created in 2010 to assist the field in organizing, standardizing, and enhancing clinical pharmacy practice and to help sites navigate the transformational changes occurring within VHA. The primary focus of this program office has been to maximize the utilization of Clinical Pharmacists as advanced practice providers with a scope of practice, thus improving care by performing essential medication management services, enhancing medication safety, and significantly improving chronic disease management in our Veteran population. Since the inception of this program office, there has been a 63 percent increase in Clinical Pharmacists practicing as advanced practice providers. Additionally, the program office has developed robust and comprehensive data collection tools, including metrics that illustrate both the performance and quality of clinical pharmacy practice in VHA. To assure the competency, consistency and standardization of clinical pharmacy practice, the program office developed comprehensive educational and communication programs focusing on key disease states and promoting expansion of clinical pharmacy practice roles.

Pharmacy Residency Program Office—The Pharmacy Residency Program Office's (PRPO) mission is to train post-doctoral pharmacists for the VA and the profession, and, over the past 15 years, the program office has trained over 6,000 pharmacists in post-graduate years (PGY) 1 and 2 and fellowships. VA is the largest post-doctoral training program in the nation, with over 286 programs nationally, and has become the residencies-of-choice for the profession. PRPO has invested heavily in the training of the Residency Program Directors and supports them with the latest information via monthly conference calls and with quarterly educational presentations on accreditation, accreditation standards, education and VHA and Pharmacy Benefits Management (PBM) Services priorities for funding additional PGY1 or PGY2 specialties. PRPO is also dedicate to the education of residents with research design courses, monthly journal clubs presented by residents and VA clinical and research experts and monthly conference calls highlighting key topics for resident learning and growth. Annually, residents are surveyed on their training experiences and one-year-out surveys to determine if the residency program met the needs of their current position, and PRPO adjusts the learning experiences to continually improve the training. PRPO has created a robust database to monitor the programs, an annual Standard of Excellence, which surveys the needs of the programs in terms of educational needs, the experience of RPD and preceptors, and the demand for expanding existing programs or initiating new programs. The RPDs and preceptors are integral in the training of residents regarding the latest therapies, development of treatment plans, professional growth through research and presentations and most importantly, direct patient care. The residency programs and residents support direct patient care and provide current and safe and effective medication management nationwide.

PBM Academic Detailing Service- Academic Detailing (AD) is a service for clinicians by clinicians that provides individualized, evidence-based, educational outreach visits

intended to meet the needs of the provider in the context of local operations. This service has demonstrated to be effective in altering prescribing habits in a variety of practice settings. The PBM Academic Detailing Service (ADS) was created in 2015 to support the expansion of Academic Detailing programs throughout VHA. The primary focus of the ADS is to oversee the provision of Basic Skills training for new academic detailers, to develop educational materials and dashboards to support VHA and PBM key initiatives, and to provide a workforce platform to collect educational encounter data.

Patient Medication Information Management and Medication Reconciliation Initiative Office - serves to collaborate with program offices, the field, and partner federal healthcare organizations to ensure patients and their caregivers have safe, effective, team-based, and patient-driven medication reconciliation as part of a larger goal to partner with patients and their medications. This office has developed patient and staff education resources, operational support, policies, metrics, and collaborative efforts to reduce variation in medication information tools and improve medication information processes. The "Partnering with Veterans and their Medications Task Force," chartered by the Under Secretary for Health, will oversee the creation and then the execution of a unified strategy via a patient medication information and medication reconciliation handbook utilizing existing literature, subject matter experts, programs in development, and programs that have been deployed. The Medication Reconciliation System Integration Deployment will inform this strategy and take part in implementation of the handbook outlining the overarching strategy.

Meds by Mail Program**:** The Pharmacy Benefits Management Services (PBM) Meds by Mail (MbM) Program is designed to provide comprehensive outpatient mail pharmacy services to qualifying beneficiaries of the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or veterans who at the time of death were rated permanently and totally disabled from a service-connected condition. Additionally, MbM also supports the CHAMPVA Spina Bifida/ Children of Women Vietnam Veterans (CWVV) programs. Under CHAMPVA, VA shares the cost of covered services, including medications, with eligible beneficiaries. The MbM program is a unique benefit that provides cost effective and efficient mail order prescription services in a partnership between PBM, CMOP and the VA Chief Business Office Purchased Care (CBOPC). MbM staff process and manage non-VA provider prescriptions including customer service and CMOP distributes medications to CHAMPVA beneficiaries. Prescriptions are dispensed by CMOP then mailed directly to the beneficiary at no cost to the patient and at significant cost avoidance to government. PBM MbM also coordinates the Virtual Pharmacy Services (VPS) program. The VPS program provides virtual outpatient pharmacy support to VAMC pharmacies to process unverified prescriptions waiting pharmacist review.

Beneficiary Travel

Beneficiary Travel
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Medical Services......	$852,797	$908,200	$888,200	$944,500	$923,700	$960,700	$35,500	$37,000

All beneficiary travel obligations will remain entirely in the Medical Services appropriation once the Veterans Choice Appropriation expires and the Medical Community Care appropriation is established. Beneficiary travel obligations include:

VA has authority to provide or reimburse to certain eligible Veterans and other beneficiaries for:

- Mileage (currently $0.415), special mode (ambulance, wheelchair van etc.) transport, and common carrier (plane, bus etc.) transport.
- The actual cost of bridge tolls, road and tunnel tolls, parking, and authorized luggage fees when supported by a receipt.
- The actual cost, in limited circumstances, of meals, lodging or both, not to exceed 50% of the local Federal employee rate.

Eligibility is based upon receipt of VA service connection and/or low income (VA pension thresholds) or special administrative authority.

Prosthetics

Prosthetics
Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Medical Services......	$2,727,077	$2,841,942	$2,851,000	$3,039,353	$3,645,677	$3,376,159	$794,677	($269,518)

Prosthetic obligations will remain entirely in the Medical Services appropriation once the Veterans Choice Program expires and the Medical Community Care Appropriation is established. Prosthetic and Sensory Aids Service (PSAS) is an integrated delivery system designed to provide medically prescribed prosthetic and sensory aids, medical devices, assistive aids, repairs and services to eligible Veterans to maximize their independence and enhance their quality of life. Although the term “prosthetic device” may suggest images of artificial limbs, it actually refers to any device that supports or replaces loss of a body part or function and includes a full range of equipment and services for Veterans. This includes but is not limited to, artificial limbs, hearing aids, speech communication aids, home oxygen, orthopedic footwear, orthopedic braces and supports, cosmetic restorations, breast prostheses, wigs; items that improve accessibility such as ramps and vehicle modifications, wheelchairs and mobility aids; and devices surgically placed in the Veteran, such as stents, joint replacements, and pacemakers. These items are provided from prescription through procurement, delivery, training, replacement, and when necessary, repair. For more information please see the Medical Care chapter.

Medical Equipment

Medical Equipment Budget Estimate & Advance Appropriation columns exclude Veterans Choice Act (dollars in thousands)								
		2016		2017		2018		
	2015	Budget	Current	Advance	Revised	Advance	Increase/Decrease	
Description	Actual	Estimate	Estimate	Approp.	Request	Approp.	2016-2017	2017-2018
Medical Services......	$872,880	$879,300	$926,700	$438,800	$1,018,000	$542,000	$91,300	($476,000)

Medical service equipment includes capitalized equipment such as laboratory, pharmacy, operating room, x-ray, and medical rehabilitation equipment, with a purchase price of $1,000,000 or more; and non-capitalized equipment, such as scientific instruments and appliances, measuring and weighing instruments, and accessories and surgical instruments that cost less than $1,000,000.

VA Long-Term Services and Supports programs:
The Medical Service portions of the VA provided Long-Term Services and Supports programs, including VA Community Living Centers, VA Adult Day Care, Home-Based Primary Care, Spinal Cord Injury Home Care, and Home Telehealth will remain in the Medical Services appropriation after the establishment of the Medical Community Care appropriation. Please see the Medical Care Chapter for more information about these programs.

VA Other Health Care Programs:
Medical Service FTE and Pharmacy costs associated with the CHAMPVA program will remain in Medical Services Appropriation. Caregiver Stipend and all previously associated Medical Services costs of Readjustment counseling will remain in the Medical Services Appropriation. Please see the Medical Care Chapter for more information about these programs.

Services Shifting to Medical Community Care:
Care in the Community contractual services will not be obligated out of the Medical Services appropriation. These services include inpatient and outpatient providers in non-VA facilities, LTSS community living centers, community adult day health care, home respite care, purchased skilled home care, homemaker/home health aide programs, community residential care, CHAMPVA contract obligations, caregiver respite, caregiver mental health, caregiver non-VA oversight, Indian Health Services, and contracted Camp Lejeune obligations. For more information about these programs please see the Medical Care chapter. For more information about community care, please see the Medical Community Care chapter.

Medical Services
Program Resource Data

Unique Patients [1/]

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Priorities 1-6.............	4,824,325	4,918,891	4,967,642	5,028,596	5,096,617	5,211,267	128,975	114,650
Priorities 7-8.............	1,223,425	1,273,263	1,200,964	1,263,289	1,180,743	1,162,776	(20,221)	(17,967)
Subtotal Veterans......	6,047,750	6,192,154	6,168,606	6,291,885	6,277,360	6,374,043	108,754	96,683
Non-Veterans 2/.......	694,120	703,235	705,743	712,601	715,928	730,875	10,185	14,947
Total Unique Patients.	6,741,870	6,895,389	6,874,349	7,004,486	6,993,288	7,104,918	118,939	111,630

Unique Enrollees [3/]

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Priorities 1-6.............	6,867,722	7,056,268	7,003,462	7,180,635	7,135,440	7,249,646	131,978	114,206
Priorities 7-8.............	2,098,201	2,326,337	2,121,250	2,323,770	2,112,363	2,096,266	(8,887)	(16,097)
Total Enrollees..........	8,965,923	9,382,605	9,124,712	9,504,405	9,247,803	9,345,912	123,091	98,109

Users as a Percent of Enrollees

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Priorities 1-6.............	70.2%	69.7%	70.9%	70.0%	71.4%	71.9%	0.5%	0.5%
Priorities 7-8.............	58.3%	54.7%	56.6%	54.4%	55.9%	55.5%	-0.7%	-0.4%
Total Enrollees..........	67.5%	66.0%	67.6%	66.2%	67.9%	68.2%	0.3%	0.3%

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.

2/ Non-Veterans include active duty military and reserve, spousal collateral, consultations and instruction, CHAMPVA workload, reimbursable reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations such as Hepatitis A&B and flu vaccinations.

3/ Similar to unique patients, the count of unique enrollees represents the count of Veterans enrolled for Veterans health care sometime during the course of the year.

Medical Services (Excluding VACAA, Section 802)
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Advance Appropriation	$45,015,527	$47,603,202	$47,603,202	$51,673,000	$51,673,000	$44,886,554	$4,069,798	($6,786,446)
Annual Appropriation Adjustment	$209,189	$1,124,197	$1,124,197	$0	$1,078,993	$0	($45,204)	($1,078,993)
Omnibus Bill (P.L. 114-113)	$0	$0	$1,244,961	$0	$0	$0	($1,244,961)	$0
Appropriation Request Subtotal	$45,224,716	$48,727,399	$49,972,360	$51,673,000	$52,751,993	$44,886,554	$2,779,633	($7,865,439)
Rescission	($28,830)	$0	$0	$0	$0	$0	$0	$0
Net Appropriation	$45,195,886	$48,727,399	$49,972,360	$51,673,000	$52,751,993	$44,886,554	$2,779,633	($7,865,439)
Transfers:								
To North Chicago Demo. Fund	($190,185)	($195,358)	($196,323)	($200,172)	($201,604)	($206,127)	($5,281)	($4,523)
To DoD-VA Hlth Care Svcs Incentive Fund	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	$0	$0
To Major Construction	($6,494)	$0	($39,051)	$0	$0	$0	$39,051	$0
To Medical Services	$0	$0	$0	$0	$0	$0	$0	$0
To Medical Community Care	$0	$0	$0	$0	($7,246,181)	$0	($7,246,181)	$7,246,181
Fr Medical Support & Compl	$57,741	$0	$0	$0	$0	$0	$0	$0
Transfers Subtotal	($153,938)	($210,358)	($250,374)	($215,172)	($7,462,785)	($221,127)	($7,212,411)	$7,241,658
Collections	$3,422,806	$3,226,548	$3,515,171	$3,299,954	$3,308,307	$3,377,255	($206,864)	$68,948
Budget Authority Total	$48,464,754	$51,743,589	$53,237,157	$54,757,782	$48,597,515	$48,042,682	($4,639,642)	($554,833)
Reimbursements	$145,979	$171,106	$149,770	$171,106	$153,243	$156,005	$3,473	$2,762
Adjustments to Obligations								
Unobligated Balance (SOY)								
No-Year	$168,251	$0	$14,907	$0	$34,850	$0	$19,943	($34,850)
Financial Statement Audit Adjustment	$0	$0	$149,222	$0	$0	$0	($149,222)	$0
H1N1 No-Year (P.L. 111-32)_	$113	$0	$142	$0	$144	$0	$2	($144)
2007 Emergency Supplemental No-Year (P.L. 110-28)	$6	$0	$6	$0	$6	$0	$0	($6)
2-Year	$59,739	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) Subtotal	$228,109	$0	$164,277	$0	$35,000	$0	($129,277)	($35,000)
Unobligated Balance (EOY)								
No-Year	($14,907)	$0	($34,850)	$0	$0	$0	$34,850	$0
Financial Statement Audit Adjustment	($149,222)	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	($142)	$0	($144)	$0	$0	$0	$144	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	($6)	$0	($6)	$0	$0	$0	$6	$0
2-Year	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) Subtotal	($164,277)	$0	($35,000)	$0	$0	$0	$35,000	$0
Change in Unobligated Balances (Non-Add)	$63,832	$0	$129,277	$0	$35,000	$0	($94,277)	($35,000)
Lapse	($32)	$0	$0	$0	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$48,674,533	$51,914,695	$53,516,204	$54,928,888	$48,785,758	$48,198,687	($4,730,446)	($587,071)
Prior Year Recoveries	$574,411	$0	$0	$721,190	$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$49,248,944	$51,914,695	$53,516,204	$55,650,078	$48,785,758	$48,198,687	($4,730,446)	($587,071)

Veterans Access, Choice, & Accountability Act 0f 2014, Section 801

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Revised Estimate	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Unobligated Balance (SOY)	$5,000,000	$1,572,900	$1,717,485	$0	$302,484	$0	($1,415,001)	($302,484)
Transfer of Unobligated Balance	($2,686,900)	$0	$0	$0	$519,113	$0	$519,113	($519,113)
Trns of Unobl. Balance, Information Technology (IT)	$14,100	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	($1,717,485)	$0	($302,484)	$0	$0	$0	$302,484	$0
VACAA Section 801 Obligations Total	$609,715	$1,572,900	$1,415,001	$0	$821,597	$0	($593,404)	($821,597)
Medical Services Obligation Total (Incl. VACAA Section 801)	**$49,858,659**	**$53,487,595**	**$54,931,205**	**$55,650,078**	**$49,607,355**	**$48,198,687**	**($5,323,850)**	**($1,408,668)**

FTE by Type
Medical Services

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Physicians	18,744	19,943	19,116	21,781	20,533	20,285	1,417	(248)
Dentists	1,016	1,108	1,056	1,111	1,159	1,070	103	(89)
Registered Nurses	51,432	52,800	52,843	54,323	56,877	54,244	4,034	(2,633)
LP Nurse/LV Nurse/Nurse Assistant	24,511	25,323	24,965	26,129	26,318	25,537	1,353	(781)
Non-Physician Providers	12,732	13,634	12,904	14,763	13,788	13,961	884	173
Health Technicians/Allied Health	64,132	65,643	65,570	68,427	69,474	66,533	3,904	(2,941)
Wage Board/Purchase & Hire	5,442	5,647	5,526	5,663	5,698	5,455	172	(243)
All Other 1/	33,183	33,107	33,793	35,288	36,215	35,931	2,422	(284)
SubTotal	211,192	217,205	215,773	227,485	230,062	223,016	14,289	(7,046)
Veterans Choice Act, Sec. 801, FTE	5,145	9,577	11,585	0	6,458	0	(5,127)	(6,458)
Total	216,337	226,782	227,358	227,485	236,520	223,016	9,162	(13,504)

1/ Details on Medical Services "All Other" FTE occupation types can be found in the chart on the next page.

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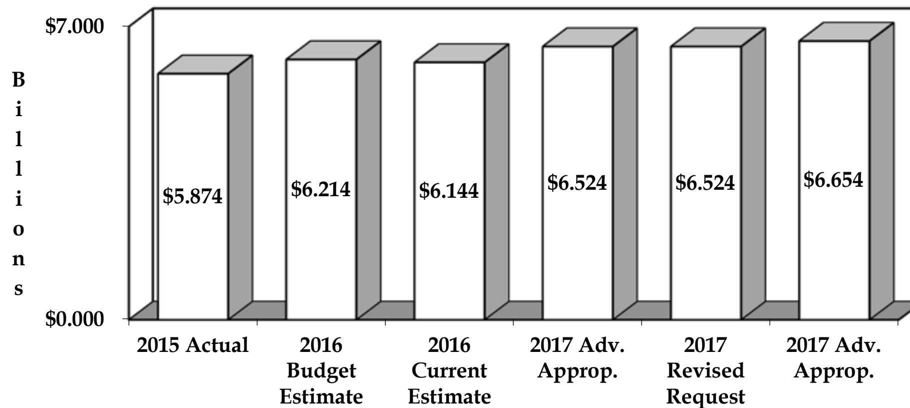
Medical Support and Compliance



Medical Support & Compliance
Net Appropriation
(Excludes Veterans Choice Act)
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Advance Appropriation	$5,879,700	$6,144,000	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Annual Appropriation Adjustment	$0	$69,961	$69,961	$0	$0	$0	($69,961)	$0
Omnibus Bill	$0	$0	($69,961)	$0	$0	$0	$0	$0
Subtotal Appropriation Request	$5,879,700	$6,213,961	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$310,039	$130,480
Rescissions	($5,609)	$0	$0	$0	$0	$0	$0	$0
Net Appropriations	$5,874,091	$6,213,961	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$310,039	$130,480

Appropriation Language

For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), [$6,524,000,000]$6,654,480,000, plus reimbursements, shall become available on October 1, [2016]2017, and shall remain available until September 30, [2017]2018: Provided, That, of the

amount made available on October 1, [2016]2017, under this heading, $100,000,000 shall remain available until September 30, [2018]2019. (Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2016.)

Appropriation Transfers
See "Appropriation Transfers & Supplementals" Chapter for a detailed explanation of the appropriation transfers that affect the Medical Support and Compliance appropriation.

2017 Funding and 2018 Advance Appropriations Request

The Medical Support and Compliance appropriation finances the supporting structures that underlie VHA's ability to deliver high quality health care services to our veterans. Over 66 percent of the 2017 total funding for this appropriation is designated for VA Medical Centers, VISNs & Other Field Activities, 24 percent of the funding is designated for National Consolidated Activities and the remaining 10 percent is designated for VHA Central Office. This funding ensures that leadership management teams are in place to govern, provide appropriate oversight for quality of care for our Veterans, essential security services are provided, needed supplies and medications are ordered, health care provider vacancies are filled, financial services and oversight are provided, required medical equipment is procured and patient encounters are appropriately recorded. Details of these critical functions are detailed in the following paragraphs.

Below, the funding represents total obligations in 2017 and 2018.

Program Resources (Excludes Veterans Choice Act)

- **$6.540 billion in 2017**
- **$6.640 billion in 2018**

In an effort to provide better visibility into the spending under this appropriation, VA is providing additional detail on obligations by the categories below. Obligations in this account finance activities at the VHA National Consolidated Activities and VHA Central Office; however, most of the resources support activities at VA Medical Centers and other VA field offices that provide or help administer direct patient care. The *following* charts reflect VA's actuals for 2015, current plan for 2016, revised request for 2017, and 2018 estimate.

Summary of Obligations by Functional Area
Medical Support and Compliance
(Excludes Veterans Choice Act)
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
VA Medical Centers, VISNs & Other Field Activities:								
VAMCs and Other Field Activities	$3,723,407	$4,054,488	$3,887,763	$4,299,118	$4,170,857	$4,234,618	$283,094	$63,761
VISN Headquarters	$169,474	$188,703	$174,000	$194,364	$163,000	$165,492	($11,000)	$2,492
Subtotal	$3,892,881	$4,243,191	$4,061,763	$4,493,482	$4,333,857	$4,400,110	$272,094	$66,253
VHA Central Office:								
VHA Central Office	$603,972	$675,703	$616,000	$695,974	$661,000	$671,105	$45,000	$10,105
Subtotal	$603,972	$675,703	$616,000	$695,974	$661,000	$671,105	$45,000	$10,105
National Consolidated Activities:								
Consolidated Patient Account Centers	$309,341	$305,000	$349,000	$314,150	$375,000	$380,733	$26,000	$5,733
Office of Informatics and Analytics	$187,509	$255,000	$239,000	$262,650	$257,000	$260,929	$18,000	$3,929
Chief Business Office Purchased Care 1/	$311,602	$265,000	$384,000	$272,950	$413,000	$419,314	$29,000	$6,314
Employee Education Service Center	$60,426	$73,703	$69,000	$75,914	$74,000	$75,131	$5,000	$1,131
VHA Service Center	$253,516	$268,000	$256,000	$276,040	$275,000	$279,204	$19,000	$4,204
Health Resource Center	$56,252	$52,703	$66,000	$54,284	$71,000	$72,085	$5,000	$1,085
Health Eligibility Center	$43,633	$49,000	$48,000	$50,470	$52,000	$52,795	$4,000	$795
Consolidated Mail Outpatient Pharmacies	$16,852	$17,000	$18,000	$17,510	$19,000	$19,290	$1,000	$290
National Center for Patient Safety	$6,293	$6,000	$8,000	$6,180	$9,000	$9,138	$1,000	$138
Subtotal	$1,245,424	$1,291,406	$1,437,000	$1,330,148	$1,545,000	$1,568,619	$108,000	$23,619
Prior Year Recoveries	$589	$0	$0	$310	$0	$0	$0	$0
Total	$5,742,866	$6,210,300	$6,114,763	$6,519,914	$6,539,857	$6,639,834	$425,094	$99,977

1/ Previously Health Administration Center

Fiscal Year 2015 Actuals Medical Support and Compliance (Excludes Veterans Choice Act)					
Description	Pay & Benefits 2/	Capital 3/	All Other 4/	Total	FTE
VA Medical Centers, VISNs & Other Field Activities:					
VAMCs and Other Field Activities..................................	$3,151,049	$20,362	$551,996	$3,723,407	35,629
VISN Headquarters..	$150,917	$32	$18,525	$169,474	1,022
Subtotal..	$3,301,966	$20,394	$570,521	$3,892,881	36,651
VHA Central Office:					
VHA Central Office..	$249,835	$567	$353,570	$603,972	1,680
Subtotal..	$249,835	$567	$353,570	$603,972	1,680
National Consolidated Activities:					
Consolidated Patient Account Centers..............................	$250,497	$72	$58,772	$309,341	3,581
Office of Informatics and Analytics..................................	$94,739	$5	$92,765	$187,509	642
Chief Business Office Purchased Care 1/.........................	$229,249	$362	$81,991	$311,602	2,699
Employee Education Service Center................................	$40,397	$447	$19,582	$60,426	377
VHA Service Center...	$244,285	$167	$9,064	$253,516	2,517
Health Resource Center...	$54,291	$181	$1,780	$56,252	830
Health Eligibility Center..	$27,622	$43	$15,968	$43,633	286
Consolidated Mail Outpatient Pharmacies........................	$16,039	$50	$763	$16,852	175
National Center for Patient Safety....................................	$5,758	$57	$478	$6,293	39
Subtotal..	$962,877	$1,384	$281,163	$1,245,424	11,146
Prior Year Recoveries..	$0	$0	$0	$589	
Total..	$4,514,678	$22,345	$1,205,254	$5,742,866	49,477

1/ Previously Health Administration Center

2/ Pay Benefits = 10 Personnel Compensation and Benefits.

3/ Capital = 31 Equipment and 32 Lands and Structures.

4/ All Other = 31 Travel & Transportation of Persons; 22 Transportation of Things; 23 Rent, Communications & Utilities; 24 Printing & Reproduction; 25 Other Contractual Services; and 26 Supplies & Materials

VA Medical Centers, VISNs & Other Field Activities

VA Medical Centers and Other Field Activities
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$3,723,407	$4,054,488	$3,887,763	$4,299,118	$4,170,857	$4,234,618	$283,094	$63,761

Funding in this account for VA Medical Centers and other field activities supports the management, operation, oversight, security, and administration of the VA's health care system. This includes medical center management teams (Director, Chief of Staff, Chief Medical Officer, and Chief Nurse), medical center support functions (quality of care oversight, security services, legal services, billing and coding activities, acquisition, procurement, and logistics activities), human resource management, logistics and supply chain management, and financial management. Of the many functions required to operate

VHA facilities, one essential function is revenue generation. This begins at the medical centers and clinics with the verification of insurance and the coding of inpatient and outpatient encounters.

Veteran Integrated Service Networks (VISN) Headquarters

Veteran Integrated Service Networks (VISN) Headquarters
dollars in thousands

		2016		2017		2018		
Description	2015 Actual	Budget Estimate	Revised Estimate	Advanced Approp.	Revised Estimate	Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$169,474	$188,703	$174,000	$194,364	$163,000	$165,492	($11,000)	$2,492

These funds provide the necessary resources for the 21 VISN offices that provide regional support, management and oversight to the medical centers, clinics and other field activities within their regions. This includes but is not limited to network leadership teams (Network Director, Deputy Network Director, Chief Financial Officer, Chief Medical Officer, and Chief Information Officer) and clinical and administrative functional leads that are centrally located to provide leadership to those programs within each VISN. Each VISN office is responsible for coordinating the delivery of health care to Veterans by leveraging and integrating operations at all of the VA health care facilities within the VISN.

VHA Central Office

VHA Central Office
dollars in thousands

		2016		2017		2018		
Description	2015 Actual	Budget Estimate	Revised Estimate	Advanced Approp.	Revised Estimate	Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$603,972	$675,703	$616,000	$695,974	$661,000	$671,105	$45,000	$10,105

VHA Central Office (VHACO) is the headquarters for one of the world's largest integrated health care systems. With a medical care budget of nearly $70 billion, VHA in 2016 anticipates employing close to 303,000 personnel, including hospitals, clinics, nursing homes, domiciliaries, and Readjustment Counseling Centers. In addition, VHA is the Nation's largest provider of graduate medical education and a major contributor to medical research. Over nine million Veterans are enrolled in VA's health care system. VHACO is led by the Under Secretary for Health whose office serves as the Department's central coordination point for the establishment or implementation of policies, practices, management and operational activities of VHA. This must be done in order to most effectively carry out the mission of Honoring America's Veterans by providing exceptional health care that improves their health and well-being. VHACO provides the strategic, policy and operational leadership that coordinates and governs VHA activities including development of strategic direction, deployment and measurement of performance, accountability, and transparency of decision making. VHACO assures organizational oversight to the vision, values and mission of VHA, and alignment with the strategic direction and goals of the administration and department.

In addition to the Office of the Under Secretary for Health, which includes the VHA Chief of Staff, Office of Research Oversight, the Office of the Medical Inspector, and Readjustment Counseling Services, VHACO also includes the Principal Deputy Under Secretary for Health, the Deputy Under Secretary for Health for Operations and Management, and the Deputy Under Secretary for Health for Policy and Services.

The Principal Deputy Under Secretary for Health provides leadership for the Office for Quality, Safety and Value, Office of Nursing, Office for Workforce Services, Office of Strategic Integration, Office of Health Equity, and Office of Finance. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) oversees field operations, providing broad and general operational direction and guidance. The DUSHOM is also responsible for other VHACO administrative programs (e.g., business operations, environmental programs management, canteen services, health care engineering, safety and technical services, acquisition and procurement, capital assets) and clinical operations (e.g., surgical services, primary care, dentistry, geriatrics, mental health, sterile processing, disability medical assessment, and the homeless program). The Deputy Under Secretary for Health for Policy and Services provides leadership for the offices responsible for health care policy, projecting the demand for health care services for strategic planning and budgeting, addressing the public health needs of Veterans, overseeing the policy development of all clinical care provided by the healthcare workforce, developing and coordinating collaboration with DoD and other federal agencies, developing and providing the health informatics and analytical and business intelligence to support the nation's largest integrated health care system, a robust research and development portfolio and ensure adherence to the highest ethical standards in health care.

National Consolidated Activities

Consolidated Patient Account Centers (CPACs)

Consolidated Patient Account Centers
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$309,341	$305,000	$349,000	$314,150	$375,000	$380,733	$26,000	$5,733

Consolidated Patient Account Center (CPAC) business model utilizes industry-proven methods, processes, business tools, and increased accountability to achieve superior levels of sustained revenue cycle management. Under the CPAC program, VHA consolidated traditional revenue program functions into seven regionalized account centers. Under this model, each of the 144 VA Hospitals maintains ownership of key patient-facing revenue functions, while back-end revenue cycle processes are performed at the CPACs.

The CPAC model was tested in a 2006 pilot that established the Mid-Atlantic CPAC. Following this, Congress enacted the Veterans' Mental Health and Other Improvements Act (P.L. 110-387) in October 2008, which mandated national implementation of the CPAC business model by 2013. All seven centers were operational by the end of 2012, one year ahead of the date mandated by the law. The seven centers include:

1. Mid Atlantic CPAC — Asheville, NC (VISNs 5, 6, and 7);
2. Mid South CPAC— Smyrna, TN (VISNs 9, 16, and 17);
3. Florida/Caribbean CPAC — Orlando, FL (VISN 8);
4. North Central CPAC — Middleton, WI (VISNs 10, 11, and 12);
5. North East CPAC — Lebanon, PA (VISNs 1, 2, 3, and 4);
6. Central Plains CPAC — Leavenworth, KS (VISNs 15, 19 and 23); and
7. West CPAC — Las Vegas, NV (VISNs 18, 20, 21 and 22).

Office of Informatics and Analytics (OIA)

Office of Informatics and Analytics
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$187,509	$255,000	$239,000	$262,650	$257,000	$260,929	$18,000	$3,929

Office of Informatics and Analytics (OIA) has the Program Office located in Washington, DC with satellite offices across the country, and offers advanced and secure health information tools, including a world-class electronic health record, patient-facing health technology applications, enterprise data systems, sophisticated analysis and measurement, user-centered decision support, and agile business intelligence. OIA facilitates evidence-based decisions for individual Veterans and their families, patient populations, clinicians, and those managing health care delivery systems.

1. **Analytics and Business Intelligence (ABI) -** The role of ABI is to provide timely, reliable and sophisticated analytic and business intelligence solutions and to facilitate evidence-based decisions for Veterans and their families, clinicians, and those managing health care delivery systems. ABI serves the data management needs of VHA to assure that managers, clinicians, researchers, and stakeholders using VA's extensive health data resources possible to deliver high quality health care in the most efficient and effective manner possible. Critical functions performed by ABI include measuring the quality, accessibility and safety of health care, evaluating productivity, assessing Veteran's satisfaction and experience of care, internal and public reporting of data (including at the point-of-care), and training employees throughout VHA to apply data thoughtfully.

2. **Connected Health Office (CHO)** – CHO collaborates with partners throughout VA to leverage technology and innovation in transforming the delivery of care for Veterans, their families, and Caregivers with unified, integrated and personalized virtual services that connect them with a state-of-the-art system of care. CHO creates solutions that enable VA health care teams to seamlessly provide and coordinate services across geography and the care continuum, as well as, produces a consistent experience for users and continuously improve based on user input, research, and evaluation. CHO's Web & Mobile Solutions develops mobile solutions, including mobile applications (apps and mobile-optimized Web sites, to assist Veterans, Caregivers and clinicians and to address a range of health, management and administrative needs. CHO's VHA Innovation Program allows critical health care innovations to emerge from the field. My Health**e**Vet,

which joined CHO in January 2014, is VA's online personal health record, which provides Veterans, active duty Servicemembers, their dependents and caregivers with opportunities and tools to make informed decisions and manage their health care.

3. **Health Informatics (HI)** – HI is the focal point for the advancement of VA's electronic health record (EHR) and information systems and serves as the primary advocate for field clinicians as it relates to health information technology (HIT). HI is the home to such programs as Veterans Integrated System Technology Architecture (VistA) Evolution, Virtual Lifetime Electronic Record (VLER) Health Program, Bar Code Medication Administration (BCMA), Informatics Patient Safety, Applied Informatics Service, Human Factors, Knowledge-Based Systems, and Informatics Patient Safety.

4. **Health Information Governance (HIG)** – HIG provides subject matter expertise, policy guidance, compliance monitoring, and support in the areas of information access, privacy, Freedom of Information Act (FOIA) requests, health care information security, data systems, person identity services, health information management (HIM), records management, data quality and library services. It represents VA on national and international health care policy initiatives regarding Veterans' data. HIG serves as VHA's subject matter and policy expert regarding data contained in Veterans' Electronic Health Records (EHR) and in national data systems.

5. **Strategic Investment Management (SIM)** – SIM informs decision making for prioritization of health-focused Information Technology (IT) funding/investments and business-driven sequencing of future health information functionality. SIM provides leadership with a comprehensive understanding of needed VHA business capabilities including business requirements, processes, information needs, IT strategy and priorities, and investment analysis. SIM provides a wide range of services including, business requirements/architecture development for health IT solution development or acquisition, business process re-engineering, software release management, health IT governance management, health IT analysis and budget development, health IT strategic planning and business transformation, as well VistA Standardization coordination with the Open Source Community. SIM is comprised of four organizational services: Business Architecture, Common Services and Investment Management, Open Source Management, and Requirements Development and Management.

6. **Program Support Operations –** This office supports all of OIA by providing budget, finance, procurement, human resources, and communication services.

Chief Business Office Purchased Care (CBOPC)

Chief Business Office Purchased Care
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$311,602	$265,000	$384,000	$272,950	$413,000	$419,314	$29,000	$6,314

Chief Business Office Purchased Care (CBOPC), previously referred to as Health Administration Center (HAC), is responsible for a broad range of activities to support the delivery of health care benefits for Veterans and eligible dependents. CBOPC provides assistance to VHA medical facilities by leading the transformation of purchased care business practices, implementing health benefits policy, and supporting the delivery of quality health care through management of the following programs:

- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- CHAMPVA In-House Treatment Initiative (CITI)
- CHAMPVA Meds by Mail Program
- Spina Bifida Health Care Program
- Children of Women Vietnam Veterans Health Care Program
- Foreign Medical Program
- Caregiver Support Program
- Non-VA Medical Care (NVC)
- Veterans Choice Program
- Patient-Centered Community Care (PC3)
- State Veterans Home (SVH) Per Diem Program
- Project Access Received Closer to Home (ARCH)
- Indian Health Services(IHS)/Tribal Health Program (THP)
- Camp Lejeune

In addition, CBOPC provides communications support for the programs it manages and stakeholder briefings for Veterans, beneficiaries, Veterans Service Officers, and other external stakeholders.

Employee Education Service Center

Employee Education Service Center
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$60,426	$73,703	$69,000	$75,914	$74,000	$75,131	$5,000	$1,131

Within VHA, the Employee Education Service Center (EES), located in Washington, D.C., with satellite offices across the country, partners with VHA program offices, VISNs, and medical centers to assess and determine learning requirements, design curricula and courses,

and deliver and evaluate education and training to meet the workforce development, continuing education, and competency-based needs of clinical, administrative and technical employees. EES maintains accreditations with professional organizations in order to ensure quality and relevance of all training offered to VHA employees who provide or support health care programs and services to Veterans. Learning is delivered via a comprehensive set of training modalities which can be offered singularly or as part of a blended learning strategy.

EES develops and delivers quality educational programs, products and services using sound educational design and evaluation and employing a variety of delivery methods designed to be responsive to VHA employees' learning needs and preferences. In addition to traditional approaches, EES employs contemporary and emerging technologies, including clinical simulation training, that meet the learning needs of a highly skilled and mobile workforce.

EES continues to lead the cultural transformation of VHA into a learning organization, which links learning outcomes to organizational health, employee engagement and patient satisfaction. EES coordinates inter-agency sharing initiatives within and beyond VA that benefit learners in a number of other Federal agencies.

VHA Service Center (VSC)

VHA Service Center
dollars in thousands

		2016		2017		2018		
	2015	Budget	Revised	Advanced	Revised	Advance	Increase / Decrease	
Description	Actual	Estimate	Estimate	Approp.	Estimate	Appropriation	2016-2017	2017-2018
Obligations (Non-801).....	$253,516	$268,000	$256,000	$276,040	$275,000	$279,204	$19,000	$4,204

The VHA Service Center (VSC), located in Independence, Ohio, provides a wide-range of fiscal, payroll, travel and/or human resource management services to the Office of Informatics and Analytics (OIA), Office of Resolution Management (ORM), and the Service Area Offices (SAO) West, East and Central organizations. The VSC also provides Fiscal Services to the Employee Education System (EES).

VSC's mission is to provide quality Fiscal and Human Resources services through superior customer service, experience, and innovation. An itemized list of Fiscal and Human Resources services is shown below. VSC is committed to education and developing our managers and employees to provide our customers with the most qualified and knowledgeable staff. In 2014, VSC provided Fiscal and HR services to over 4,300 customers from VA Central Office, VHA and the Veterans Benefits Administration (VBA).

VSC Services:

Fiscal: Financial Accounting & Budgeting, Payroll, Travel, Auditing, Purchases

Human Resources: Recruitment & Staffing, Classification, Personnel Security, (federal employees/contractors), Employee/Labor Relations, Benefits, Performance and Recognition review

Health Resource Center (HRC)

Health Resource Center
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$56,252	$52,703	$66,000	$54,284	$71,000	$72,085	$5,000	$1,085

Health Resource Center (HRC) provides customer service and support to Veterans, their beneficiaries, caregivers, other government agencies and the general public regarding VA health benefits, eligibility, billing and pharmacy-related inquiries. HRC also assists with a variety of other interests within VA, such as disaster support, payroll administration and technical support. HRC has served as a national point of contact for VA in support of Veterans and related administrative initiatives since 2002. 2014, the HRC responded to over 6 million Veteran inquiries by way of phone, email, and web chat.

HRC has a primary campus on the grounds of the Eastern Kansas Health Care System in Topeka, Kansas, and a second campus on the grounds of the Central Texas Health Care System in Waco, Texas.

HRC is organizationally aligned under CBO.

Health Eligibility Center (HEC)

Health Eligibility Center
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$43,633	$49,000	$48,000	$50,470	$52,000	$52,795	$4,000	$795

Health Eligibility Center (HEC), located in Atlanta, GA, supports VA's health care delivery system by providing centralized eligibility verification and enrollment processing services. HEC determines a Veteran's health eligibility and facilitates the process by providing guidance to the field, informational outreach, training, policy development and implementation. HEC enables the ability to execute a seamless handoff from enrollment decision to provision of care. Additionally, the HEC provides direct and indirect systems management support to numerous other VA business lines improving the ability to provide care to Veterans.

Consolidated Mail Outpatient Pharmacies (CMOP)

Consolidated Mail Outpatient Pharmacies
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$16,852	$17,000	$18,000	$17,510	$19,000	$19,290	$1,000	$290

VA CMOP program provides outpatient pharmaceutical dispensing support services to Veterans being cared for at VA healthcare facilities and medical centers located within each of the VISNs throughout the United States. The CMOP acts as an extension of the medical facility pharmacies providing the fulfillment services for 80 percent of all outpatient prescriptions provided to Veterans by VHA. This is accomplished through the use of highly automated technologies that support the dispensing of over 474,000 prescriptions every work day and 118.9 million prescriptions a year. The CMOP program consists of a network of seven pharmacies located in Chelmsford, MA; Charleston, SC; Dallas, TX; Hines, IL; Leavenworth, KS; Murfreesboro, TN; and Tucson, AZ. CMOP activities are funded through user fees paid by the VHA medical facilities utilizing the service. CMOP provides prescription fulfillment services, i.e., filling and mailing outpatient prescriptions, directly to beneficiaries of the Indian Health Service as well as all of VHA. Seventy-eight IHS/tribal health program sites have been set up to participate in the CMOP program.

National Center for Patient Safety (NCPS)

National Center for Patient Safety
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$6,293	$6,000	$8,000	$6,180	$9,000	$9,138	$1,000	$138

NCPS, a highly collaborative branch of the Office of Quality Safety and Value (QSV), is field-based in Ann Arbor, MI and White River Junction, VT, with a minimal presence in Washington, DC. The fundamental mission of NCPS is "prevention of patient harm." NCPS approaches, products, services, and research are developed on behalf of and for use by Veterans, Facilities, Networks and Central Office Program Offices and are based on High Reliability Organization (HRO) and Human Factors Engineering (HFE) experience and science. Some core functions include: information and tools designed for Veterans and their families/caregivers (e.g., The Daily Plan, Healthcare Literacy); training and education for all levels of VHA staff and trainees (e.g., Basic Patient Safety, Clinical Team Training, Residency Curriculum); national data collection, analysis and feedback related to adverse events and close calls (e.g., Root Cause Analysis, Healthcare Failure Mode and Effects Analysis) and; analysis of high risk situations and dissemination of solution based information and guidance (e.g., Alerts, Advisories, Product Recalls, Lessons Learned, etc.).

Prior Year Recoveries

Prior Year Recoveries
dollars in thousands

Description	2015 Actual	2016 Budget Estimate	2016 Revised Estimate	2017 Advanced Approp.	2017 Revised Estimate	2018 Advance Appropriation	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations (Non-801).....	$589	$0	$0	$310	$0	$0	$0	$0

This is an accounting change to record prior year recoveries as required by Federal accounting policy under OMB Circular No. A-11 guidance and is being reflected for the first time in the 2015 Actuals. Because this is a technical change that does not affect the actual resource levels provide for Veterans services, there are no projections for future years. VA has modified its financial accounting system to be able to accurately monitor and record recoveries.

Medical Support and Compliance Program Resource Data

Medical Support & Compliance (Excluding VACAA, Section 802)
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Advance Appropriation	$5,879,700	$6,144,000	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Annual Appropriation Adjustment	$0	$69,961	$69,961	$0	$0	$0	($69,961)	$0
Omnibus Bill (P.L. 114-113)	$0	$0	($69,961)	$0	$0	$0	$69,961	$0
Appropriation Request Subtotal	$5,879,700	$6,213,961	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Rescission	($5,609)	$0	$0	$0	$0	$0	$0	$0
Net Appropriation	$5,874,091	$6,213,961	$6,144,000	$6,524,000	$6,524,000	$6,654,480	$380,000	$130,480
Transfers:								
To North Chicago Demo. Fund	($26,608)	($27,332)	($27,405)	($28,067)	($28,206)	($28,839)	($801)	($633)
To DoD-VA Hlth Care Svcs Incentive Fund	$0	$0	$0	$0	$0	$0	$0	$0
To Major Construction	($1,611)	$0	($84,687)	$0	$0	$0	$84,687	$0
To Medical Services	($57,741)	$0	$0	$0	$0	$0	$0	$0
Fr Medical Support & Compl	$0	$0	$0	$0	$0	$0	$0	$0
Transfers Subtotal	($85,960)	($27,332)	($112,092)	($28,067)	($28,206)	($28,839)	$83,886	($633)
Budget Authority Total	$5,788,131	$6,186,629	$6,031,908	$6,495,933	$6,495,794	$6,625,641	$463,886	$129,847
Reimbursements	$10,671	$23,671	$13,823	$23,671	$14,063	$14,193	$240	$130
Adjustments to Obligations								
Unobligated Balance (SOY)								
No-Year	$1,503	$0	$248	$0	$250	$0	$2	($250)
Financial Statement Audit Adjustment	$0	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0	$0	$0	$0	$0
2-Year	$41,149	$0	$98,784	$0	$29,750	$0	($69,034)	($29,750)
Unobligated Balance (SOY) Subtotal	$42,652	$0	$99,032	$0	$30,000	$0	($69,032)	($30,000)
Unobligated Balance (EOY)								
No-Year	($248)	$0	($250)	$0	$0	$0	$250	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0	$0	$0	$0	$0
2-Year	($98,784)	$0	($29,750)	$0	$0	$0	$29,750	$0
Unobligated Balance (EOY) Subtotal	($99,032)	$0	($30,000)	$0	$0	$0	$30,000	$0
Change in Unobligated Balances (Non-Add)	($56,380)	$0	$69,032	$0	$30,000	$0	($39,032)	($30,000)
Lapse	($145)	$0	$0	$0	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$5,742,277	$6,210,300	$6,114,763	$6,519,604	$6,539,857	$6,639,834	$425,094	$99,977
Prior Year Recoveries	$589	$0	$0	$310	$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$5,742,866	$6,210,300	$6,114,763	$6,519,914	$6,539,857	$6,639,834	$425,094	$99,977

Veterans Access, Choice, & Accountability Act 0f 2014, Section 801

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Revised Estimate	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Unobligated Balance (SOY)	$0	$17,000	$27,088	$0	$7,310	$0	($19,778)	($7,310)
Transfer of Unobligated Balance	$27,500	$0	$0	$0	$0	$0	$0	$0
Trns of Unobl. Balance, Information Technology (IT)	$0	$0	$0	$0	$8,952	$0	$8,952	($8,952)
Unobligated Balance (EOY)	($27,088)	$0	($7,310)	$0	$0	$0	$7,310	$0
VACAA Section 801 Obligations Total	$412	$17,000	$19,778	$0	$16,262	$0	($3,516)	($16,262)
Medical Care Obligation Total (Incl. VACAA Section 801)	**$5,743,278**	**$6,227,300**	**$6,134,541**	**$6,519,914**	**$6,556,119**	**$6,639,834**	**$421,578**	**$83,715**

FTE by Type
Medical Support and Compliance
(Excludes Veterans Choice Act)

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Physicians	567	651	566	666	566	566	0	0
Dentists	12	10	11	11	11	11	0	0
Registered Nurses	2,850	3,365	2,998	3,441	2,998	2,998	0	0
LP Nurse/LV Nurse/Nurse Assistant	71	105	80	107	80	80	0	0
Non-Physician Providers	192	227	225	233	225	225	0	0
Health Technicians/Allied Health	1,057	1,119	996	1,148	996	996	0	0
Wage Board/Purchase & Hire	954	993	1,021	1,016	1,021	1,021	0	0
All Other 1/	43,774	47,550	45,153	48,678	46,453	46,453	1,300	0
Subtotal	49,477	54,020	51,050	55,300	52,350	52,350	1,300	0
Veterans Choice Act, Sec. 801, FTE	2	36	200	0	170	0	(30)	(170)
Total	49,479	54,056	51,250	55,300	52,520	52,350	1,270	(170)

1/ The All Other category includes: Administrative Support Clerk, Administrative Specialist, Police , Personnel Management Specialist, Management And Program Analyst, Medical Records Clerk/Technician, Budget/Fiscal, Contract Administrator, Supply Technician, Medical Support Assistance, and other staff that are necessary for the effective operations of VHA Medical Support & Compliance.

Veterans Choice Act, Public Law 113-146, Section 801

On August 7, 2014, President Obama signed into law the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146) ("Veterans Choice Act"). The 2016 Budget supports implementation of the Veterans Choice Act and the Administration's goal of providing timely, high-quality health care for our Nation's veterans. The Veterans Choice Act provided $5 billion in mandatory funding in Section 801 to increase veterans' access to health care by hiring more physicians and staff and improving the VA's physical infrastructure.

Within the Support & Compliance Appropriation estimates of obligations for 2016 and 2017 are $19,778,000 and $16,262,000 respectively. The obligations are consistent with the needs of the Veterans Choice Act and will be spent on staffing and on activations for major and major lease projects to outfit new clinical and administrative space necessary to enhance services to veterans in the short-term while strengthening the underlying VA system to better serve veterans in the future.

Veterans Choice Act, Public Law 113-146
Section 801
Medical Support & Compliance
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Estimate	2018 Advance Approp. 2/	2016-2017 Increase/ Decrease	2017-2018 Increase/ Decrease
Activations...	$0	$0	$3,516	$0	$0		($3,516)	$0
Leases, Emergency:								
Leases, Emergency...	$0	$0	$0	$0	$0	$0	$0	$0
Leases, Pipeline:								
Leases in the Pipeline...	$0	$0	$0	$0	$0	$0	$0	$0
Leases, Sustainment...	$0	$0	$0	$0	$0	$0	$0	$0
Section 301/302:								
HPEAP Modification..	$0	$0	$0	$0	$0	$0	$0	$0
Staffing Shortage & Report (Sect. 301)..............	$136	$16,000	$15,512		$15,512		$0	($15,512)
Supervising Faculty Salary.................................	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal...	$136	$16,000	$15,512	$0	$15,512	$0	$0	($15,512)
Staffing:								
Hiring Medical Staff...	$276	$1,000	$750	$0	$750	$0	$0	($750)
Supplies/Equipment:								
Supplies/Equipment..	$0	$0	$0	$0	$0	$0	$0	$0
NRM/Legionella:								
Non-Recurring Maintenance...............................	$0	$0	$0	$0	$0	$0	$0	$0
Legionella...	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal...	$0	$0	$0	$0	$0	$0	$0	$0
Obligations Total..	**$412**	**$17,000**	**$19,778**	**$0**	**$16,262**	**$0**	**($3,516)**	**($16,262)**

1/ 2017 Advance Appropriation assumed that all Section 801 funds would be obligated by end of Fiscal Year 2016.
1/ 2018 Advance Appropriation assumes that all Section 801 funds would be obligated by end of Fiscal Year 2017.

Veterans Choice Act, Public Law 113-146
Section 801
Medical Support & Compliance
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Unobligated Balance (SOY)...	$0	$17,000	$27,088	$0	$7,310	$0	($19,778)	($7,310)
Trns of Unobligated Balance...	$27,500	$0	$0	$0	$8,952	$0	$8,952	($8,952)
Trns of Unobl. Balance, Information Technology (IT).....	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)...	($27,088)	$0	($7,310)	$0	$0	$0	$7,310	$0
Obligations Total...	**$412**	**$17,000**	**$19,778**	**$0**	**$16,262**	**$0**	**($3,516)**	**($16,262)**

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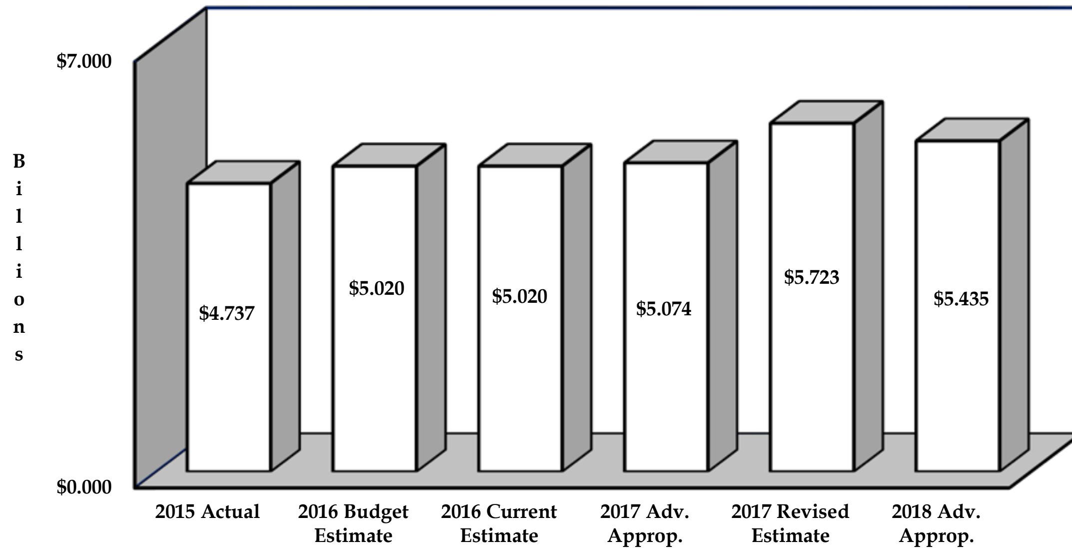
Medical Facilities



Medical Facilities
Net Appropriations Total
(Excludes Veterans Choice Act)
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Advance Appropriation	$4,739,000	$4,915,000	$4,915,000	$5,074,000	$5,074,000	$5,434,880	$159,000	$360,880
Annual Appropriation Adjustment	$0	$105,132	$105,132	$0	$649,000	$0	$543,868	($649,000)
Subtotal Appropriation Request	$4,739,000	$5,020,132	$5,020,132	$5,074,000	$5,723,000	$5,434,880	$702,868	($288,120)
Rescission	($2,000)	$0	$0	$0	$0	$0	$0	$0
Net Appropriations	$4,737,000	$5,020,132	$5,020,132	$5,074,000	$5,723,000	$5,434,880	$702,868	($288,120)

Appropriation Language

For necessary expenses for the maintenance and operation of hospitals, nursing homes, domiciliary facilities, and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and

purchase of materials; for leases of facilities; and for laundry services; **[**$105,132,000**]***$649,000,000*, which shall be in addition to funds previously appropriated under this heading that became available on October 1, **[**2015**]***2016*; and, in addition, **[**$5,074,000,000**]***$5,434,880,000*, plus reimbursements, shall become available on October 1, **[**2016**]***2017*, and shall remain available until September 30, **[**2017**]***2018*: *Provided*, That, of the amount made available on October 1, **[**2016**]***2017*, under this heading, $250,000,000 shall remain available until September 30, **[**2018**]***2019*. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2016.)*

Appropriation Transfers
See "Appropriation Transfers & Supplementals" chapter for a detailed explanation of the appropriation transfers that affect the Medical Facilities appropriation.

2017 Funding and 2018 Advance Appropriations Request

The Medical Facilities appropriation supports the operation and maintenance of the Department of Veterans Affairs' (VA) hospitals, community-based outpatient clinics (CBOC), community living centers, domiciliary facilities, Vet Centers, and the health care corporate offices. The appropriation also supports the administrative expenses of planning, designing, and executing construction or renovation projects at these facilities. The Veterans Health Administration (VHA) operates approximately 5,559 buildings on 15,968 acres of land, and over 1,604 leases, encompassing over 15 million square feet of space in its portfolio.

The staff and associated funding supported by this appropriation are responsible for: keeping the VA hospitals and clinics climate controlled; maintaining a clean and germ- and pest- free environment; sanitizing and washing hospital linens, surgical scrubs, and clinical coats; cleaning and sterilizing the medical equipment; keeping the hospital signage clear and current; maintaining the trucks, buses and cars in good operating condition; ensuring the parking lots and walk ways are sanded and free of snow and ice; cutting the grass; keeping the boiler plants and air conditioning units operating effectively; and undertaking certain repairs and alterations to the buildings to keep them in good condition. Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations; see Volume 4 for additional detail.

2017 Annual Appropriation Adjustment

Update to the 2017 Advance Appropriation Request
Medical Facilities
(Excludes Veteran Choice Act)
(dollars in thousands)

Description	2017 Advance Approp.	2017 Revised Estimate	Increase/ Decrease
Engineering & Environmental Management Services	$619,481	$650,903	$31,422
Plant Operation	$901,436	$764,000	($137,436)
Leases	$691,900	$838,102	$146,202
Transportation Services	$178,409	$165,000	($13,409)
Grounds Maintenance & Fire Protection	$102,249	$103,000	$751
Recurring Maintenance & Repair	$750,339	$593,000	($157,339)
Non-Recurring Maintenance	$460,600	$1,057,473	$596,873
Operating Equipment Maintenance & Repair	$238,293	$206,000	($32,293)
Engineering Service	$873,818	$1,128,000	$254,182
Other Facilities Operation Support	$68,957	$32,000	($36,957)
Textile Care Processing & Management	$171,305	$185,000	$13,695
Recovery of Prior Year Obligations	$15,000	$0	($15,000)
Obligations Total	$5,071,787	$5,722,478	$650,691
Funding Availability:			
Appropriation	$5,074,000	$5,074,000	$0
Trns to North Chicago Demo. Fund	($37,436)	($37,620)	($184)
Reimbursements	$20,223	$17,098	($3,125)
Unobligated Balance	$0	$20,000	$20,000
Recovery of Prior Year Obligations	$15,000	$0	($15,000)
Funding Availability Total	$5,071,787	$5,073,478	$1,691
Annual Appropriation Adjustment	$0	$649,000	$649,000

Additional 2017 Appropriation Request – Medical Facilities

A 2017 advance appropriation of $5.074 billion for Medical Facilities was enacted in Public Law (P.L.) 114-113. The budget requests an additional $649 million to support the operation and maintenance of VA facilities. The additional funding is required primarily for increased costs in administrative contract services, leases, and non-recurring maintenance (NRM). Obligations for NRM are expected to increase by $596.9 million over the 2017 advance to address high-priority emerging capital needs as identified through the Strategic Capital Investment Planning (SCIP) process. Leases are expected to increase by $146 million. The 2017 request will support 24,209 FTE (non-Veterans Choice Act), which is a decrease of 222 FTE over the initial advance appropriation estimate.

The funding below represents total estimated obligations in 2017 and 2018 (excluding Veterans Choice Act).

Program Resources (Excluding Veterans Choice Act)

- **$5.722 billion in 2017**
- **$5.414 billion in 2018**

The programmatic needs in this section reflect VA operational changes that impact resources in 2017 and 2018. Included under this heading are provisions for costs associated with utilities, engineering, capital planning, leases, laundry services, grounds maintenance, trash removal, housekeeping, fire protection, pest management, facility repair and maintenance, and property disposition and acquisition.

Veterans Integrated Service Networks (VISN) Realignment

As a result of MyVA VISN Realignment, VHA has a new realigned map with five districts. VISN structure has been modified to reduce the number of VISNs from 21 to 18, and to bring the VISNs in line with MyVA districts. Multiple factors were weighted in the process, including alignment with state boundaries, the population of Veterans served, and the number of health care systems within each VISN. The analysis supported a reduction in the number of VISNs to 18 to allow for a reasonable span of control, with 6 to 11 health care systems in the majority of the VISNs, while simultaneously reducing variation in Veteran population, enrollees, patients, FTE staff, and budget.

Medical Care
Number of Installations 1/

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Veterans Integrated Service Networks (VISN) 7/	**21**	**21**	**21**	**21**	**18**	**18**	(3)	0
VA Medical Centers (VAMC), Total 2/	**167**	**167**	**168**	**167**	**168**	**168**	0	0
Included in VA Medical Centers, Total:								
VA Hospitals	144	144	144	144	144	144	0	0
Community Living Centers	135	135	136	135	136	138	0	2
Residential Rehabilitation Care (DRRTP)	113	111	116	111	120	120	4	0
VAMC-Based Outpatient Care Sites	167	167	168	167	168	168	0	0
Health Care Centers (HCC) 3/	**14**	**14**	**20**	**14**	**20**	**20**	0	0
Community-Based Outpatient Clinics (CBOC)	**755**	**763**	**763**	**763**	**766**	**766**	3	0
Multi-Specialty CBOC 4/	187	186	186	186	186	186	0	0
Primary Care CBOC 5/	568	577	577	577	580	580	3	0
Other Outpatient Services Sites, Total 6/	**280**	**268**	**268**	**268**	**268**	**268**	0	0
Included in Other Outpatient Services Sites, Total:								
Dialysis Centers	71	75	74	75	74	74	0	0
Community Resource and Referral Centers (CRRC)	30	29	30	29	30	30	0	0
Vet Centers	**300**	**300**	**300**	**300**	**300**	**300**	0	0
Mobile Vet Centers	**80**	**80**	**80**	**80**	**80**	**80**	0	0

1/ In an effort to better clarify the types of outpatient health care settings, VA developed and implemented a new Site Classifications and Definitions Handbook 1006.2 (effective December 30, 2013). As a result, the above table provides more granular level of detail (based on the services provided) and is consistent with the new counting methodology.

2/ A VA Medical Center (VAMC) is a facility that provides two or more categories of care (inpatient, outpatient, residential rehabilitation, or institutional extended care). Using the new site classifications and definitions:

- A VA Hospital provides both inpatient acute care and outpatient care; it may also provide residential rehabilitation care and/or institutional extended care.
  - In 2015, the number of VAMCs has increased from 150 to 167, of which 144 are VA Hospitals. The following six facilities that were classified as VA Hospitals in 2014 are now classified as VAMC-Based Outpatient Care Sites, since they no longer provide inpatient acute services: Canandaigua, NY; New Orleans, LA; Kerrville, TX; West Texas Health Care System (HCS), TX; Walla Walla, WA; and, Palo Alto-Menlo Park, CA.
- A Community Living Center (CLC) provides institutional extended care services and may be part of a VA Hospital (e.g., a wing), or a free-standing structure.
- Residential Rehabilitation Care (i.e., a Domiciliary Residential Rehabilitation Treatment Program (DRRTP)) provides rehabilitative care in a residential setting. Like a CLC, it may be part of a VA Hospital or a free-standing structure.
- A VAMC-Based Outpatient Care site is a VA Medical Center that provides outpatient care. By definition, all VA Hospitals provide outpatient care, but some free-standing Community Living Centers and/or DRRTPs also provide outpatient care and are therefore included in this classification.

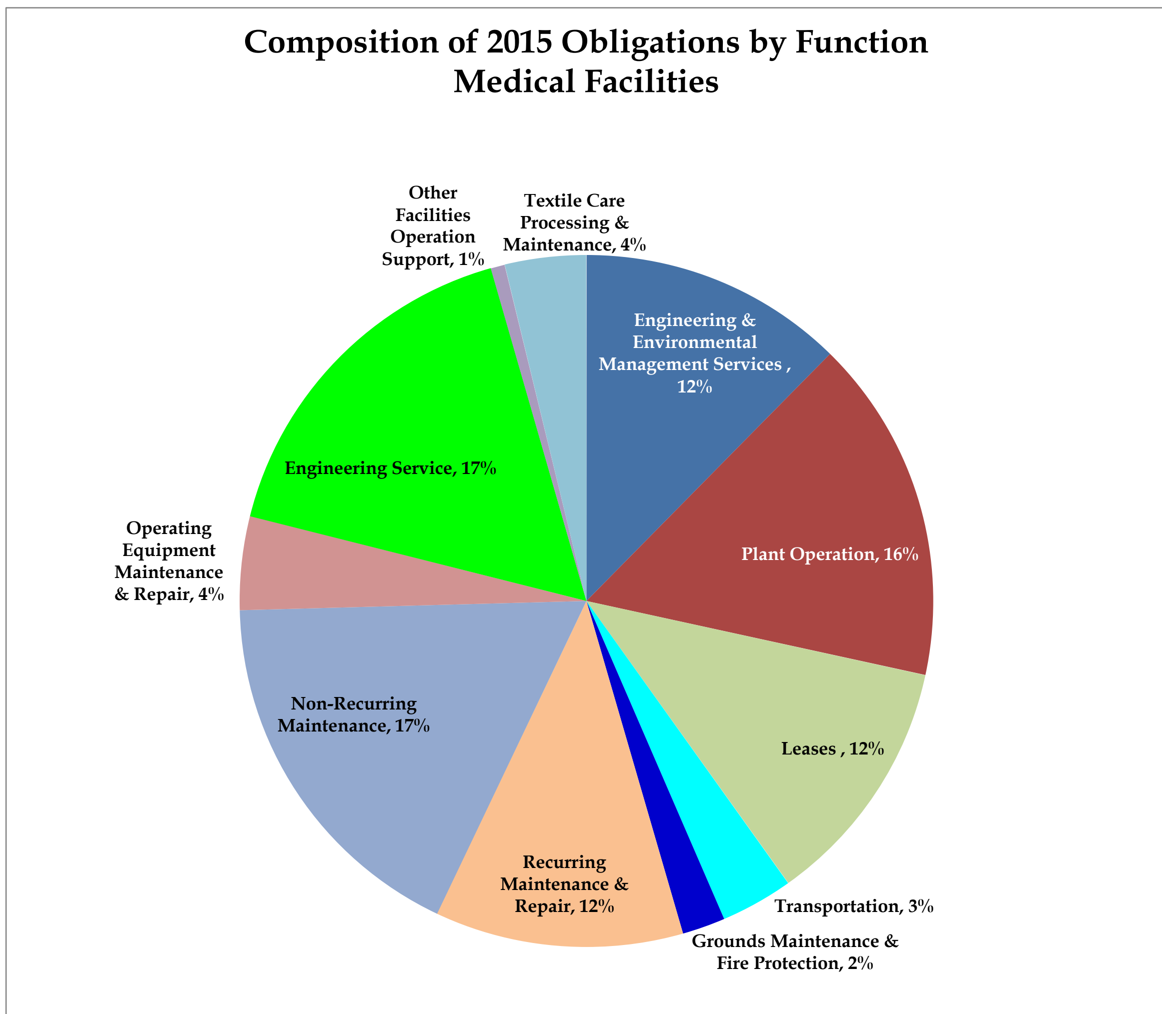
3/ A Health Care Center (HCC) is a VA-owned, VA-leased, or contract clinic operated 5 days per week that provides primary care, mental health care, on-site specialty services, and performs ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia.

4/ A Multi-Specialty Community-Based Outpatient Clinic (formerly known as CBOC) is a VA-owned, VA-leased, mobile or contract clinic that offers both primary and mental health care and two or more specialty services physically on site.

5/ A Primary Care Community-Based Outpatient Clinic (formerly known as Mobile Outpatient Clinic) is a VA-owned, VA-leased, mobile, or contract clinic that offers both primary and mental health care services (on site or via Telehealth).

6/ An Other Outpatient Services site is a site where Veterans receive services that do not meet the criteria to be classified as a CBOC or HCC (e.g., Dialysis Centers, CRRC). VA or VHA personnel provide information and support services. Other services could be more clinical in nature, in which clinical services are provided to remote areas through a Telehealth clinic or other arrangement. Any services provided in the venue external to a VA clinic or facility must be associated with, attached to, and coordinated by a health care delivery site located in a clinic or facility.

7/ Memorandum on VISN Realignment 2016: the existing VISN structure will be modified to reduce the number of VISNs from 21 to 18, starting on October 1, 2015.



Percentages may not add up due to rounding.

Medical Facilities
Excludes Veterans Choice Act, Public Law 113-146
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Engineering & Environmental Management Services 2/........	$582,784	$615,591	$615,816	$619,481	$650,903	$664,281	$35,087	$13,378
Plant Operation..	$757,712	$874,598	$764,000	$901,436	$764,000	$824,400	$0	$60,400
Leases 2/..	$551,902	$493,300	$570,775	$691,900	$838,102	$811,900	$267,327	($26,202)
Transportation..	$158,809	$173,097	$165,000	$178,409	$165,000	$178,000	$0	$13,000
Grounds Maintenance & Fire Protection............................	$94,425	$99,205	$103,000	$102,249	$103,000	$111,100	$0	$8,100
Recurring Maintenance & Repair......................................	$545,811	$728,000	$593,000	$750,339	$593,000	$639,800	$0	$46,800
Non-Recurring Maintenance..	$825,043	$708,000	$417,838	$460,600	$1,057,473	$600,000	$639,635	($457,473)
Operating Equipment Maintenance & Repair......................	$205,557	$231,198	$206,000	$238,293	$206,000	$222,300	$0	$16,300
Engineering Service...	$782,893	$847,802	$1,028,000	$873,818	$1,128,000	$1,128,000	$100,000	$0
Other Facilities Operation Support....................................	$30,879	$66,904	$32,000	$68,957	$32,000	$34,500	$0	$2,500
Textile Care Processing & Maintenance.............................	$178,945	$166,205	$185,000	$171,305	$185,000	$199,600	$0	$14,600
Obligations [Before Prior Year Recoveries].......................	$4,714,760	$5,003,900	$4,680,429	$5,056,787	$5,722,478	$5,413,881	$1,042,049	($308,597)
Prior Year Recoveries...	$10,654	$0	$0	$15,000	$0	$0	$0	$0
Obligations Total [After Prior Year Recoveries].................	$4,725,414	$5,003,900	$4,680,429	$5,071,787	$5,722,478	$5,413,881	$1,042,049	($308,597)

1/ 2015 Actual includes Object Class 10, 21-26 & 31, 32, 41 and 43.
2/ 2017 estimate for leases differs from Budget Appendix due to publication deadlines.

Fiscal Year 2015 Actuals
Medical Facilities
(Excludes Veterans Choice Act)
(dollars in thousands)

Description	Pay & Benefits 1/	Capital 2/	All Other 3/	Total	FTE
Engineering & Environmental Management Services......................	$373,191	$24,510	$185,083	$582,784	3,602
Plant Operation...	$124,767	$9,405	$623,540	$757,712	1,304
Leases...	$433	$53,879	$497,590	$551,902	0
Transportation..	$85,730	$933	$72,146	$158,809	1,249
Grounds Maintenance & Fire Protection...	$59,630	$2,783	$32,012	$94,425	734
Recurring Maintenance & Repair..	$280,534	$63,426	$201,851	$545,811	3,271
Non-Recurring Maintenance..	$7,658	$803,050	$14,335	$825,043	104
Operating Equipment Maintenance & Repair....................................	$68,998	$12,219	$124,340	$205,557	837
Engineering Service...	$584,516	$4,815	$193,562	$782,893	11,262
Other Facilities Operation Support..	$0	$3,901	$26,978	$30,879	0
Textile Care Processing & Maintenance..	$75,451	$30,800	$72,694	$178,945	1,281
Obligations [Before Prior Year Recoveries].......................................	$1,660,908	$1,009,721	$2,044,131	$4,714,760	23,644
Prior Year Recoveries..	$0	$0	$0	$10,654	0
Obligations Total [After Prior Year Recoveries]...............................	$1,660,908	$1,009,721	$2,044,131	$4,725,414	23,644

1/ Pay Benefits = Object Class (OC) 10, Personnel Compensation & Benefits
2/ Capital = OC 31, Equipment; and OC 32, Lands and Structures
3/ All Other = OC 21, Travel & Transportation of Persons; OC 22, Transporations of Things; OC 23, Rent, Communications, & Utilities; OC 24, Printing & Reproduction; OC 25, Other Contractual Services; and 26 Supplies & Materials.

Engineering and Environmental Management Services

Description	2016		2017		2018		
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Request	Advance Approp.	Increase / Decrease 2016-2017	2017-2018

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)...	$582,784	$615,591	$615,816	$619,481	$650,903	$664,281	$35,087	$13,378

Engineering and Environmental Management Services provide the design, oversight, and management of all engineering activities that take place in VHA facilities. Examples include: planning and implementation of disability accessibility projects, sidewalk and road repairs, and installation of equipment.

Plant Operations

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)...	$757,712	$874,598	$764,000	$901,436	$764,000	$824,400	$0	$60,400

Plant Operations support all the basic functions of the hospitals and medical clinics. Examples of these activities include the purchase of utilities, such as water, electricity, steam, gas, and sewage; general operations supervision; and operation of emergency electrical power systems, elevators, renewable energy, and all plant operations.

Leases

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)...	$551,902	$493,300	$570,775	$691,900	$838,102	$811,900	$267,327	($26,202)

VHA has approximately 1,604 leases, encompassing over 15 million square feet of space in its portfolio. Leases fall into the following two primary categories: space procured by the General Services Administration (GSA) on behalf of VA and space procured directly by VA (via delegated authority from GSA) in commercial venues. Leases can have many functions, ranging from clinical space for CBOCs to warehouses for storage of supplies and equipment, all in support of the operational needs of the local medical center. Leases complement the portfolio of VA-owned medical facilities and provide additional flexibility in providing services to Veterans in the right place and at the right time.

VA's 2017 budget includes an authorization request for six replacement outpatient clinic leases only. VA is not requesting authorization for any new lease presences in 2017 as the Department suspended the establishment of new points of care until the Commission on Care recommendations are received and incorporated into VA's infrastructure strategy. All previous leasing commitments will be honored, including VACAA. VA is also awaiting Congressional authorization of 18 leases submitted in VA's 2015 and 2016 Budget requests.

VHA typically does not utilize GSA to procure medical facility space on behalf of VA. Instead, VHA utilizes a delegation of authority from GSA to procure the space directly. This delegation is granted on a lease-by-lease basis by GSA, following GSA's review of the lease data. However, all of the procurement and contracting activities are managed by VHA. These leases are critical to meeting Veteran needs by allowing VA to operate

clinics or other necessary services close to Veteran populations, while maintaining flexibility so these points of service can be relocated or resized on a regular basis due to shifting demographic trends. Although owned facilities provide some benefit over leasing in some situations, the flexibility and adaptability provided by leasing is key to VHA's mission.

Transportation Services

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$158,809	$173,097	$165,000	$178,409	$165,000	$178,000	$0	$13,000

Transportation Services include the costs to operate facilities' motor vehicles, including the purchase and operations of VA vans and buses, facility maintenance vehicles, and the clinical motor vehicle pool operations.

Grounds Maintenance and Fire Protection

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$94,425	$99,205	$103,000	$102,249	$103,000	$111,100	$0	$8,100

Grounds Maintenance and Fire Protection costs are associated with the maintenance of roads, walks, parking areas, and lawn management, as well as fire truck operation, supplies, and materials.

Recurring Maintenance and Repair

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$545,811	$728,000	$593,000	$750,339	$593,000	$639,800	$0	$46,800

Recurring Maintenance and Repair services encompass all projects where the minor improvement is below $25,000, such as maintenance service contracts and routine repair of facilities and the upkeep of land. Examples include: painting interior and exterior walls; the repair of water leaks in pipes and roofs; and the replacement of light bulbs, carpet, and ceiling and floor tiles.

Non-Recurring Maintenance (NRM)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$825,043	$708,000	$417,838	$460,600	$1,057,473	$600,000	$639,635	($457,473)

VHA uses its NRM projects to make additions, alterations, and modifications to land, buildings, other structures, nonstructural improvements of land, and fixed equipment (when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure). NRM projects are renovations within the existing square footage of a facility, or renovations requiring the expansion of new space (up to 1,000

square feet of new space). NRM projects include renovations up to $10 million, although there is no upper limit for infrastructure projects, which improve the basic, underlying framework and fundamental systems serving VA facilities (e.g., boiler replacement, utilities modernization).

VHA uses its NRM program as its primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments (FCA). These assessments are performed at each facility every three years, and highlight a building's most pressing and mission critical repair and maintenance needs. VHA specifically supports research and development infrastructure projects by ensuring that the Office of Research and Development is involved in the identification of gaps to support the Strategic Capital Investment Planning (SCIP) process. This inclusion ensures a research focus for mitigation within a 10-year window of identified research infrastructure deficiencies.

NRM projects are broken into three categories, as defined below.

Sustainment Projects

Sustainment is the provision of resources for improvements to existing buildings to ensure they are state-of-the-art and in good condition to continue to house the services provided to Veterans. These projects are primarily within the building's envelope and range from $25,000 to $10 million, including costs associated with the expansion of space (not to exceed 1,000 square feet). Budget formulation is supported by the sustainment projects submitted and prioritized through the Strategic Capital Investment Planning (SCIP) process.

Infrastructure Improvements

These projects improve the infrastructure of existing buildings and land beyond sustainment. They include reducing the FCA deficiency backlog, upgrading and replacing infrastructure systems, demolishing buildings, land improvements, and surface parking. These projects start at $25,000, and have no upper limit due to their pure infrastructure nature. Budget formulation for these projects is also supported and prioritized through the SCIP process.

The FCA deficiency backlog for infrastructure include all infrastructure systems and components that received grades of D or F by independent consultants. Demolition of buildings is an initiative used to remove vacant and underutilized buildings from our inventory, allowing us to reinvest operational savings for services to our Veterans.

Clinical Specific Initiatives

Clinical Specific Initiative (CSI) projects are emergent projects that cannot be planned due to dynamic health care environments. Associated funding for these projects is distributed to the VISNs at the beginning of each year to obligate towards VHA's high-four profile categories: women's health/Patient Aligned Care Team (PACT), mental health, high-cost/high-tech equipment, and donated buildings.

Examples of uses for this funding include: immediate acquisition of modular buildings upon notification that VA Central Office mandates the hiring of staff; flexibility needed for room retrofit to install high-tech/high-cost equipment, which has about a six-month lead time from when the high-tech/high-cost equipment is ordered; and providing medical centers the ability to respond rapidly to create quick access points for special interests, such as women's health. This funding provides flexibility to meet the unplanned capital demands of these high-priority VHA programs. Budget formulation is based on current year needs.

Operating Equipment Maintenance and Repair

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$205,557	$231,198	$206,000	$238,293	$206,000	$222,300	$0	$16,300

Operating Equipment Maintenance and Repair costs are associated with maintenance and repair of all non-expendable operating equipment, furniture and fixtures, when performed by maintenance personnel or procured on a contractual basis, including rental equipment.

Engineering Service

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$782,893	$847,802	$1,028,000	$873,818	$1,128,000	$1,128,000	$100,000	$0

The Environmental Management Service is associated with the oversight and management of environmental management activities, including the recycling operation; pest management; grounds management; environmental sanitation operations; bed services and patient assistance; and the collection, removal, and transportation of all waste materials.

Other Facilities Operation Support

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$30,879	$66,904	$32,000	$68,957	$32,000	$34,500	$0	$2,500

This function includes other costs associated with inpatient and outpatient providers and miscellaneous benefits and services.

Textile Care Processing and Management

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$178,945	$166,205	$185,000	$171,305	$185,000	$199,600	$0	$14,600

Textile Care Processing and Management includes the receipt, washing, drying, dry cleaning, folding, and return of textiles such as bed linens, surgical towels, and nursing uniforms. Processing also involves the activities concerning maintenance and repair of textile processing equipment. Textile management activities include the procurement, inventory, delivery, issuance, repair, and marking all of the various types of textiles contained within the facility.

Medical Facilities Program Resource Data

Medical Facilities (Excluding VACAA, Section 802)
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Advance Appropriation	$4,739,000	$4,915,000	$4,915,000	$5,074,000	$5,074,000	$5,434,880	$159,000	$360,880
Annual Appropriation Adjustment	$0	$105,132	$105,132	$0	$649,000	$0	$543,868	($649,000)
Omnibus Bill (P.L. 114-113)	$0	$0	$0	$0	$0	$0	$0	$0
Appropriation Request Subtotal	$4,739,000	$5,020,132	$5,020,132	$5,074,000	$5,723,000	$5,434,880	$702,868	($288,120)
Rescission	($2,000)	$0	$0	$0	$0	$0	$0	$0
Net Appropriation	$4,737,000	$5,020,132	$5,020,132	$5,074,000	$5,723,000	$5,434,880	$702,868	($288,120)
Transfers:								
To North Chicago Demo. Fund	($35,490)	($36,455)	($36,635)	($37,436)	($37,620)	($38,464)	($985)	($844)
To DoD-VA Hlth Care Svcs Incentive Fund	$0	$0	$0	$0	$0	$0	$0	$0
To Major Construction	($80,735)	$0	($312,539)	$0	$0	$0	$312,539	$0
To Medical Services	$0	$0	$0	$0	$0	$0	$0	$0
To Medical Community Care	$0	$0	$0	$0	$0	$0	$0	$0
Fr Medical Support & Compl	$0	$0	$0	$0	$0	$0	$0	$0
Transfers Subtotal	($116,225)	($36,455)	($349,174)	($37,436)	($37,620)	($38,464)	$311,554	($844)
Budget Authority Total	$4,620,775	$4,983,677	$4,670,958	$5,036,564	$5,685,380	$5,396,416	$1,014,422	($288,964)
Reimbursements	$13,512	$20,223	$16,855	$20,223	$17,098	$17,465	$243	$367
Adjustments to Obligations								
Unobligated Balance (SOY)								
No-Year	$321	$0	$617	$0	$800	$0	$183	($800)
Financial Statement Audit Adjustment /1	$0	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	$0	$0	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$6,012	$0	$7,370	$0	$7,600	$0	$230	($7,600)
2-Year	$86,881	$0	$4,629	$0	$11,600	$0	$6,971	($11,600)
Unobligated Balance (SOY) Subtotal	$93,214	$0	$12,616	$0	$20,000	$0	$7,384	($20,000)
Unobligated Balance (EOY)								
No-Year	($617)	$0	($800)	$0	$0	$0	$800	$0
Financial Statement Audit Adjustment /1	$0	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)	$0	$0	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	($7,370)	$0	($7,600)	$0	$0	$0	$7,600	$0
2-Year	($4,629)	$0	($11,600)	$0	$0	$0	$11,600	$0
Unobligated Balance (EOY) Subtotal	($12,616)	$0	($20,000)	$0	$0	$0	$20,000	$0
Change in Unobligated Balances (Non-Add)	$80,598	$0	($7,384)	$0	$20,000	$0	$27,384	($20,000)
Lapse	($125)	$0	$0	$15,000	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$4,714,760	$5,003,900	$4,680,429	$5,071,787	$5,722,478	$5,413,881	$1,042,049	($308,597)
Prior Year Recoveries	$10,654	$0	$0		$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$4,725,414	$5,003,900	$4,680,429	$5,071,787	$5,722,478	$5,413,881	$1,042,049	($308,597)

Veterans Access, Choice, & Accountability Act 0f 2014, Section 801

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Revised Estimate	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Unobligated Balance (SOY)	$0	$755,000	$1,226,139	$0	$348,229	$0	($877,910)	($348,229)
Transfer of Unobligated Balance	$1,771,600	$0	$0	$0	($332,717)	$0	($332,717)	$332,717
Trns of Unobl. Balance, Information Technology (IT)	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	($1,226,139)	$0	($348,229)	$0	$0	$0	$348,229	$0
VACAA Section 801 Obligations Total	$545,461	$755,000	$877,910	$0	$15,512	$0	($862,398)	($15,512)
Medical Care Obligation Total (Incl. VACAA Section 801)	**$5,270,875**	**$5,758,900**	**$5,558,339**	**$5,071,787**	**$5,737,990**	**$5,413,881**	**$179,651**	**($324,109)**

1/ The $312.5 million transfer to Major Construction for Aurora, CO is reflected as an appropriation transfer instead of an unobligated balance transfer, as shown in the 2017 President's Budget appendix, due to publication deadlines.

FTE by Type
Medical Facilities

Account	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Physicians	0	0	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0	0
Registered Nurses	1	0	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	5	0	0	0	0	0	0	0
Non-Physician Providers	1	0	0	0	0	0	0	0
Health Technicians/Allied Health	117	120	120	121	120	120	0	0
Wage Board/Purchase & Hire	19,578	19,935	19,935	20,118	19,935	19,935	0	0
All Other 1/	3,942	4,154	4,154	4,192	4,154	4,154	0	0
SubTotal	23,644	24,209	24,209	24,431	24,209	24,209	0	0
Veterans Choice Act, Sec. 801, FTE	0	0	12	0	0	0	(12)	0
Total	23,644	24,209	24,221	24,431	24,209	24,209	(12)	0

1/All Other category includes maintenance controllers, engineers/architects, administrative support clerks, safety and occupational health specialists, fire protection and prevention staff, engineering technicians, hospitals housekeepers and managers, industrial hygienists, administrative specialists, and other staff that are necessary for the effective operations of VHA medical facilities.

Veterans Choice Act, Public Law 113-146, Section 801

On August 7, 2014, President Obama signed into law the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146; Veterans Choice Act). The 2017 President's Budget supports the implementation of the Veterans Choice Act and the Administration's goal of providing timely, high-quality health care for our Nation's Veterans. The Veterans Choice Act provided $5 billion in mandatory funding in Section 801 to increase Veterans' access to health care by hiring more physicians and staff, and improving VA's physical infrastructure.

Within the Medical Facilities Appropriation, estimates of obligations for 2016 and 2017 are $877,910,000 and $15,512,000 respectively. The obligations are consistent with the needs of the Veterans Choice Act and will be spent on staffing, leases, non-recurring maintenance and support legionella efforts, enhancing services to Veterans in the short-term while strengthening the underlying VA system to better serve veterans in the future.

Veterans Choice Act, Public Law 113-146
Section 801
Medical Facilities
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Estimate	2018 Advance Approp. 2/	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Activations	$0	$0	$2,753	$0	$0	$0	($2,753)	$0
Leases, Emergency:								
Leases, Emergency	$19,165	$9,500	$21,501	$0	$0	$0	($21,501)	$0
Leases, Pipeline:								
Leases in the Pipeline	$38,442	$139,600	$100,000	$0	$0	$0	($100,000)	$0
Leases, Sustainment	$0		$162,208	$0	$0	$0	($162,208)	$0
Section 301/302:								
HPEAP Modification	$0	$0	$0	$0	$0	$0	$0	$0
Staffing Shortage & Report (Sect. 301)	$0	$0	$15,512	$0	$15,512	$0	$0	($15,512)
Supervising Faculty Salary	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$15,512	$0	$15,512	$0	$0	($15,512)
Staffing:								
Hiring Medical Staff	$0	$0	$0	$0	$0	$0	$0	$0
Supplies/Equipment:								
Supplies/Equipment	$0	$0	$0	$0	$0	$0	$0	$0
NRM/Legionella:								
Non-Recurring Maintenance	$473,021	$532,600	$444,154	$0	$0	$0	($444,154)	$0
Legionella	$14,833	$73,300	$131,782	$0	$0	$0	($131,782)	$0
Subtotal	$487,854	$605,900	$575,936	$0	$0	$0	($575,936)	$0
Obligations Total	**$545,461**	**$755,000**	**$877,910**	**$0**	**$15,512**	**$0**	**($862,398)**	**($15,512)**

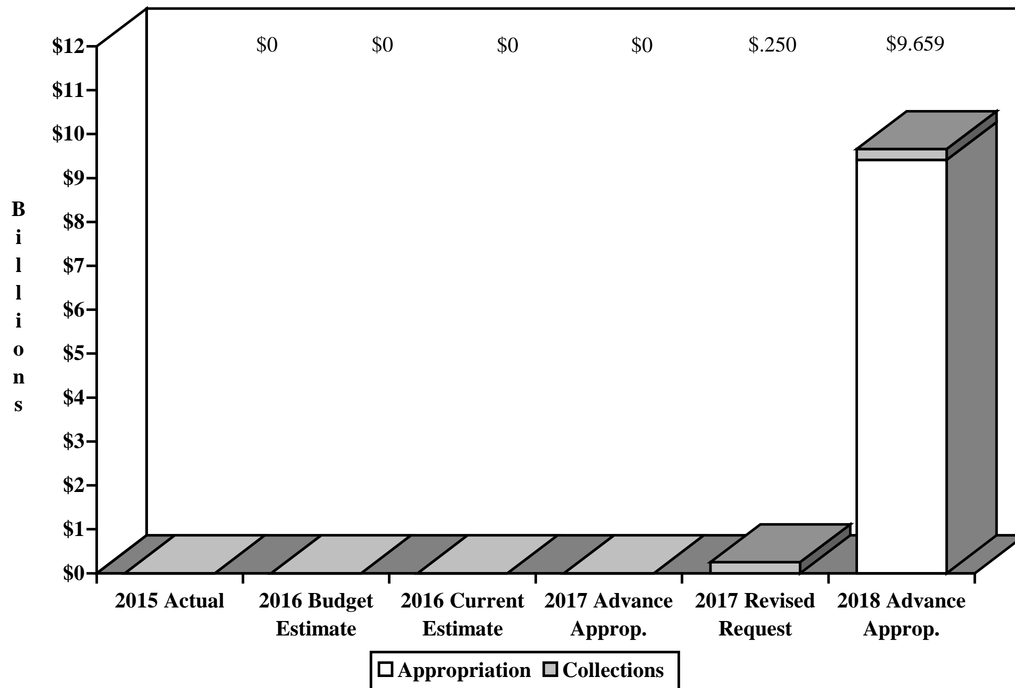
1/ 2017 Advance Appropriation assumed that all Section 801 funds would be obligated by end of Fiscal Year 2016.
1/ 2018 Advance Appropriation assumes that all Section 801 funds would be obligated by end of Fiscal Year 2017.

Veterans Choice Act, Public Law 113-146
Section 801
Medical Facilities
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp. 1/	2017 Revised Estimate	2018 Advance Approp. 2/	Increase/ Decrease 2016-2017	Increase/ Decrease 2017-2018
Unobligated Balance (SOY)..	$0	$1,572,900	$1,226,139	$0	$348,229	$0	($877,910)	($348,229)
Trns of Unobligated Balance...	$1,771,600	$0	$0	$0	($332,717)	$0	($332,717)	$332,717
Trns of Unobl. Balance, Information Technology (IT).....	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)..	($1,226,139)	$0	($348,229)	$0	$0	$0	$348,229	$0
Obligations Total..	**$545,461**	**$1,572,900**	**$877,910**	**$0**	**$15,512**	**$0**	**($862,398)**	**($15,512)**

1/ 2016 President's Submission assumed all Section 801 funds would be obligated by 2016.
1/ 2017 President's Submission assumes all Section 801 funds will be obligated by 2017.

Medical Community Care



Medical Community Care
Net Appropriations & Collections

(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Request	2018 Advance Approp.	2016 to 2017 Increase/ Decrease	2017 to 2018 Increase/ Decrease
Advance Appropriation	$0	$0	$0	$0	$0	$9,409,118	$0	$9,409,118
Collections	$0	$0	$0	$0	$250,000	$250,000	$250,000	$0
Total	$0	$0	$0	$0	$250,000	$9,659,118	$250,000	$9,409,118

Appropriation Language

For necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, $7,246,181,000, plus reimbursements, to be derived from amounts appropriated in title II of division J of Public Law 114–113 under the headings "Medical Services", "Medical Support and Compliance", or "Medical Facilities" which became available on October 1, 2016; and, in addition, $9,409,118,000 shall become available on October 1, 2017, and shall remain available until September 30, 2018: Provided, That, of the amount made available on October 1, 2017, $1,500,000,000 shall remain available until September 30, 2019.

Description:
The Budget creates a new Medical Community Care appropriations account, as required by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (P.L. 114-41). The Budget provides VA with the flexibility to transfer amounts among the new Medical Community Care account and the other three medical care accounts as needed. The Budget also enables VA to transfer collections from the Medical Care Collections Fund into the Medical Community Care account.

Appropriation Transfers
The Medical Services Appropriation will transfer $7,246,181,000 on October 1st, 2016 into the Medical Community Care Appropriation.

Medical Community Care Purpose
The Medical Community Care fund consolidates all community care programs under a single appropriation for both Veterans and beneficiaries. This appropriation authorizes the Secretary to furnish Hospital Care and Medical Services to eligible Veterans through contracts or agreements with certain eligible entities, as well as pay for care for eligible beneficiaries.

VA believes that utilizing one fund will align with VA's vision for the future of health care delivery, which aims to provide Veterans and beneficiaries the best care anywhere both inside and outside VA. The Medical Community Care program for Veterans will provide a simplified program that is easy to understand and administer, and that meets the needs of Veterans, employees, and community providers. It will improve the Veteran experience with community care, and continue to recognize community care as a pillar for delivering health care to Veterans. This includes delivering personalized, proactive, and patient-driven health care; using metrics and data analytics to drive improvement; using innovative technologies and care models to optimize health outcomes; and maintaining a high-performing network to deliver community care.

After a Veteran is enrolled in VA health care, the criteria for VA's various methods for purchasing community care are then applied to determine when a Veteran may receive his or her health benefits outside of a VA facility. VA is responsible for payment for the care and services furnished under this program. When care is provided for a non-service connected condition, VA will use existing authority to bill and collect from third-party insurance when a Veteran has other health insurance.

This fund will also include the resources for select health care programs that VA provides for certain beneficiaries (CHAMPVA, Camp Lejeune, etc.). The programs generally serve as another form of health care available to beneficiaries of Veterans who have specific eligibility. VA acts as the payer for these various programs when the beneficiary receives community care.

2017 Funding and 2018 Advance Appropriations Request
The following tables provide an itemized breakout of the obligations by program of the Medical Community Care appropriation. Descriptions of each program can be found in the Medical Care Chapter.

Legislative Proposals

As part of its legislative package in conjunction with the Budget, VA will transmit a legislative proposal to amend authorities at 38 U.S.C. 117 and 31 U.S.C. 1105 to provide authority for the Department to receive advance appropriations for the Medical Community Care account.

In addition, VA will request several of the legislative proposals included in the "Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care" report transmitted to Congress on November 1, 2015, as required by Title IV of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (P.L. 114-41). These proposals are intended to make immediate improvements to community care, with a focus on necessary business process enhancements to the referral and authorization process, customer service, and claims processing and payment. These changes are expected to improve the Veteran experience with community care.

VA is continuing to examine how the Veterans Choice Program interacts with other VA health programs, including the delivery of direct care. In addition, VA is evaluating how it will adapt to a rapidly changing health care environment and how it will interact with other health providers and insurers. As VA continues to refine its health care delivery model, we look forward to providing more detail on how to convert the principles outlined in the New Veterans Choice Plan into an executable, fiscally-sustainable future state. In addition, we plan to receive and potentially incorporate recommendations from the Commission on Care and other stakeholders.

Medical Community Care Obligations by Program
(Dollars in Millions)

Description	2017 Revised Request	2018 Advance Approp.	2017 to 2018 Increase/ Decrease
Health Care Services:			
Ambulatory	$1,115,015	$2,097,494	$982,479
Inpatient Care	$782,836	$1,472,619	$689,783
Mental Health	$57,431	$108,035	$50,604
Dental Care	$59,336	$111,618	$52,282
Health Care Services [Total]	$2,014,618	$3,789,766	$1,775,148
Long Term Care:			
Community Nursing Home	$1,012,378	$1,064,090	$51,712
Community Non-Institutional Care	$1,435,725	$1,507,295	$71,570
State Nursing Home	$1,268,888	$1,388,354	$119,466
State Home Domiciliary	$66,361	$70,583	$4,222
State Adult Day Care	$1,029	$1,195	$166
Subtotal	$3,784,381	$4,031,517	$247,136
Other VA Programs Care:			
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,619,874	$1,763,652	$143,778
Caregivers	$28,059	$24,981	($3,078)
Indian Health Servcies	$28,062	$29,358	$1,296
Camp Lejeune - Veteran Purchased Care	$11,347	$11,794	$447
Camp Lejeune Family	$9,840	$8,050	($1,790)
Subtotal	$1,697,182	$1,837,835	$140,653
Total Obligations	$7,496,181	$9,659,118	$2,162,937

Medical Community Care Program Resource Data

Medical Community Care Appropriation Workload 1/			
Description	2017 Revised Request	2018 Advance Approp.	2017 to 2018 Increase/ Decrease
Outpatient Visits (Non-Mental Health - Non Non-Institutional Care)...	3,708,864	5,014,754	1,305,890
Mental Health Outpatient Visits..	361,359	399,948	38,589
Contract Hospital Patients Treated (Non-Mental Health).....................	135,467	166,759	31,292
Contract Hospital Patients Treated (Psychiatry)..................................	21,027	26,572	5,545
Community Nursing Home Patients Treated.......................................	31,093	37,387	6,294
State Nursing Home Patients Treated...	31,619	32,084	465
State Home Domiciliary Patients Treated..	4,905	4,854	(51)
State Adult Day Health Care Average Daily Census............................	47	53	6
Dental Procedures...	379,050	543,967	164,917
Non-Institutional Care (Visits Procedures) 2/.....................................	10,343,294	13,754,767	3,411,473

1/ Excludes Medical Services and Veterans Choice Act appropriations workload
2/ Also counts in Outpatient Visits (Non-Mental Health)

Medical Community Care (Excluding VACAA, Section 802)
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase/Decrease 2016-2017	Increase/Decrease 2017-2018
Advance Appropriation	$0	$0	$0	$0	$0	$9,409,118	$0	$9,409,118
Annual Appropriation Adjustment	$0	$0	$0	$0	$0	$0	$0	$0
Omnibus Bill (P.L. 114-113)	$0	$0	$0	$0	$0	$0	$0	$0
Appropriation Request Subtotal	$0	$0	$0	$0	$0	$9,409,118	$0	$9,409,118
Rescission	$0	$0	$0	$0	$0	$0	$0	$0
Net Appropriation	$0	$0	$0	$0	$0	$9,409,118	$0	$9,409,118
Transfers:								
From Medical Services	$0	$0	$0	$0	$7,246,181	$0	$7,246,181	($7,246,181)
Transfers Subtotal	$0	$0	$0	$0	$7,246,181	$0	$7,246,181	($7,246,181)
Collections	$0	$0	$0	$0	$250,000	$250,000	$250,000	$0
Budget Authority Total	$0	$0	$0	$0	$7,496,181	$9,659,118	$7,496,181	$2,162,937
Reimbursements	$0	$0	$0	$0	$0	$0	$0	$0
Adjustments to Obligations								
Unobligated Balance (SOY)								
No-Year	$0	$0	$0	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)								
No-Year	$0	$0	$0	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (P.L. 111-32)_	$0	$0	$0	$0	$0	$0	$0	$0
2007 Emergency Supplemental No-Year (P.L. 110-28)	$0	$0	$0	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
Change in Unobligated Balances (Non-Add)	$0	$0	$0	$0	$0	$0	$0	$0
Lapse	$0	$0	$0	$0	$0	$0	$0	$0
Obligations Subtotal (Excluding Prior Year Recoveries)	$0	$0	$0	$0	$7,496,181	$9,659,118	$7,496,181	$2,162,937
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0	$0
Obligations Total (Including Prior Year Recoveries)	$0	$0	$0	$0	$7,496,181	$9,659,118	$7,496,181	$2,162,937

Veterans Access, Choice, and Accountability Act of 2014

The Veterans Choice Act

On August 7, 2014, the President signed into law the Veterans Access, Choice, and Accountability Act of 2014 (“Choice Act”; P.L. 113-146). The Choice Act provides vital resources to increase Veterans’ access to medical care while building infrastructure to ensure VA has the staff, facilities, and necessary support for a strong VA health care system. The Choice Act provides $5 billion in mandatory funding for VA to hire physicians and other medical personnel and improve VA’s physical infrastructure. The Choice Act also provides $10 billion in mandatory funding to establish a temporary program ("Veterans Choice Program") that is aimed at improving Veterans’ access to health care by allowing eligible Veterans who meet certain wait-time or distance standards to use health care providers outside of the VA system. The Veterans Choice Program provides eligible Veterans with quick access to non-VA care and offers a measure of short-term relief from the pressure of escalating health care requirements as some Veterans who would otherwise receive care in the VA health care system but who instead choose to participate in the new program.

Department of Veterans Affairs
Veterans Choice Act Program Activity [1]
(Obligations - $ in 000s)

	2015 Actual	2016 Estimate	2017 Estimate	Total
Section 801				
Medical Services	609,715	1,415,001	821,597	2,846,313
Medical Support and Compliance	412	19,778	16,262	36,452
Medical Facilities	545,461	877,910	15,512	1,438,883
Subtotal	1,155,588	2,312,689	853,371	4,321,648
Information Technology	53,566	308,934	0	362,500
Minor Construction	97,522	102,500	115,830	315,852
Section 801 Total	**1,306,676**	**2,724,123**	**969,201**	**5,000,000**
Section 802				
Veterans Choice Act -Administration	322,057	100,000	158,441	580,498
Veterans Choice Act - Program	412,872	1,531,264	4,661,378	6,605,514

Information Technology Support	17,757	49,743	0	67,500
Emergency Hepatitis C	407,661	0	0	407,661
Emergency Care in the Community	2,338,827	0	0	2,338,827
Section 802 Total	**3,499,174**	**1,681,007**	**4,819,819**	**10,000,000**

Note 1*: After the end of fiscal year 2015, external auditors advised VA to adjust its obligations downward by $1.7 billion for obligations which were either not closed or completely documented. Accordingly, VA made the adjustment, not reflected above, but will reexamine it in 2016 to verify the accuracy of the audit estimates and recommendation.*

In 2017, VA will use the Choice Act funds in concert with annual appropriations to meet VA staffing and infrastructure needs and expand non-VA care to Veterans who are eligible for the Veterans Choice Program based on either: (1) distance to a VA facility; or (2) their wait time to see a VA medical professional. Specifically, VHA plans to spend $1.4 billion in 2016, and $853.4 million in 2017, to support the more than 9,700 new medical care staff hired through the Choice Act. These staff include primary care, specialty care, and mental health care providers. In 2016, in addition to the administrative expenses in the table above, VA intends to invest an another $421 million to support care coordination, streamlined referrals and authorizations, claims management, training, and communication through information technology by developing a portal for community providers, to improve Veterans' transition between VA and community providers.

In addition to staffing, a key part of the Veterans Choice Act funding is allocated to improving VA facilities. Of these funds:

- $283.7 million will be for medical facility leases in 2016;
- Nearly $444.2 million will provide physical improvements for VA facilities; through Non-Recurring Maintenance funds in 2016;
- $102.5 million will support Minor Construction projects in 2016 and $115.8 million in 2017, which will enhance Veterans access and improve patient privacy; and
- $131.8 million will fund Legionella prevention and control improvements in 2016.

VA will also use $362.5 million of Veterans Choice Act funds for IT improvements, including $225.2 million for IT infrastructure and $136.9 million for IT development, including the Medical Appointment Scheduling System. VA will also hire an additional 192 IT staff in 2016 to support increased access.

These investments, together with the 2017 Budget, will provide authorities, funding, and other tools to enhance service to Veterans in the short-term, while strengthening the underlying VA system to better serve Veterans in the future

The Choice Act, Section 101, established the Choice Program, a temporary program to furnish hospital care and medical services to eligible Veterans through non-VA health care providers. Amendments to the Choice Act were made on September 26, 2014 by the Department of Veterans Affairs Expiring Authorities Act of 2014 (P. L. 113-175); on December 16, 2014, by the Consolidated and Further Continuing Appropriations Act of 2015 (P. L. 113-235); on May 22, 2015, by the Construction Authorization and Choice Improvement Act (P. L. 114-19); and on July 31, 2015, by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (P. L. 114-41). VA has published regulations implementing the Choice Program.

Veterans Choice Program Regulations

As required by the Choice Act, on November 5, 2014, VA published an interim final rulemaking, RIN 2900-AP24, that amended sections 17.108, 17.110, and 17.111 of title 38 of the Code of Federal Regulations (CFR), and established new regulations at 38 CFR 17.1500 through 17.1540 to implement the Choice Program. VA published another interim final rulemaking on April 24, 2015, modifying the methodology for calculating distances under the Choice Act from geodesic, or straight-line, distance to driving distance. On October 29, 2015, VA published a Final Rule, adopting minor changes to the regulations to reflect statutory amendments authorizing VA to pay higher than Medicare rates in Alaska and Maryland. On December 1, 2015, VA published a third interim final rulemaking, RIN 2900-AP60, to make additional revisions required by amendments to the Choice Act made by the Construction Authorization and Choice Improvement Act of 2014 and the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.

VA signed contracts with two private health care companies to assist with the administration of the Choice Program.The two contractors' main tasks are to schedule appointments for eligible Veterans and operate a call center to answer Veterans' questions about the Choice Program. VA continues to work with the contractors to make improvements to the delivery of benefits through the Choice Program. As required by the Choice Act, VA issued a Veterans "Choice Card" to every Veteran who is potentially eligible for the program. This includes Veterans who became eligible for the Choice Program as a result of the above-described amendments to the Choice Act and implementing regulations.

For example, as noted above, in April 2015 VA changed the way it measures distance for purposes of determining eligibility for the Choice Program. This change resulted in an expansion of eligibility. Accordingly, VA sent follow-up letters notifying Veterans who are now eligible under the revised mileage calculation. VA also contacted Veterans who became eligible as a result of the more recent amendments to the law, which, among other things, removed the requirement that a Veteran had enrolled in VA health care on or before August 1, 2014.

In accordance with section 101(k) of the Choice Act, Choice Program claims processing and payment was centralized to ensure efficiency of processing and accuracy of a proper

payment. Claims are processed by Chief Business Office Purchased Care (CBOPC), Support Claims Processing Unit (SCPU) and the Financial Service Center (FSC), utilizing the Veterans Integrated Service Network (VISN) 15, St. Louis VA medical center (VAMC) claims processing systems (local VistA and the Fee Basis Claims System (FBCS)). VA continues to work with contractors to improve the efficiency and accuracy of claims payment.

Another authority provided under P.L. 114-41 increased from 60 days to one year the period of time that could be considered to be part of a single episode of care (EOC). This change dramatically reduces the administrative burden on Veterans and community providers by reducing the frequency with which they must reapply for authorization for continuing care.

On October 1, 2015 a memo titled “VA Care in the Community and use of the Veterans Choice Program” provided a hierarchy of care. This change clarified procedures for care in the community and immediately led to increased utilization of the Choice Program relative to other VA Care in the Community programs.

Veterans Access, Choice, & Accountability Act of 2014
Section 802
(dollars in thousands)

2015 Actual

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emerg. Comm. Care 0172XE	Information Technology Dev. 0172XD	Information Technology Sustain. 0172XO	Information Technology Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)...	$9,932,000	$523,520	$6,059,980	$500,000	$2,848,500	$45,937	$21,809	$254	$10,000,000
Unobligated Balance (EOY)...	($6,450,583)	($201,463)	($5,647,108)	($92,339)	($509,673)	($43,974)	($6,036)	($233)	($6,500,826)
Obligations Subtotal Prior to Audit Adjustment..........................	$3,481,417	$322,057	$412,872	$407,661	$2,338,827	$1,963	$15,773	$21	$3,499,174
Financial Statement Audit Adjustment (Unobl. Bal. (EOY)).......	($1,700,000)	($100,000)	$0	$0	($1,600,000)	$0	$0	$0	($1,700,000)
Obligations Total After Adjustment...	$1,781,417	$222,057	$412,872	$407,661	$738,827	$1,963	$15,773	$21	$1,799,174

2016 Budget Estimate

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emerg. Comm. Care 0172XE	Information Technology Dev. 0172XD	Information Technology Sustain. 0172XO	Information Technology Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)...	$7,008,173	$367,419	$6,640,754	$0	$0	$0	$0	$0	$7,008,173
Unobligated Balance (EOY)...	($3,567,467)	($183,621)	($3,383,846)	$0	$0	$0	$0	$0	($3,567,467)
Obligations Total	$3,440,706	$183,798	$3,256,908	$0	$0	$0	$0	$0	$3,440,706

2016 Current Estimate

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emerg. Comm. Care 0172XE	Information Technology Dev. 0172XD	Information Technology Sustain. 0172XO	Information Technology Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)...	$8,150,583	$301,463	$5,647,108	$92,339	$2,109,673	$43,974	$6,036	$233	$8,200,826
Unobligated Balance (EOY)...	($4,819,319)	($101,463)	($4,115,844)	($92,339)	($509,673)	$0	($500)	$0	($4,819,819)
Obligations Total 1/...	$3,331,264	$200,000	$1,531,264	$0	$1,600,000	$43,974	$5,536	$233	$3,381,007

2017 Advance Appropriation

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Emerg. Comm. Care 0172XE	Information Technology Dev. 0172XD	Information Technology Sustain. 0172XO	Information Technology Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)...	$3,567,467	$183,621	$3,383,846	$0	$0	$0	$0	$0	$3,567,467
Unobligated Balance (EOY)...	$0	$0	$0	$0	$0	$0	$0	$0	$0
Obligations Total	$3,567,467	$183,621	$3,383,846	$0	$0	$0	$0	$0	$3,567,467

2017 Revised Estimate

Description	Medical Care Total	Admin. 0172XA	Medical Care 0172XB	Emergency Hepatitis C 0172XC	Comm. Care 0172XE	rmation Technology Dev. 0172XD	rmation Technology Sustain. 0172XO	rmation Technology Pay/Adm 0172XZ	Overall Total
Unobligated Balance (SOY)8...	$4,819,319	$158,441	$4,660,878	$0	$0	$0	$500	$0	$4,819,819
Transfer of Unobligated Balances...	$500	$0	$500	$0	$0	$0	($500)	$0	$0
Unobligated Balance (EOY)...	$0	$0	$0	$0	$0	$0	$0	$0	$0
Obligations Total After Adjustment...	$4,819,819	$158,441	$4,661,378	$0	$0	$0	$0	$0	$4,819,819

*Authority to obligate Choice Act funds for Emergency Hepatitis C and Community Care expired on October 1, 2016, thus those balances reverted to Medical Care.

1/ Includes $1.7 billion in obligations as a result of the financial statement audit adjustment

Financial Statement Audit Adjustment

In November 2015, VA's auditors reported that they believed that VA overestimated its fiscal year 2015 obligations by $1.8 billion because those obligations did not have sufficient supporting documentation. VA and the auditors, in the time allowed, could not identify the overstatement by appropriation. VA management agreed to reflect the finding with the understanding that VA would identify which accounts and to what extent the overstatement occurred and take corrective actions to remediate the audit condition. VA is undertaking the necessary analysis and corrective actions to address this issue.

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Enrollee Health Care Projection Model (EHCPM), CHAMPVA Model, and Program of Comprehensive Assistance for Family Caregivers (PCAFC) Stipend Projection Model

Models Used to Inform the Budget Request

The Department of Veterans Affairs (VA) uses three actuarial models to support formulation of the majority of the VA health care budget, to conduct strategic and capital planning, and to assess of the impact of potential policies and changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (Model), the Civilian Health and Medical Program Veterans Administration (CHAMPVA) Model, and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Stipend Projection Model.

Activities and programs that are not projected by any of these three models are called "non-modeled," and can change from year to year. In general, they include non-recurring maintenance (NRM), state-based long term services and supports (LTSS) programs, readjustment counseling, recently enacted programs, and some components of CHAMPVA programs (i.e., spina bifida, foreign medical program, children of women Vietnam Vets).

VA Enrollee Health Care Projection Model

The VA Enrollee Health Care Projection Model supports more than 90 percent of the VA health care budget. The Model, which was first developed in 1998, is a sophisticated health care demand projection model and uses actuarial methods and approaches to project Veteran demand for VA health care. These approaches are consistent with the actuarial methods employed by the Nation's insurers and public providers, such as Medicare and Medicaid.

The Model projects enrollment, utilization, and expenditures for the enrolled Veteran population for over 90 categories of health care services 20 years into the future. The Model consists of three main components. First, VA uses the Model to project how many Veterans will be enrolled in VA health care each year and their age, gender, priority level, and geographic location. Next, VA uses the Model to project the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA (known as "reliance"). Finally, total health care expenditures are developed by multiplying the expected VA utilization by the anticipated cost per service.

The projections are supported by extensive research and analyses of the Veteran enrollee population and the drivers of demand for VA health care. VA program, field, and research staff provide expertise on program strategies and initiatives, the unique needs of the enrollee population, and the VA health care system.

The 2015 Model (Base Year 2014; i.e., based on 2014 actual enrollment, utilization, and expenditure), was used to build the 2017/2018 Veterans Health Administration (VHA) Medical Care budget request. The expenditure bases used to build the projections include the Medical Services, Medical Support & Compliance, and Medical Facilities appropriations, but exclude non-recurring maintenance. The projections include all care provided in VA facilities or paid for by VA (Care in the Community). Note: the total amount of care that VA purchases in the community, which is reflected in the Medical Services budget, includes services not modeled by the EHCPM: CHAMPVA, State Veteran Home, Caregivers, and Disability Management.

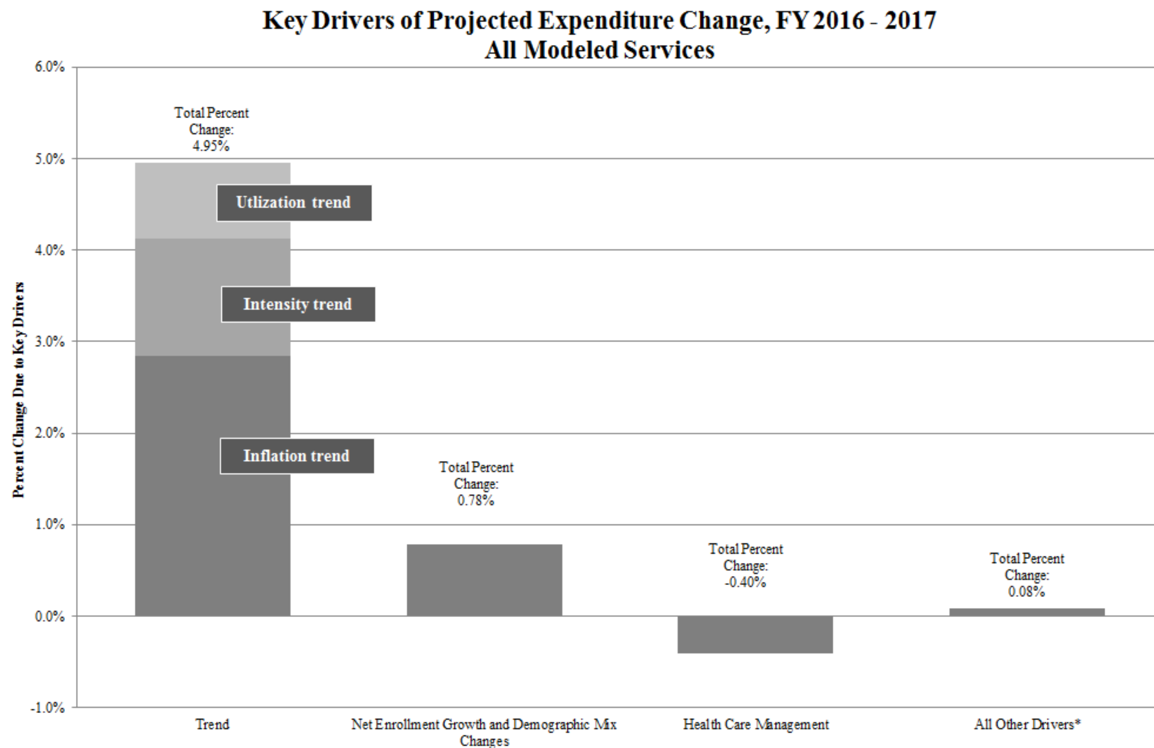
Key Drivers of Growth in Projected Resource Requirements

In projecting future Veteran demand for VA health care, the Model accounts for the unique characteristics of the Veteran population, VA health care system, environmental factors impacting Veteran enrollment, and use of VA health care services.

Historically, growth in expenditure requirements to provide care to enrolled Veterans has been primarily driven by health care trends, the most significant of which is medical inflation. Health care trends are key drivers of annual cost increases for all health care providers – Medicare, Medicaid, commercial providers, and the VA health care system. These increases in VA’s cost of care are independent of any growth in enrollment or demographic mix changes. Enrollment dynamics also contribute to a portion of the expenditure growth; however, their impact varies significantly by the type of health care service. It is also assumed that VA’s level of management while providing health care will improve over time, and is expected to reduce the cost of providing care to enrollees.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2017 for all modeled services. Note: Figure A does not include the impact of the Veterans Choice Act or the VA Budget and Choice Improvement Act. See Figure C in the Net Enrollment Growth and Demographic Mix Changes section and Enrollee Reliance on VA Health Care in this chapter for a discussion of the impact of the Veterans Choice Program.

Figure A



* Modeled initiatives, economic conditions, and reliance changes

These cost drivers and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections.

Health Care Trends

Health care trends represent significant cost drivers for health care in the United States and in the VA health care system. Health care trends (inflation, utilization, and intensity) represent anticipated changes in health care utilization and cost due to advances in technology, including new diagnostics, drugs, and treatments, as well as price inflation. Health care trends increase VA's projected expenditure requirements independent of any enrollment growth or demographic mix changes. The health care trends incorporated into the Model are informed by Federal policy and anticipated trends in Medicare, together with VA-specific trends for pharmacy and prosthetics, and private sector trends for services that VA routinely purchases (for example, maternity services).

Inflation is comprised of personnel and non-personnel components. Inflation on VA's personnel costs is determined by Federal wage policy, including wage increases. VA's projected inflation for pharmacy and prosthetics products is based on VA's well managed purchasing programs for these products. VA's expected inflation on supplies, utilities, etc., is based on projected Consumer Price Index - Urban (CPI-U) and Producer Price Index (PPI) inflation trends for these items.

Utilization and intensity trends increase health care costs due to changes in health care practice and new technology. VA's costs are driven by these trends similar to other health care insurers and providers, because Veterans expect access to these advances in the VA health care system. The newly approved drug therapy to treat individuals infected with Hepatitis C is an example of how new technology increases VA's costs to care for the enrolled Veteran population. These expensive drugs significantly increased VA's expected intensity trend for pharmacy in the 2015 Model.

VA's utilization and intensity trends for Medicare-covered medical services are informed by anticipated Medicare utilization and intensity trends, as projected by the Center for Medicare and Medicaid Services' Office of the Actuary. They have been adjusted downward for efficiencies in the VA health care system as compared to Medicare's primarily fee-for-service environment. VA's pharmacy and prosthetics trends are set by VA workgroups to reflect VA's unique practice patterns for these services.

Net Enrollment Growth and Demographic Mix Changes

Veteran demand for VA health care is influenced by the following demographic characteristics of the Veteran population and environmental factors. Many of these factors are dynamic and are expected to change over time. Some can be anticipated (e.g. changing demographics) and some cannot (e.g. future economic downturns).

- Growth of the Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn (OEF/OIF/OND) and female Veteran populations.

- Enrollee age, gender, mortality, income, travel distance to VA facilities, and geographic migration patterns.

- Increases in prevalence of service-connected conditions and changes in enrollee income levels. These are associated with transitions between enrollment priorities.

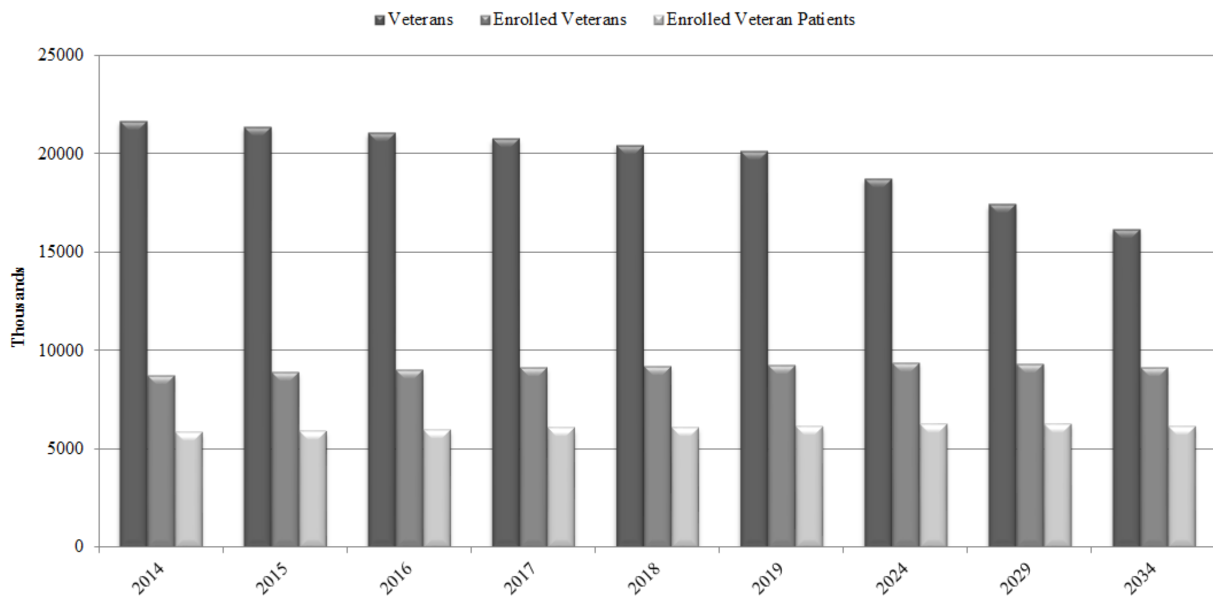
- Health care utilization patterns of OEF/OIF/OND, female, and new enrollees, and other enrollee cohorts with unique utilization patterns for particular services.

- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) and the long-term downward trend in labor force participation.

- New policies, such as the elimination of net worth from the VA Means Test, regulations, and legislation, such as the five-year OEF/OIF/OND combat enrollment eligibility period and the Clay Hunt Suicide Prevention for American Veterans Act.

In the 2015 Model, using current assumptions, Veteran enrollment in VA is projected to grow by 5.6 percent from 2015 to 2025 even though the Veteran population is declining (see Figure B). This growth is largely due to the high enrollment rates for Gulf War and OEF/OIF/OND Veterans. After 2025, enrollment is projected to decline slightly as the impact of mortality in the enrollee population begins to outweigh new enrollment. As described below, costs for VA health care are dependent not just on the number of enrollees but on the demographics of the enrolled Veteran population.

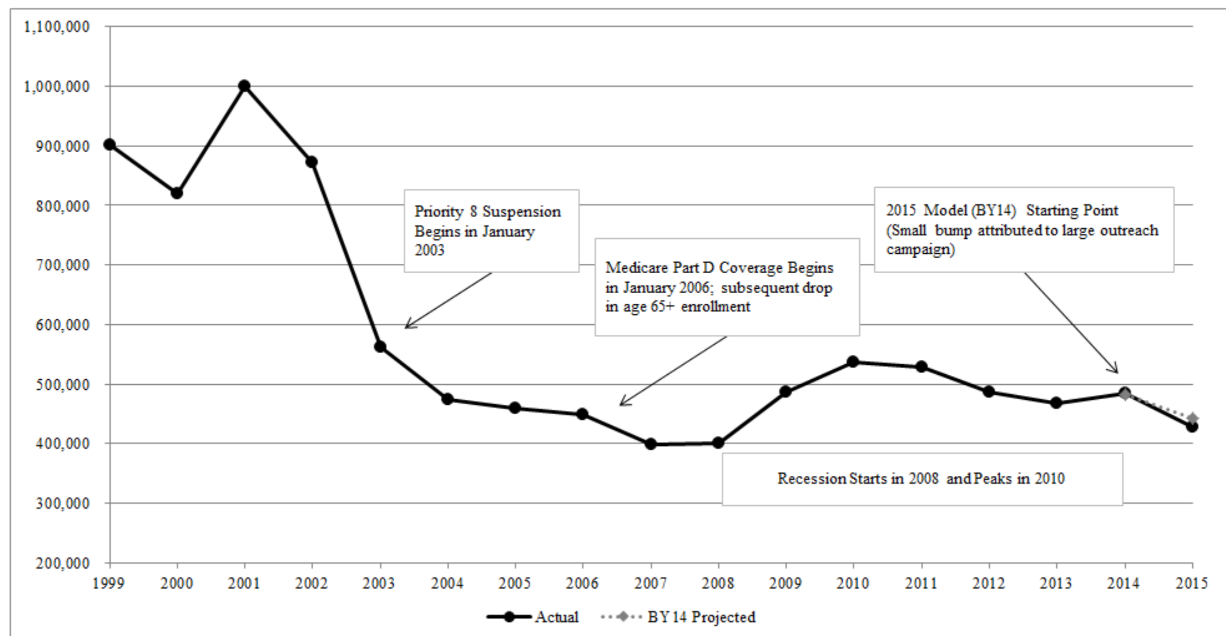
Figure B



Veteran enrollment in VA is dynamic and responds to all of the demographic factors discussed above. Changes in the broader environment also impact Veterans' decisions to enroll. The decrease in new enrollment in 2006 and 2007, seen in Figure C, was partially driven by the availability of the new Medicare drug benefit (Part D). The chart also shows the growth in new enrollment as a result of the economic recession and the decline in new enrollment as the economy has recovered. The slight uptick in 2015 was driven by VHA enrollment outreach efforts related to the Affordable Care Act. Of note, it is sometimes difficult to ascertain causal impacts due to the multiple factors changing over any given time period.

As can be seen in Figure C, new enrollment in 2015 was projected to be lower than previous years (dotted line), and actual enrollment (solid line) was in line with this expectation. Thus, even in the Veterans Choice Act environment, greater than expected new enrollment was not the driver of the growth in enrollee demand for VA health care in 2015. This growth was the result of current enrollees increasing their reliance on VA versus their other health care options (Medicare, Medicaid, commercial insurance, etc.). See the section on Enrollee Reliance in this chapter for details.

Figure C



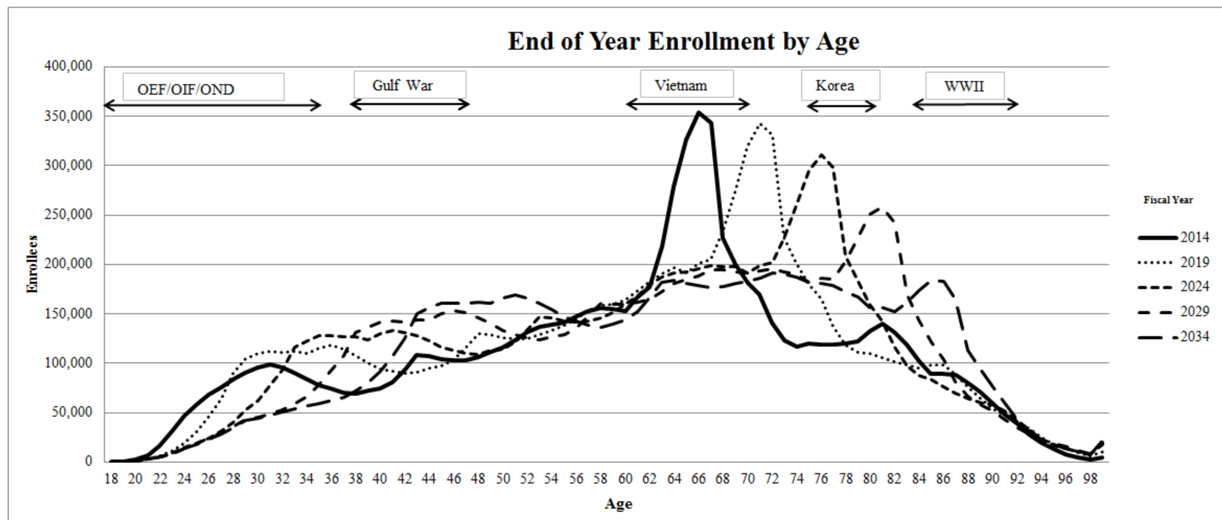
**Note that approximately 3.6 Million Veterans were auto-enrolled in October 1998 based on having been a part of the health care system prior to eligibility reform. To preserve scale, the graph only shows FY 1999 new enrollment after October 1998. In August 2015, VHA removed enrollment records where there was no evidence that the Veteran was enrolled, a user, or otherwise entitled to services. This counting adjustment was made to all previous periods in Figure C above to the extent that it impacted counts of new enrollment each year.*

While the enrolled Veteran population is expected to continue to grow, net enrollment growth (new enrollment minus deaths) is not a significant driver of increases in annual expenditure requirements for VA health care. This is because the enrollees who are dying are generally sicker and more reliant on VA health care than new enrollees. However, the cost of caring for enrollees can change due to other demographic factors (e.g., aging) and changes in the broader environment (e.g., the economic recession).

Within the enrollee population, two dynamic demographic trends are impacting the projected future cost of VA health care: the aging of the Vietnam Era enrollee population and the increasing number of enrollees being adjudicated for service-connected disabilities, which increases the number of enrollees in Priorities 1, 2, and 3. These demographic trends combine in the Vietnam Era enrollee population with particular implications for demand for long term services and supports.

Figure D shows actual enrollment in 2014 and projected enrollment by age, and highlights the relative size of the Vietnam Era enrollee cohort compared to other period-of-service cohorts.

Figure D*



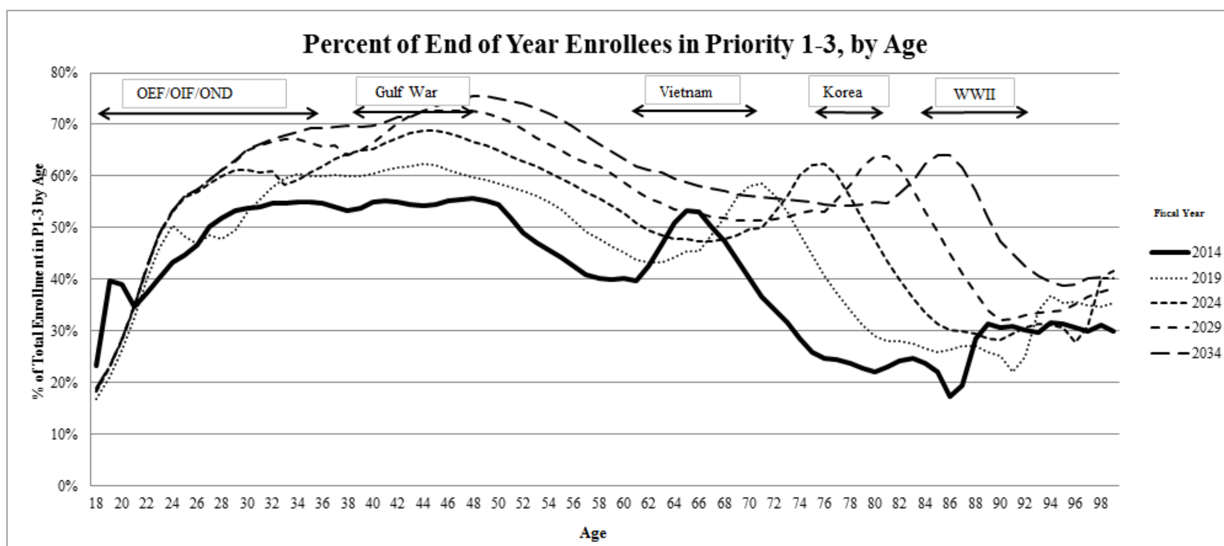
* The period of service cohorts in this and other charts are defined by enrollee age in 2013 because enrollee level data on period of service is not available for all enrollees. Note, an enrollee may be in the age range for the cohort and not have served in the conflict, and the cohorts are not mutually exclusive.

An enrollee's enrollment priority is dynamic. In recent experience, approximately 40 percent of new enrollees transitioned to a new priority level within three years of enrolling. Enrollees transition between Priorities 5, 7, and 8 due to changes in income. Enrollees also transition into Priorities 1, 2, and 3 as a result of adjudication for service-connected disabilities by the Veteran Benefits Administration.

The number of enrollees being adjudicated for service-connected disabilities has escalated in recent years. Enrollees in Priorities 4 to 8 had a 3.4 percent probability of transitioning into the service-connected Priorities 1 to 3 in 2014. These enrollees are also expected to increase their reliance on VA health care, resulting in an increase in the cost of care.

Figure E shows the significant projected growth in service-connected status for OEF/OIF/OND, Gulf War, and Vietnam enrollee populations over the next 20 years. As a result of the increasing numbers of enrollees moving into Priorities 1 to 3, projected enrollment in Priorities 5, 7, and 8 is declining slightly.

Figure E



As of 2013, 5 percent of enrollees had transitioned into Priority 1a (70 percent or higher service-connected disability) over the previous three years, compared with 2 percent as of 2007. The Priority 1a population is projected to grow by 25 percent between 2015 and 2018, and 74 percent between 2015 and 2025.

Aging and the changes in the Priority 1a population are significant drivers of projected expenditure increases for LTSS. VA is mandated by law to provide continuing care nursing home services to Priority 1a enrollees. Additionally, World War II enrollees are in the age bands (greater than age 75) that are the highest users of LTSS and are driving the recent and near-term annual growth in LTSS expenditure requirements, and Vietnam Era Veterans will be an increasing driver of LTSS expenditures, with most having aged beyond age 75 by 2026.

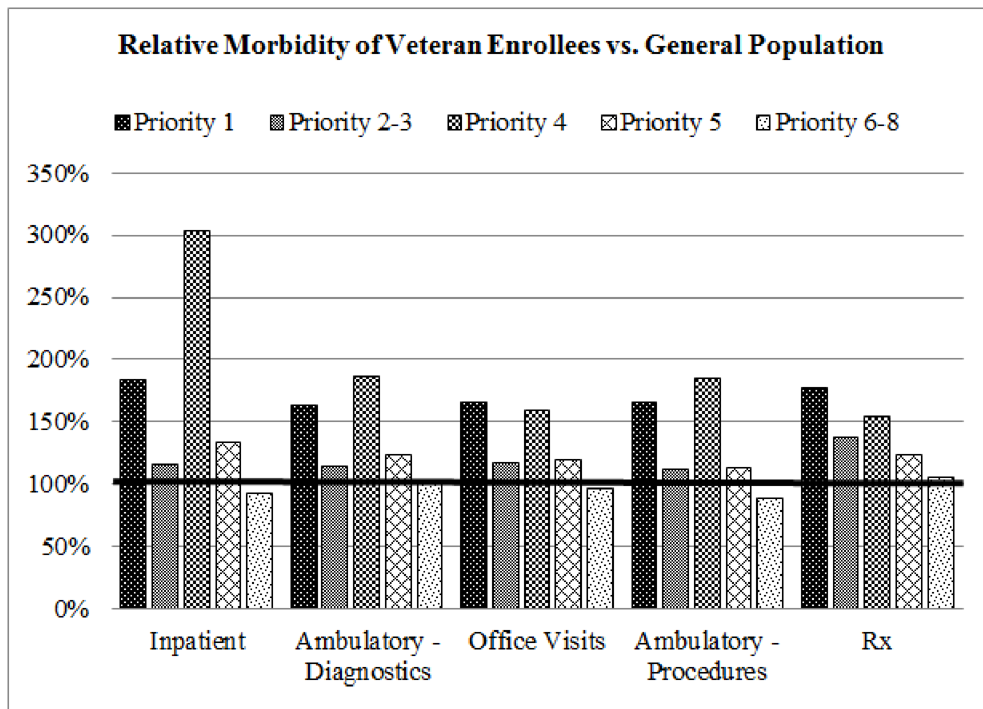
Enrollee Morbidity

The VA enrollee population consists largely of older males, which is typically the segment of the population with the highest healthcare costs. Even after accounting for the age and gender mix of the enrollee population, the VA enrollee population is significantly more morbid (sicker) than the general population in the United States (U.S.), and this higher morbidity further increases VA's cost of providing care.

In the 2013 VHA Survey of Enrollees, 31 percent of enrollees rated their health as "fair" or "poor" compared to other people their age. Only 12 percent of the U.S. population responded similarly in Centers for Disease Control's (CDC) National Center for Health Statistics' 2012 National Health Interview Survey. Similarly, only 37 percent of enrollees rated their health as "excellent" or "very good" compared to 61 percent of the U.S. population in the CDC survey. Using a diagnosis-based methodology, the average morbidity of the VA enrollee population is estimated to be approximately 40 percent higher than that of the general U.S. population.

Morbidity varies significantly by priority level and health care service. For example, the morbidity of Priority 4 (catastrophically disabled) enrollees results in inpatient care costs that are five times that of the general U.S. population, even after accounting for the demographic differences in the populations. Figure F shows the relative morbidity of enrollees compared to the morbidity of the general population by priority for several large categories of health care services. In the figure, 100 percent reflects the cost of health care based on the morbidity of the general U.S. population.

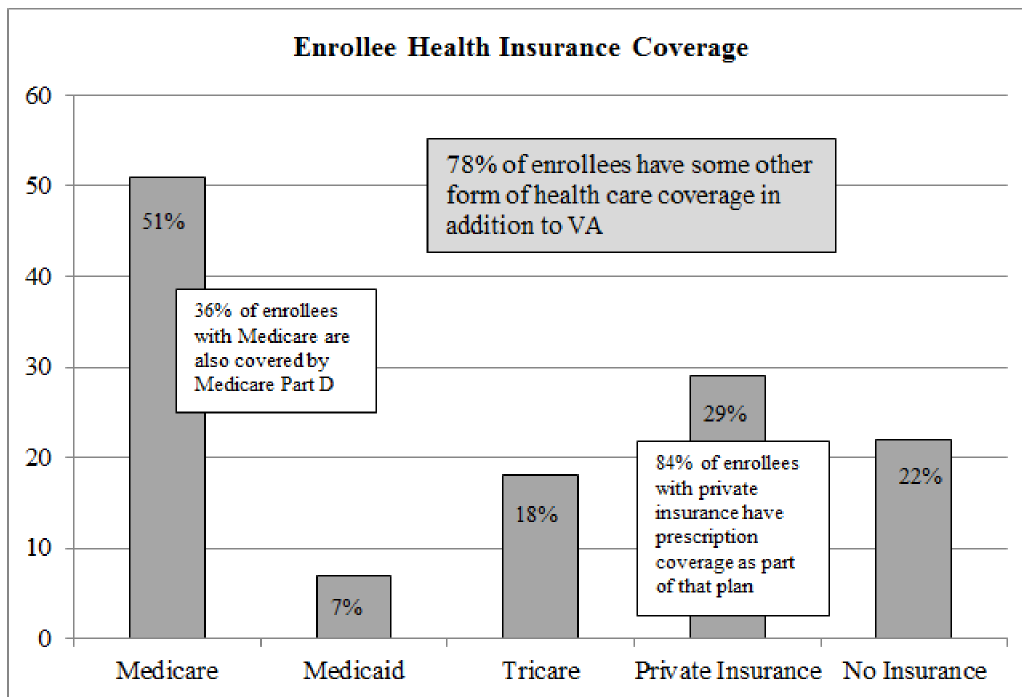
Figure F



Enrollee Reliance on VA Health Care

A unique aspect of the enrolled Veteran population is that enrollees have many options for health care coverage in addition to VA: Medicare, Medicaid, TRICARE, and private insurance. According to the 2014 VHA Survey of Enrollees, approximately 78 percent of enrollees have some type of public or private health care coverage in addition to VA: 51 percent are enrolled in Medicare, and of those, 36 percent are also covered by Medicare Part D (Figure G).

Figure G



As a result, most enrollees do not use VA as their primary health care provider. On average, enrollees rely on VA for only 34 percent of their health care needs. This represented $53 billion in 2014. If the Veterans enrolled in 2014 had chosen to receive all of their health care in VA (100% reliance), this would have required an additional $91 billion for a total of $144 billion in 2014.

Like Veteran enrollment and demographics, enrollee reliance on VA health care is dynamic. Changes in enrollee reliance occur as a result of many factors: enrollee movement into service-connected priorities, changing economic conditions, VA's efforts to provide Veterans access to the services they need (e.g., mental health and homeless initiatives); VA's efforts to enhance its practice of health care (e.g., Patient Aligned Care Teams (PACT)); the opening of new or expanded facilities; the cost sharing associated with services (e.g., dialysis) in the private sector compared to VA.

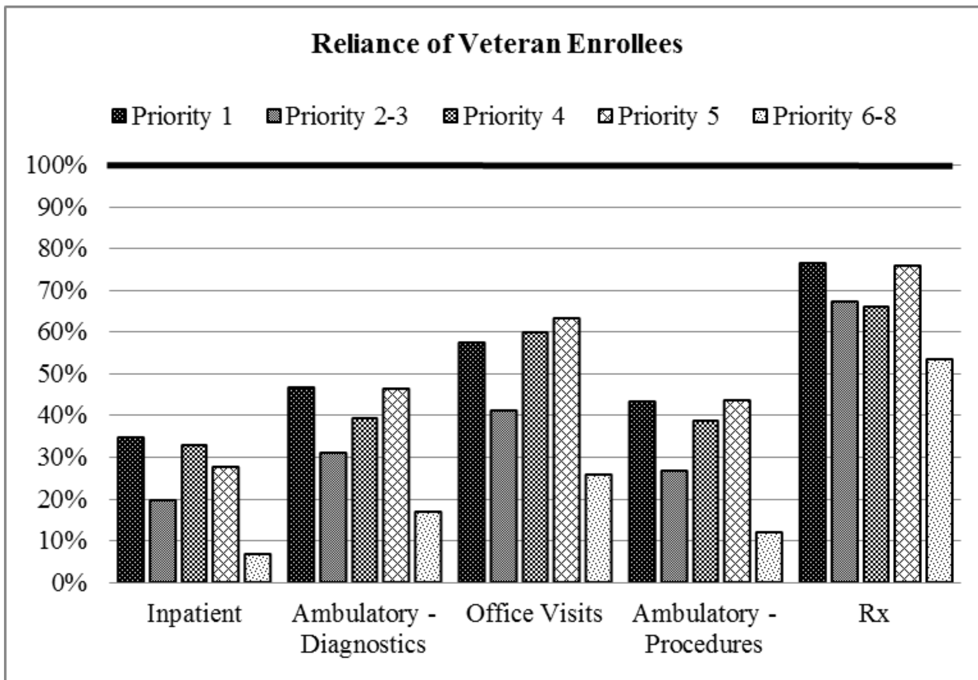
In 2015, the Veterans Choice Act significantly expanded access to VA health care for enrolled Veterans. The Veterans Choice Act increased VA's in-house capacity by funding medical FTE growth in VA facilities and expanded eligibility for care in the community for enrollees residing more than 40 miles from a VA facility and to assure access to care within 30 days. This additional capacity facilitated an increase in current enrollees' reliance on VA health care by more than half a percent over the level expected in 2015. As noted earlier, higher than expected new enrollment was not a driver of the growth in services in 2015 (Figure C). At the end of fiscal year 2015, the VA Budget and Choice

Improvement Act also further expanded eligibility for care in the community paid for by VA.

As a result, enrollee reliance is expected to continue to increase beyond what would have been expected in the pre-Veterans Choice Act environment. This expected increase in enrollee reliance significantly increased the projected resources required to provide care to enrolled Veterans in 2017 over the 2017 Advanced Appropriation level.

Figure H shows reliance by priority for several large categories of health care services. For example, Priority 4 enrollees get approximately 35 percent of the inpatient care they need in VA.

Figure H



Enrollee Cohorts

Within the enrollee population, several cohorts of enrollees exhibit unique health care utilization patterns that reflect their morbidity and/or reliance on VA health care. These include OEF/OIF/OND, Pre Enrollees, post-Vietnam Era, Vietnam Era, World War II Era, and female enrollees.

- OEF/OIF/OND enrollees have notably higher utilization rates than non-OEF/OIF/OND enrollees of the same age for many services. For mental health services, this is attributable to higher morbidity levels. However, for other services, the difference is attributable to the higher utilization rates typically experienced by new enrollees, and therefore, is not expected to persist over time. OEF/OIF/OND represents 14 percent of the enrollee population in 2014 and is expected to grow to 21 percent in 2024.

- Enrollees who used VA prior to the Eligibility Reform Act of 1996 ("Pre" enrollees) differ from those who enrolled after ("Post" enrollees). Pre enrollees are both sicker and more reliant on VA for health care and therefore, have higher utilization rates. These higher utilization rates are observed even after accounting for the higher average age of the Pre enrollees. Pre enrollees represented only 20 percent of enrollees in 2014, but accounted for 37 percent of modeled expenditures. Since there are no new Pre enrollees, this group is declining over time due to mortality; Pre enrollees are projected to decline to 11 percent of the population by 2024, but still account for 23 percent of expenditures.

- Enrollees who served immediately after Vietnam (those born between 1953 and 1963) have the highest healthcare utilization relative to other enrollees of the same age. These enrollees exhibit higher than expected needs for almost all mental health and substance abuse services and for a number of non-mental health services as well (e.g. emergency room visits). This cohort represents about 18 percent of the enrollee population in 2014.

- Vietnam Era enrollees (those born between 1947 and 1952) exhibit higher-than average levels of utilization for some services, notably mental health and homeless services. Currently, this cohort is aging into Medicare eligibility with a corresponding drop in reliance on VA health care. As they age and transition into Priority 1a, Vietnam Era enrollees are expected to be significant users of LTSS. Vietnam Era enrollees represent 17 percent of the enrollee population in 2014.

- World War II Era enrollees are high utilizers of Long Term Services and Supports, since those services are typically provided to older enrollees. This cohort represents less than 7 percent of overall enrollment in 2014.

- Women are one of the fastest growing enrollee cohorts. Women comprise 7 percent of the enrollee population in 2014 and are expected to grow to 10 percent by 2025. Females tend to use more health care than males at younger ages and fewer services than males at older ages. Women enrollees also use a different mix of services than the historically male-dominated enrollees. For example, females are more likely to use physical therapy and preventive services, but less likely to use cardiovascular services.

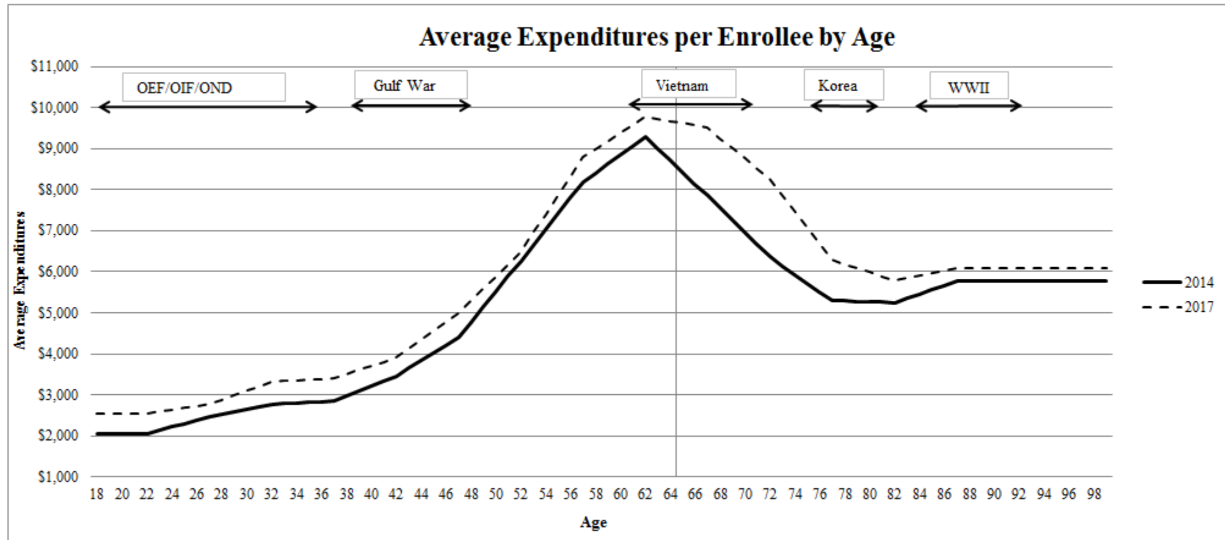
Expenditure Requirements by Enrollee Age

As discussed, many demographic and environmental factors influence Veteran demand for VA health care and the resources required to provide that care. Some of these factors increase VA's resource requirements and some decrease VA's resource requirements. Figure I shows the net impact of all the factors on expenditures.

In Figure I, the actual 2014 expenditures by age highlight the impact of key factors influencing the cost per enrollee. For the under age 65 enrollee population, the figure shows the impact of the increase in the need for health care services as enrollees age. It

also highlights how the impact of aging is mitigated by a steep decline in reliance on VA health care beginning at age 65, when enrollees typically become eligible for Medicare. Figure I also displays the projected increase in expenditure requirements to provide care to enrolled Veterans in 2017.

Figure I



Dynamics of the VA Health Care System

The VA health care system is continually evolving due to VA's efforts to enhance its practice of health care, provide Veterans access to the services they need, and improve its level of health care management.

The Model includes assumptions for initiatives to increase capacity for mental health, homeless, and LTSS. These initiatives are discussed in the service-specific discussions in the next section.

The Model also includes assumptions that VA's level of management in providing health care will improve over time and reduce the cost of providing care to enrollees. The majority of these efficiencies result from improvements in VA's management of inpatient care. The future improvements are expected to result from a wide range of activities that collectively improve VA's level of management, including:

- VHA's well-established inpatient system redesign initiative (FIX), which focuses on improving management processes, such as early discharge planning
- Admission appropriateness and continued stay reviews through the National Utilization Management Initiative (NUMI)
- Improved coordination of care as a result of the Patient Aligned Care Team (PACT) initiative, VA's model for patient-centered medical homes, as well as expansion of home telehealth services, and other disease management activities that result in reductions in hospitalizations for ambulatory care sensitive conditions

- A focus on creating alternative services, such as intensive outpatient mental health programs, support services, and alternative locations of care.

Expenditure Requirements by Service Category

The following sections discuss the key drivers of increases in expenditure requirements for categories of health care services.

Ambulatory Primary and Specialty Care

Ambulatory care projections are developed for the full range of services provided under a typical private sector health plan (e.g., office visits, radiology, pathology, surgeries) as well as specialized services offered by VA (e.g., nutritional counseling, hearing aid services, recreational therapy). These services are broadly classified into Diagnostics and Therapies, Evaluation and Management Services (office visits), and Professional Services and Procedures.

Requirements to provide ambulatory care services to enrolled Veterans are expected to grow in both 2017 and 2018. The projected increase in expenditures is largely due to the impact of health care trends. VA's cost of providing ambulatory services is expected to increase due to inflation and changes in health care practice that increases the cost per service (intensity trends). Further, utilization of ambulatory care is expected to grow due to changes in health care practice independent of any changes in enrollee demographics. For example, utilization of ambulatory surgery and the cost per service of ambulatory surgeries is expected to increase as more complex surgeries are provided in the ambulatory environment.

Modeled Ambulatory Primary and Specialty Care

Diagnostics and Therapies

- Radiology
- Pathology
- Cardiovascular
- Office Administered Drugs and Misc. Medical
- Dialysis and Related Services
- Physical Medicine
- Chiropractic
- Immunizations
- Recreational Therapy
- Allergy Testing and Immunotherapy

Evaluation and Management Services

- Office Visits, including Physical Exams, Urgent Care Visits, and Telephone Care Visits

Professional Services and Procedures

- Surgery and Anesthesia
- Emergency Room Visits
- Hearing and Speech Exams
- Hearing Aid Services
- Prosthetics and Orthotics Services
- Vision Exams
- Maternity
- Nutritional Counseling
- Compensation & Pension Exams
- Medication Therapy Management
- Ambulance

Enrollment dynamics are driving small increases in annual expenditure requirements for ambulatory care. Net enrollment growth (new enrollment minus deaths) and the growth in the Priority 1-3 population has a positive impact. Aging has a relatively neutral impact overall for ambulatory services due to the drop in enrollee reliance on VA health care at age 65. However, the impact of aging is material for some services. For example, use of hearing aid services increases significantly with age, while use of maternity services decreases significantly with age.

Changes in enrollee reliance are increasing VA's expenditure requirements for providing dialysis services. From 2008 to 2012, enrollees' reliance on VA for dialysis services increased an average of 9.5 percent per year from 2008 to 2014. Reliance for dialysis services is expected to continue to increase by 24 percent over the 2014 to 2018 period (approximately 5.5 percent per year). This increase in reliance is due in part to lower cost sharing in VA. In VA, enrollees pay a $15 copayment per treatment, and many enrollees do not pay a copayment. For many Medicare enrollees, the copayment is 20 percent or approximately $50 per treatment. For enrollees, this represents a potential savings of as much as $7,500 per year.

Pharmacy – Outpatient Prescriptions

Pharmacy workload projections are developed for prescription drugs that are typically covered under a private sector health plan, as well as pharmacy items that are not, but that are covered by VA, such as over-the-counter (OTC) medication and supplies.

Modeled Pharmacy

Outpatient Prescriptions
- Prescription Drugs
- Over-the-Counter Medication
- Prescription Related Supplies

Requirements to provide pharmacy services to enrolled Veterans are expected to grow in both 2017 and 2018. The projected increase in expenditures is largely due to the impact of health care trends. VA moderates the impact of inflation on prescription drugs with its well managed pharmacy benefit management program and contracting practices; however, inflation is still increasing VA's cost of providing prescription drugs.

Inflation trends for drug ingredient costs in the 2015 EHCPM reflect an unanticipated surge in generic drug costs currently affecting the entire industry. Ingredient costs for VA generic drugs increased approximately 10 percent in the first quarter of 2015 compared to the first quarter of 2014. This growth is expected to be moderated by generics entering the market with projected lower unit costs. The net ingredient cost trend assumption projected in the model is approximately 5 percent for 2015, 4 percent in 2016, and 3.5 percent in 2017.

The development of new high-cost drugs is a rapidly evolving issue that poses a high degree of uncertainty to VA, Medicare, Medicaid, and commercial providers. The 2015 EHCPM includes estimated costs for the new Hepatitis C drugs, but does not include estimates for other emerging high-cost drugs. These costs will be estimated as more information becomes available on their expected release date and actual price.

Inpatient Acute Care

Inpatient projections are developed for acute bed-days of care for medicine, surgery, and maternity. In order to support workforce planning, the Model also projects utilization for inpatient encounters that occur during inpatient stays. The inpatient encounters projected by the Model include diagnostics, therapies, professional services, and procedures provided in an inpatient environment. The cost of all inpatient encounters is included in the cost of acute bed-days of care.

Requirements to provide inpatient acute services to enrolled Veterans are expected to grow in both 2017 and 2018. The projected increase in expenditures is largely due to the impact of health care trends. VA's cost of providing acute inpatient services is expected to increase due to inflation and changes in health care practice that increases the cost of services (intensity trends). For example, as more surgeries are performed in an ambulatory environment, the average cost per service of the remaining inpatient surgeries, which are more complex, is expected to increase.

While the cost per service of inpatient medical and surgical care is increasing, utilization is expected to decline slightly due to two factors:

- Net enrollment growth (new enrollment minus deaths) is reducing inpatient utilization because the enrollees who are dying are generally sicker and more reliant on VA for inpatient care than new enrollees.

- Improvements in VA's level of management in inpatient care reduces utilization by improving management processes (e.g. early discharge planning), reducing hospitalizations for ambulatory care sensitive conditions and readmissions through care coordination, disease management, expansion of home telehealth services, etc., and the continuing transition of care from an inpatient to outpatient environment.

VA's cost of providing inpatient maternity care is increasing due to high health care trends for maternity services in the private sector (most maternity care is purchased) and an increase in utilization due to the growth in enrollment for younger, female Veterans.

Modeled Inpatient Acute Care

Inpatient Acute
- Medicine
- Surgery
- Maternity Deliveries
- Maternity Non-Deliveries

Inpatient Encounters
- Medication Therapy Management
- Surgical Procedures
- Cardiovascular
- Miscellaneous Medical
- Pathology
- Physical Medicine
- Radiology
- Recreational Therapy
- Mental Health
- Psychotherapy
- Substance Abuse
- Psychosocial Rehabilitation and Recovery Centers
- Mental Health Intensive Case Management
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Aftercare/Screening/Outreach
- Homeless

Mental Health Care

Mental health projections are developed for a continuum of primary and specialty care services including general outpatient mental health, evidence-based psychotherapies, intensive outpatient programs, residential rehabilitation treatment, and inpatient mental health care. These services treat a variety of common mental health conditions in primary care as well as treatment in specialty mental health programs for conditions requiring more specialized and/or intensive interventions including the most severe and persisting mental health conditions.

Requirements to provide mental health services to enrolled Veterans are expected to grow in both 2017 and 2018. The projected increase in expenditures is due to the impact of health care trends, primarily inflation, on the cost per service and VA's initiatives to expand access to mental health care.

Utilization of several mental health services is expected to grow (independent of any change due to enrollment dynamics) due to VA's initiatives to increase capacity and patient referrals: Mental Health Residential Rehabilitation and Compensated Work Therapy/Transitional Residence (CWT/TR) are projected to grow 12 percent and 13 percent respectively through 2017 due to access initiatives. Homeless is projected to grow by 9 percent through 2017. These assumptions are revisited with each annual Model update.

Overall, the impact of enrollment dynamics on utilization of mental health services is minimal. However, enrollment dynamics are driving growth in mental health services for certain segments of the enrollee population.

- The continued growth of the OEF/OIF/OND enrollee population (27 percent from 2014 to 2017) and their increase in service-connected conditions (and the resulting transition into service-connected Priorities 1-3) is driving increases in utilization between 21 and 52 percent per service from 2014 to 2017.

- In addition, post-Vietnam Era enrollees (those born between 1951 and 1961) use a significant amount of mental health and substance abuse services.

Modeled Mental Health Care

Mental Health Inpatient
- Acute Psychiatric
- Acute Substance Abuse
- Mental Health Residential Rehab
- Compensated Work Therapy/Transitional Residence (CWT/TR)
- Sustained Treatment and Rehabilitation (STAR)

Mental Health Outpatient
- Outpatient Mental Health
- Psychotherapy
- Outpatient Substance Abuse
- Mental Health Office Visits
- Psychosocial Rehabilitation and Recovery Centers
- Mental Health Intensive Case Management
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Aftercare/Screening/Outreach
- Homeless

However, the aging of the non-OEF/OIF/OND enrollee population is mitigating the projected growth in utilization of mental health services because use of mental health services declines at older ages. For example, utilization of Mental Health Residential Rehabilitation and Compensated Work Therapy services peaks between ages 40 to 55 and drops off dramatically by age 65 as enrollees age into Social Security.

The growth in expenditure requirements slows from 2017 to 2018 as the access initiatives end and utilization changes solely based on the demographics of the enrollee population.

Rehabilitative Care

Projections are developed for two special rehabilitative care inpatient services provided by VA: Blind Rehabilitation, and Spinal Cord Injury/ Disorders (SCI/D) services. These services promote the health, independence, quality of life, and productivity of individuals.

Modeled Inpatient Rehabilitative Care

- Blind Rehabilitation Services
- Spinal Cord Injury and Disorders

VA operates 13 Blind Rehabilitation Centers, which provide 4-6 weeks of inpatient adjustment-to-blindness training to help blinded veterans achieve a realistic level of independence. VA operates 25 Spinal Cord Injury Centers. These provide expertise in treating new and longstanding spinal cord injuries and disorders and provide rehabilitation, medical care, prosthetics, and training in skills needed to live and work with SCI/D and maintain quality of life.

Requirements to provide Rehabilitative Care to enrolled Veterans are expected to grow in both 2017 and 2018. The projected increase in expenditures is largely due to the impact of inflation on the cost per bed day for rehabilitative care.

Priority transitions are also driving increases in expenditure requirements for these services. Aging is driving growth in utilization for Blind Rehabilitation inpatient services, as diagnoses of vision problems increase with age.

SCI/D utilization rates for Pre enrollees (those who enrolled prior to Eligibility Reform) are approximately five times that of Post enrollees. Therefore, as Pre enrollees become a smaller portion of the total enrolled population (due to deaths), the overall SCI/D utilization rate is falling.

Prosthetics

VA provides a full range of medically-prescribed medical equipment and products to enrolled Veterans. VA is the largest and most comprehensive provider of prosthetic devices and sensory aids in the country. Although the term "prosthetic device" may suggest images of artificial limbs, it actually refers to any device that supports or replaces a body part or function. These include devices worn by the Veteran, such as an artificial limb or hearing aid; those that improve accessibility, such as wheelchairs, ramps, and vehicle modifications; and implants surgically placed in the Veteran, such as hips and pacemakers. The relative cost of these devices varies dramatically (i.e., Basic medical supplies cost very little while sophisticated implant and artificial limbs are much more expensive.).

Modeled Prosthetics

- Glasses/Contacts
- Hearing Aids
- Surgical Implants
- Cardiothoracic Surgical Implants
- Medical Equipment & Supplies (e.g. diabetic socks, blood pressure monitors, dressing aids)
- Home Telehealth Devices
- Oxygen
- Respiratory Equipment
- Wheelchairs
- Orthotics
- Artificial Limbs
- Blind Aids (e.g. magnifiers, talking products, training computer software)
- VA Specialized Products and Services (e.g. environmental modifications (ramps), services for service dogs)

Requirements to provide prosthetic services to enrolled Veterans are expected to grow in both 2017 and 2018. The projected increase in expenditures is due to health care trends and enrollment dynamics.

The cost of prosthetics devices grows each year due to inflation and changes in health care practice. Extensive development and use of national committed-use contracts, as well as regional and local contracts, are expected to mitigate the expected inflation trends for prosthetics to some extent. These contracts provide quality assurance through active participation of clinicians and subject matter experts in developing requirements of the devices and the ability to obtain best value for VA. The cost of prosthetic devices such as cardiothoracic surgical implants, hearing aids, artificial limbs, and wheelchairs is also expected to increase due to advancements in technology (intensity trends); for example, hearing aids with wireless or frequency modulation technology are replacing less sophisticated, less expensive hearing aids.

Changes in health care practice also drive growth in prosthetics utilization independent of any changes in enrollee demographics. With the increased use of technologies in all aspects of health care, more clinical specialties are using advanced prosthetic technology and devices to treat patients. Clinicians are better informed about the availability of technologies and are becoming more comfortable with prescribing these devices to treat and assist patients with specific conditions. As a result, VA has observed an increase in the number of purchase orders, work actions, and associated prosthetic devices that are prescribed and provided per unique patient. In recent years, VA has seen the portfolio of prosthetic devices expanded and the types of available and prescribed devices diversified. For example, wireless communication devices and other devices compatible with hearing aids are being prescribed and provided in conjunction with hearing aids with wireless capabilities. The increased diversity of prosthetic devices coupled with technological advances is driving material increases in utilization of prosthetic devices.

The increasing number of enrollees being adjudicated for service-connected disabilities is also driving material increases in prosthetics utilization. As enrollees transition from non-service connected priorities into Priorities 1 to 3, they are expected to reflect the significantly higher utilization rates of prosthetics, particularly for blind aids, artificial limbs, wheelchairs, and VA specialized products and services.

Aging has a relatively minor impact overall for prosthetic services for enrollees eligible for Medicare due to a decrease in enrollee reliance on VA health care beginning at age 65 with Medicare eligibility. However, the impact of aging is material for some services. For example, the use of hearing aids (which are not covered by private insurance or Medicare) increases significantly with age, while utilization of surgical implants declines as enrollees elect to use Medicare for surgical procedures. Aging is driving material increases in utilization of hearing aids, blind aids, wheelchairs, VA specialized products and services, and oxygen.

The continued growth of the OEF/OIF/OND enrollee population (27 percent from 2014-2017) and their increase in service-connected conditions (and the resulting transition into

service connected Priorities 1-3) is driving significant growth in utilization for prosthetics services for this population. Since this population is not yet eligible for Medicare (with the corresponding decline in reliance on VA), aging is driving increases in this population's use of prosthetics, particularly for cardiothoracic surgical implants, home telehealth devices, oxygen, respiratory equipment, and hearing aids.

Long Term Services and Supports

Long Term Services and Supports include the full range of services provided to help Veterans with functional limitations and chronic health conditions in non-acute settings. These services are provided through facility based care (nursing homes) or via home and community based services (HCBS).

Facility based care is provided in VA Community Living Centers (CLC), Community Nursing Homes (CNH), and State Veterans Homes for durations of both short-stay (90 days or less) and long-stay (more than 90 days). HCBS are provided through both VA and via purchased care. State Veterans Homes provide both facility based and HCBS, but are not included in the Model.

Modeled Long Term Services and Supports

Facility Based Services

- VA Community Living Centers, long-stay (>90 days)
- VA Community Living Centers, short-stay
- Community Nursing Homes, long-stay
- Community Nursing Homes, short-stay

Home and Community Based Services

- VA Adult Day Health Care
- Community Adult Day Health Care
- Home Based Primary Care
- Home Respite Care
- Purchased Skilled Home Care
- Home Hospice Care
- Homemaker/ Home Health Aide Programs
- Spinal Cord Injury & Disorders Home Care
- Community Residential Care
- Home Telehealth

Requirements to provide LTSS to enrolled Veterans are expected to increase in both 2017 and 2018. The projected growth for expenditures is primarily the impact of two enrollment dynamics that are having a very significant impact on LTSS in both facility and HCBS settings: priority transitions and the aging of the enrollee population. Inflation is also driving some growth for these services.

Enrollees transitioning into service-connected priorities are driving significant growth in utilization for facility-based LTSS as well as HCBS. In particular, the growth in Priority 1a enrollees (70 percent service connected or more) is driving significant growth for long-stay facility-based LTSS. VA is legislatively mandated by the Veterans Millennium Health Care and Benefits Act (PL 106-117) to provide continuing care in a nursing home for enrolled Veterans who have a 70 percent or greater service-connected disability, as well as those who need such care for a service-connected disability, or who have a rating of total disability based on individual un-employability.

The aging of the enrollee population is also having a significant impact on expenditures and utilization. Unlike other modeled services, reliance on certain LTSS does not decline after Medicare eligibility, due to limited Medicare coverage for long-stay nursing home services and HCBS. Currently, World War II and Korea era enrollees are in the age bands that are the highest users of LTSS. Vietnam era Veterans will be an increasing driver of

LTSS, with most having aged beyond 75 by 2026. CLC short-stay, which is used primarily for post-acute care and hospice care, is impacted less by aging than the other facility based care categories.

Projected utilization for LTSS reflects programmatic changes in delivery of these services. VHA, reflecting similar shifts in the health care system at large, is focusing efforts to provide care in the most appropriate setting for enrollees. This change includes deliberate shifts to CLC short-stay care for those who are in an inpatient setting and are not ready to be discharged to home, but no longer need acute care. It also includes VA's initiative to provide care through HCBS rather than in nursing homes when appropriate. These efforts are driving some growth for short-stay facility based care and HCBS, but are mitigating expected growth for long-stay facility based care.

Dental

Projections are developed for three categories of dental care services based on the intensity and complexity of the service. By law, VA provides dental care to enrollees based on special eligibility criteria, which are different than eligibility criteria for other VA medical care benefits. Providing preventive and basic dental services to enrollees aligns with VA's mission to provide enhanced preventive oral health services for eligible dental patients to maximize their health outcomes in the health care setting of their choice.

Modeled Dental Care

- Preventive and Basic Dental Services
- Minor Restorative Dental Services
- Major Restorative Dental Services

Requirements to provide dental services to enrolled Veterans are expected to grow in both 2017 and 2018. The projected increase is primarily due to the increase in service-connected conditions (and the transition into service connected Priorities 1-3) and the resulting increase in eligibility for dental services. VA's cost of providing dental services is also expected to increase due to inflation.

Impact of 2015 Model Update

Health care is very dynamic. Further, the Model projections supporting the VA budget are developed based on data that are three years removed from the beginning of the budget year (four years for the Advance Appropriation). During this time, new policies, legislation, regulations, and external factors, such as the economic recession, can occur and change the projected demand for VA health care.

Each year, the Model is updated in order to reflect the most recent data and emerging experience. Key updates for the 2015 Model include:

- Updates to the Veteran and enrollee projections resulted in increased expenditure requirements starting in 2017 and continuing through the out years:
    - Incorporated new Veteran population projections (VetPop2014), which slightly increased Veteran and enrollee projections.

- o VetPop2014 included a revised counting method for female Veterans, compared to VetPop2011, leading to lower female Veteran projections. However, female enrollee projections are stable between the 2014 and 2015 Models since they are based on actual enrollment patterns.
- o Increased the percent of the Veteran population with service-connected disabilities from 19 percent to 22 percent in 2017 and from 22 percent to 27 percent in 2024 and, incorporated higher rates of enrollees transitioning into service-connected Priorities 1 to 3. This change also significantly increased the non-enrolled pool of OEF/OIF/OND Veterans in Priority 1, allowing for more new projected enrollment for this younger cohort in the 2015 Model.

Historically, the most significant factors changing the Model's projections have been external and could not have been anticipated in advance, including the civilian wage freeze policy, the impact of the recession, American Reinvestment and Recovery Act (ARRA) funding, and the 2007 and 2008 VA supplemental funding.

Civilian Health and Medical Program Model

The Civilian Health and Medical Program Veterans Administration (CHAMPVA) Model, which was adopted in 2010, projects the cost of providing medical coverage to the spouse or widow(er) and to the children of a Veteran, also referred to as a sponsor, who is rated permanently and totally disabled due to a service-connected disability, or was rated permanently and totally disabled due to a service-connected condition at the time of death, or died of service-connected disability, or died on active duty and the dependents are not otherwise eligible for Department of Defense TRICARE benefits. In 2014, CHAMPVA covered 403,171 beneficiaries. The number of beneficiaries is expected to rise to approximately 431,000 in 2016 and 444,000 in 2017.

The 2015 CHAMPVA Model was developed using data from 2006 to 2014, publically available research, and input from a development team, including subject matter experts from VHA and VHA's CHAMPVA program. The CHAMPVA Model consists of two major components: the enrollment model and the claims cost model. The enrollment model projects the number of beneficiaries enrolled in CHAMPVA, while the claims cost model projects expenditures for providing care to beneficiaries.

The enrollment model projects the number of CHAMPVA beneficiaries in two phases. For each fiscal year, the number of sponsors is projected and then the number of beneficiaries of those sponsors is projected. Within a given year, sponsors are projected by age, gender, degree of service-connected disability, whether the sponsor is living or deceased, and the sponsor's enrollment lag (the number of years a sponsor delays enrolling a beneficiary), while beneficiaries are projected by age, beneficiary type, and gender (if the beneficiary is a spouse).

The claims cost model is driven by several factors including: enrollment counts produced from the enrollment model, assumed annual claim cost trends, age/gender factors, and actual fiscal year 2014 CHAMPVA medical claims data. The projected beneficiaries from the enrollment model are then linked to the claims cost model to generate expenditures.

The Program of Comprehensive Assistance for Family Caregivers (PCAFC) Stipend Projection Model

The Program of Comprehensive Assistance for Family Caregivers (PCAFC) Stipend Projection Model was developed in 2016. This model provides stipend payment cost projections which make up the majority of total PCAFC costs. The Program provides comprehensive assistance to caregivers of certain Veterans and Servicemembers whom were seriously injured during service on or after September 11, 2001. For enrolled Veterans, their primary caregivers are eligible for a monthly stipend payment, healthcare expense reimbursement through the CHAMPVA program (if they have no other health insurance), education and training, mental health care services, respite care services, and travel, lodging and per diem expenses in order to attend required Caregiver training, and to travel to and from the Veteran's medical appointments.

The model includes projections for Veteran sponsor counts, caregiver counts, and stipend payment counts and sums. These cost projections are limited to stipend costs only and are not projections for the total costing of the PCFAC.

Projected stipend payments are developed using a combination of projected enrollment pattern assumptions, stipend payment trends, and projected payment tier enrollment distribution.

The PCAFC Stipend Projection Model projections are based on two key assumptions. The first is that the new caregiver enrollment rate will continue through 2020 at the same rate that has been observed in 2014 and 2015 (through August). The second is that the number of caregivers discontinuing in the program will remain at a constant rate observed in 2014 and 2015 (about one percent per month).

Since program inception in May 2011, there has been a steady increase in the number of new caregivers. Beginning in 2014, it appears the rate of new caregiver applications reached a steady state. Going forward, significant numbers of Veterans enrolling in PCAFC will be those who separated five or more years ago rather than just recent separations. This is due to Veterans transitioning from low service-connected disabilities to higher service-connected disabilities over time. Many Veterans may not be eligible for the CPACF shortly after separation, but may be eligible years later once their disability has progressed to the point of requiring Caregiver assistance.

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Explanation of Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act):

- **Veterans Choice Act.** On August 7, 2014, President Obama signed into law the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146) ("Veterans Choice Act"). The 2016 budget supports implementation of the Veterans Choice Act and the Administration's goal of providing timely, high-quality health care for our Nation's veterans. The Veterans Choice Act provided $5 billion in mandatory funding in Section 801 to increase Veterans' access to health care by hiring more physicians and staff and improving the VA's physical infrastructure. It also provided $10 billion in mandatory funding in Section 802 through 2017 to establish a temporary program ("Veterans Choice Program") improving veterans' access to health care by allowing eligible veterans who meet certain wait-time or distance standards to use health care providers outside of the VA system.

  The $10 billion was deposited in the Veterans Choice Fund in 2014, for purposes of operating the Veterans Choice Program. In July 2015, Congress provided emergency authority for Hepatitis C ($500,000,000) and Care in the Community ($3,848,500,000) by passing Public Law 114-41, the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, which gave VA temporary authority to use Section 802 funds on other programs. This authority ended on October 1, 2015 and does not extend into 2016.

  The $5 billion was deposited in the Medical Services account in 2014. In 2015, the transfer of Unobligated Balance Funds reflects transfers from Medical Services to Medical Support & Compliance ($27,500,000), Medical Facilities ($1,771,600,000), Information Technology ($376,600,000), and Minor Construction ($511,200,000). Of the amounts allocated to each Medical Care account, the following funding was available for obligation in 2015, while the remaining was reserved for apportionment in 2016: $740,200,000 for Medical Services, $10,500,000 for Medical Support and Compliance, and $1,016,600,000 for Medical Facilities.

Annual Appropriation Adjustment in 2015:

- **$209,189,000 Addition to the Medical Services Appropriation.** This reflects an addition to the funds previously appropriated under Medical Services that became available on October 1, 2014. The authority for the addition to Medical Services

Appropriation is provided in the Consolidated and Further Continuing Appropriations Act, 2015 (Public Law 113-235), Division I.

Explanation of Rescissions in 2015:

- **$36,439,135 Rescission to the three Medical Care Appropriations.** This reflects the VHA portion of a total VA rescission of $41,000,000. For Medical Care, $36,439,135 of annual appropriations from Medical Services ($28,829,839), Medical Support and Compliance ($5,609,461), and Medical Facilities ($1,999,835) is rescinded. The authority for the rescissions is provided in the Consolidated and Further Continuing Appropriations Act, 2015 (Public Law 113-235), Division I, Section 233.

Explanation of Appropriation Transfers in 2015:

- **$88,840,000 Transfer to Major Construction from Medical Care Appropriations.** This reflects a transfer to Major Construction from Medical Services ($6,494,000), Medical Support and Compliance ($1,611,000), and Medical Facilities ($80,735,000) to carry out the major medical facility construction project in Denver. The authority for this transfer is provided in Public Law 114-25, Section 2, signed on June 15, 2015.

- **$15,000,000 Transfer to the DoD–VA Health Care Sharing Incentive Fund (JIF) from Medical Support and Compliance.** Title 38, section 8111(d)(2), states that, "To facilitate the incentive program, there is established in the Treasury a fund to be known as the "DoD–VA Health Care Sharing Incentive Fund." Each Secretary shall annually contribute to the fund a minimum of $15,000,000 from the funds appropriated to that Secretary's Department. Such funds shall remain available until expended and shall be available for any purpose authorized by this section."

- **$252,283,000 Transfer to Joint DoD–VA Medical Facility Demonstration Fund.** This reflects a transfer to the Joint DoD–VA Medical Facility Demonstration Fund from Medical Services ($190,185,000), Medical Support and Compliance ($26,608,000) and Medical Facilities ($35,490,000). The authority for this transfer is provided in Public Law 113-235, section 222 the "Consolidated and Further Continuing Appropriations Act, 2015," signed on December 16, 2014. The Demonstration Fund supports the continuing operations of the Captain James A. Lovell Federal Health Care Center (FHCC), in North Chicago, which began operations on December 20, 2010.

- **$57,740,900 Transfer of 1 Percent to Medical Services Appropriation from Medical Support and Compliance Appropriation**. The purpose of this transfer is to appropriately realign staff and costs to the correct appropriation. In accordance with Sec. 106 of Public 113-146, staff performing duties associated with payments for hospital care, medical services, and other health care from non-Department of Veterans Affairs providers were realigned from VA Medical Centers to the Chief Business Office. This realignment incorrectly identified the staff as being appropriately funded from the Medical Support and Compliance account, whereas the

staff was funded by the Medical Services account when they were aligned with VA medical centers. In addition, staff performing comparable functions for care provided internally at VA facilities remained funded by the Medical Services account. The VA General Counsel has advised that realignment to a consistent account is appropriate in accordance with the "pick and stick" rule of appropriations law. The authority for this transfer was provided in Public Law 113-235, section 202 of the "Consolidated and Further Continuing Appropriations Act, 2015," signed on December 16, 2014.

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Proposed Legislation

Legislative Proposals	FY 2017 Obligations	FY 2017 Collections
Extend Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Eligibility for Covered Children Up to Age 26	$55,934	$0
Grants for Transportation of Highly Rural Veterans	$3,083	$0
Continuing Professional Education Requirements for all full-time Certified Advanced Practice Registered Nurses (APRNs)	$6,464	$0
Enhance Veteran safety by Exempting Copayment Requirements for Naloxone Rescue Kits and Education	$100	$0
Title 38 Appointment and Compensation System for Medical Center Directors and Network Directors	$8,813	$0
Veterans Transportation Service (VTS) - Transportation of Individuals to and from Facilities of VA	-$1,720	$0
U.S.C. 7675, which defines Breach of Agreement Under Employee Incentive Scholarship Program	-$42	$0
VA Payment for Medical Foster Home	-$8,732	$0
Smoke-Free Environment	-$7,863	$0
Expand VA's Income Verification Matching Authority	$0	$16,436
Legislative Proposals Total	**$56,037**	**$16,436**

This chapter includes only those legislative proposal that have budget implications. For VHA proposed legislation with no cost impacts, please see Volume 1, Part 2.

Extend Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Eligibility for Covered Children Up to Age 26

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$55,934	$0	$55,934	0

Proposed Program Change in Law:

VA proposes to amend section 1781 of title 38 of the United States Code (U.S.C.) to extend eligibility for coverage of children under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) until they reach age 26 so that eligibility for children under CHAMPVA will be consistent with certain private sector coverage under the Affordable Care Act (ACA).

Current Law or Practice:

Currently, under title 38, U.S.C., an unmarried child of a qualifying Veteran can be covered under CHAMPVA until the age of 18 (or after if the child became permanently incapable of self-support before attaining the age of 18). Eligibility can be extended until the age of 23, if the child is pursuing a course of instruction at an approved school.

Section 2714 of the Public Health Service Act, as amended by ACA, requires group health plans and health insurance issuers that offer dependent coverage of children, to make such coverage available for adult children until age 26. Because CHAMPVA is not considered a group health plan or health insurance issuer as those terms are defined by law, those requirements do not apply to CHAMPVA, and a legislative change is required to extend CHAMPVA coverage for children beyond the age limits specified above.

Justification:

VA proposes to extend coverage of children under CHAMPVA up to age 26 regardless of marital status or school enrollment status so that eligibility for children under CHAMPVA will be consistent with certain private sector coverage under the ACA.

VA recommends providing this benefit to the beneficiary at no additional cost, such as a premium, since the Veteran sponsor has a permanent and total service-connected disability, passed away due to a service-connected disability, was at the time of death permanently and totally disabled from a service-connected condition(s), or died on active military service in the line of duty, which may create a financial hardship for CHAMPVA beneficiaries.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations............	$55,934	$59,502	$64,081	$68,950	$74,279	$322,746
Collections............						
Appropriation.......	$55,934	$59,502	$64,081	$68,950	$74,279	$322,746

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations............	$79,999	$86,150	$92,792	$100,023	$107,702	$789,412
Collections............						
Appropriation.......	$79,999	$86,150	$92,792	$100,023	$107,702	$789,412

Grants for Transportation of Highly Rural Veterans

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$3,083	$0	$3,083	0

Proposed Program Change in Law:

VA proposes amending the existing Grants for Transportation of Highly Rural Veterans program to assist enrolled Veterans living in rural and highly rural areas with innovative transportation options, enhancing access to VA health care. The amendment would expand the Grants for Transportation of Highly Rural Veterans program and leverage current volunteer state and community resources to provide innovative transportation options.

VA suggests the following new program attributes for the Grants for Transportation of Highly Rural Veterans program using rural urban commuting area (RUCA) 10.1:

- Increase the amount available per grant from $50,000 to $100,000;
- Expand eligible entities, to include qualified county governments; and
- Redefine rural and highly rural, also referred to as "rural urban commuting area," to the definitions adopted by VA on October 1, 2014.

VA also proposes the authorization for appropriations, for each fiscal year from 2017 through 2026, to be used for operating the Grant Program for Transportation of Highly Rural Veterans.

Current Law or Practice:

Public Law (P.L.) 111-163, Section 307, of the Caregivers and Veterans Omnibus Health Services Act of 2010, specifies that VA "shall establish a grant program to provide innovative transportation options to veterans in highly rural areas." Eligible applicants under the law include Veteran Service Organizations (VSOs) and State Veteran Agencies (SVAs) seeking to provide innovative transportation services to Veterans residing in highly rural counties (i.e., those having an average of seven or less persons per square mile). Selected grantees are eligible to receive grants up to a maximum amount of $50,000. Transportation services provided to rural Veterans using these grants are provided free of charge.

To conduct the program, P.L. 111-163 authorized $3 million to be appropriated each year from 2010 through 2014. Due to delays caused by the need to promulgate regulations and the need to twice extend the application process, VA did not award the first set of grants until 2014. Public Law 114-58, Department of Veterans Affairs Expiring Authorities Act of 2015, extended the existing authorization of appropriations through 2016.

Justification:

Veterans from rural and highly rural areas are less likely to access health care services through the VA or the private sector for both physical and mental illnesses. VA wants to ensure that all Veterans, including those living in remote areas, can receive the health care they need, and have earned through their service in the U.S. Armed Forces.

This authority amendment will also allow more states to become eligible under the Grants for Transportation of Highly Rural Veterans program. Currently, only 25 states are eligible to participate in the program under the present highly rural definition. The updated RUCA definition will increase eligibility to all 50 states.

Although VSOs, SVAs, and county governments already participate in the Veteran transportation program, additional grants will encourage them to employ innovative approaches to providing transportation services for Veterans located in highly rural areas. Funds granted through this expanded program will help provide grantees greater flexibility to employ new, innovative transportation approaches, resulting in improved service and greater health care access for Veterans living in rural and highly rural areas. Transportation services provided through the transportation grant program will be free of charge to eligible Veterans.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations............	$3,083	$3,083	$3,083	$3,083	$3,083	$15,415
Collections............						
Appropriation.......	$3,083	$3,083	$3,083	$3,083	$3,083	$15,415

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations............	$3,083	$3,083	$3,083	$3,083	$3,083	$30,830
Collections............						
Appropriation.......	$3,083	$3,083	$3,083	$3,083	$3,083	$30,830

Reimbursement of Continuing Professional Education for all full-time Board Certified Advanced Practice Registered Nurses (APRNs)

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$6,464	$0	$6,464	0

Proposed Program Change in Law:

VA proposes to amend section 7411 of title 38 of the United States Code (U.S.C.) to include authority to reimburse continuing professional education (CPE) requirements for full-time board certified APRNs. The proposed legislative authority would offer APRNs the same non-discretionary continuing education funding currently provided to physicians in the amount of $1,000 per physician per annum.

Current Law or Practice:

Title 38 U.S.C section 7411 allows for CPE reimbursement, up to $1,000 per year, for full-time board certified physicians and dentists. The VA physician CPE reimbursement program originated from legislation establishing CPE funding as a permanent standing budget item each year to benefit physicians and dentists only. This funding is not subject to inclusion or denial by Congress and is not available to APRNs who have a state requirement for continuing education related to their national and specialty certifications.

Justification:

Physicians and dentists are not the only medical care providers who benefit from CPE. In 2011, the Institute of Medicine report titled "Future of Nursing" documented that continuing education for APRNs is imperative for the continued improvement of quality outcomes in patient care. Additionally, Zaccagnini & White (2014) reported that APRNs are "well educated regarding biophysical and psychosocial sciences in their nursing preparation, but the rapid changes and discoveries occurring in these fields necessitate constant updating of the advanced nurse practitioner's knowledge." This practice should be an "ongoing, lifelong quest for knowledge and growth," requiring "up-to-date clinical and technical skills" to maintain quality outcomes (Zaccagnini & White, 2014, p. 11). Further, the trend is for doctoral-prepared APRNs with the clinical-based Doctorate of Nursing Practice (DNP) instead of a traditional Doctor of Philosophy (PhD) degree.

In agreement with recommendations from the National Institute of Health, American Association of Colleges of Nursing (AACN), The Robert Wood Johnson Group, and others, the importance of ensuring continuing education for APRNs is essential to maintaining high-quality care. In an effort to support high-quality care, VHA is currently re-engineering its care delivery system to offer preventative, community-based health care to more Veterans by moving generally from a hospital-based, specialty-driven system to a system characterized by primary care and care management. By sharing resources,

consolidating facilities, and entering into contractual arrangements, the overall goal is to improve the availability, quality, efficiency, and effectiveness of patient care. A key to accomplishing this transformation is the timely recruitment and successful retention of quality practitioners as VA molds and reshapes its operations to meet current challenges.

Each state has an individual continuing education requirement for APRNs. Some states also have a requirement that APRNs obtain National certification. National certification requires APRNs to meet all practice requirements while holding an active registered nurse license in a U.S. state or territory, or the legally recognized, professional equivalent in another country. Any hours of practice as a licensed practical nurse or a licensed vocational nurse, or work performed outside of the nursing field do not qualify as part of the practice hour requirement. Practice hours may be either part of employment or voluntary.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations............	$6,464	$6,464	$6,464	$6,464	$6,464	$32,320
Collections............						
Appropriations......	$6,464	$6,464	$6,464	$6,464	$6,464	$32,320

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations............	$6,464	$6,464	$6,464	$6,464	$6,464	$64,640
Collections............						
Appropriations......	$6,464	$6,464	$6,464	$6,464	$6,464	$64,640

Enhancing Veteran Safety by Exempting Copayment Requirements for Naloxone Rescue Kits and Education

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$100	$0	$100	0

Proposed Program Change in Law:

VA proposes to amend section 1722 of title 38 of the United States Code (U.S.C.) to eliminate copayment requirements for dispensing naloxone rescue kits. This amendment attempts to reverse the toxic effects of opioid overdoses and educate Veterans, and where Veterans consent, their families about opioid use. VA proposes adding the following sentence to 38 U.S.C. 1722A(a)(3). "Copayment is not required when opioid antagonists are prescribed to Veterans at high risk for overdoses of specific medications or substances to reverse the effects of those overdoses."

VA also proposes amending 38 U.S.C. 1710 to include language exempting copyaments for education about the use of naloxone rescue kits. VA proposes adding the following lanquage to subsection (g)(4). "This subsection does not apply to patient-education about opioid antagonists prescribed to reverse the effects of overdoses of specific medications or substances."

Current Law or Practice:

It is not clear from current law, regulations, and administrative guidance if copayments should be required for medications, such as naloxone kits, prescribed as a preventive intervention. However, 38 U.S.C. 1722A indicates that copayments are required for medications used for treatment of conditions or disabilities.

Justification:

Veterans with ongoing opioid use disorders often feel invulnerable to the adverse effects of these medications, even after periods of abstinence when their reduced tolerance puts them at increased risk of overdose if they relapse. By offering naloxone kits without requiring a copayment, both VA as a health care system and each Veteran's medical care provider can appropriately emphasize the unpredictable risk associated with opioid use and have a profound impact on Veteran patients' safety.

In 2014, the number of VA patients receiving opioid medications on an outpatient basis for pain management was 1,001,000. In that same year, the number of VA patients diagnosed with opioid use disorders was 57,000. In 2011, the most recent year for which definitive data are available from the National Death Index, the number of fatal opioid overdoses among Veteran patients who used VA services in 2010 or 2011 was 677, and

the total number of opioid overdoses recorded as VHA encounter-based diagnoses was approximately 2,450.

The number of Veterans at risk for an opioid overdose over a one year period was estimated using a risk stratification model developed by the VA Program Evaluation Resource Center using VA clinical and administrative data, including overdose risk factors , clinical diagnoses, and health care utilization measures. Using a 5 percent risk of overdose or suicide attempt as the cut-off for defining a high-risk population, the model estimates that approximately 19.3 percent of patients with an opioid use disorder and/or an opioid prescription, or about 204,000 patients, would derive potential benefits from the availability of a naloxone kit.

Naxolone kits require a prescription to be dispensed to the patient, and VA providers have been educated on identifying patients on their panel that would benefit from obtaining this prescription as a precautionary measure. VA has educational tools for providers, patients, and their family members to know when and how to use a naloxone kit during an emergency. This medication is not needed in every household; however, it does need to be available to treat overdoses for patients who are considered high risk. VA providers clinically determine the risk level for their patients who are exposed to opioids and then prescribe naloxone kits, as a safety measure, when appropriate.

The "gift" of the kit would represent an occasion when risks could be discussed in the most favorable context and when the patient is most likely to accept information that could be life-saving. It also presents an opportunity, with patient permission, to actively involve other concerned individuals in overdose prevention and naloxone distribution training. This is intended to communicate the risk associated with opioid use and train concerned individuals to recognize opioid overdose and provide timely rescue from an overdose, if needed.

The annual number of Veterans receiving opioid prescriptions and/or being seen for opioid use disorder has stabilized over recent years. Cost estimates provided for waiving copayments recognize that the shelf life of naloxone kits is approximately one year and that it would be necessary to repeat prescriptions and dispensing every year. VA also expects that a relatively consistent number of kits would need to be dispensed in subsequent years.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations...............	$100	$100	$99	$99	$100	$498
Collections...............						
Appropriations........	$100	$100	$99	$99	$100	$498

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations...............	$100	$100	$100	$101	$101	$1,000
Collections...............						
Appropriations........	$100	$100	$100	$101	$101	$1,000

Title 38 Appointment and Compensation System for Medical Center Directors and Network Directors

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$8,813	$0	$8,813	0

Proposed Program Change in Law:

VA proposes to establish an appointment and compensation system under Title 38 for the Veterans Health Administration (VHA) occupations of Medical Center Director and Veterans Integrated Service Network (VISN) Director, both of which have significant impact on the overall management of VA's health care system. Under this proposal, the appointments and rates of pay for employees who occupy these positions would be set and adjusted by the Secretary without regard to the provisions of Title 5, United States Code (U.S.C.), with a maximum basic rate of pay set no more than the amount established in Title 3 U.S.C. 102. These positions would remain eligible for performance awards in accordance with VA guidance and Secretary approval.

Director pay would be determined for each covered executive based on the methodology of a compensation system for VHA physicians and dentists found under 38 U.S.C 7431, Pay for Physicians and Dentists, established by Public Law (P.L.) 108-445. Each executive would be evaluated against appropriate market pay criteria including but not limited to: complexity of the assignment, applicable labor market salary data, experience, accomplishments, and overall results-driven performance. The aggregate pay limitation for this system would be the same as the VHA physicians and dentists pay system no more than the amount of $400,000 established under 38 U.S.C 7431(e)(4).

Current Law or Practice: There is no authority for VA to make appointments or set rates of pay for these positions under U.S.C. Title 38 sections 7401 and 7404.

Justification: VHA has a challenge addressing the rapidly evolving and changing health care industry. Health care leaders, from large multi-hospital systems and academic medical centers to smaller community hospitals and physician practices, are addressing ways to achieve transformation of the health care enterprise. In order for VHA to be part of this transformation, VHA must have executive leadership with the skill set to provide enterprise solutions for our Nation's Veterans and for other persons served by VHA and who work with VHA to provide care. While there are many reasons why individuals choose to serve Veterans in VHA's hospital system, compensation is one of the key drivers to ensure VHA is successful in recruitment and retention of dedicated health care leadership who can make the tough decisions in delivering sustainable quality health care and continual performance improvement for our Nation's Veterans.

The sustainability of VHA quality health care is dependent on our greatest asset – the individuals who work within the VHA system – and VHA must have the ability to recruit

the best talent, finding individuals who live by VA core values of integrity, pursuit of excellence, accountability, and collaboration, and who have a passion for the mission. To recruit the health care executive who represents a depth of expertise across the health care industry and who will ensure the system maintains its transparency and accountability, the salary structure of VHA senior health care executives must be addressed. In order to successfully recruit qualified candidates who can best meet the challenges of the health care industry, VHA's executive salary structure must be more comparable to private industry.

The executive skill sets required to lead and manage the largest integrated health care system in the United States are separate and distinct from other Federal executives, and as such, deserving of compensation more closely aligned with the private sector. These senior healthcare executives have oversight of the Nation's largest integrated healthcare delivery system within all 50 states, several U.S. territories, and the District of Columbia. Within the 21 VISNs, there are 144 VA Hospitals; 14 Health Care Centers (HCC); 186 Multi-Specialty Community-Based outpatient clinics; 568 Primary Care Community-Based outpatient clinics; 264 Outpatient Services Sites; 135 community living centers; 108 domiciliary rehabilitation treatment programs; 300 readjustment counseling centers; and 80 mobile vet centers. VHA seeks consideration of this legislative proposal to ensure that VHA is best prepared to meet and exceed the call to deliver quality health care to our Nation's Veterans.

This proposal will help to mitigate the three key factors affecting the ability of VA to attract and retain high quality, experienced senior health care executives:

1. Existing pay compression within the current SES pay system and the close proximity rates of pay within the VA system for direct reports to SES, resulting in declining SES applicant pools;
2. High number of SES employees eligible for retirement; and
3. Available private sector pay for comparable health care leadership positions.

Pay Compression. Recent changes in pay for non-Senior Executive Service (SES) VHA leaders paid under other pay systems has exacerbated the issue of pay inequity. While these recent changes have addressed much needed pay issues for these other deserving groups of senior leaders and key clinical executive leaders such as physicians, dentists, nurses and pharmacists, it has also served to highlight the pay disparity between SES and non-SES senior health care leaders throughout VHA.

The growing inequity in pay for VHA senior health care executives becomes more apparent when Medical Center Director's compensation, at an average of $168,941, is compared to that of their direct reports – medical center Associate Directors, Chiefs of Staff, and Nurse Executives. Public Law 108-445 implemented a market-based pay system for physicians and dentists. As a result, the average rate of pay for Chiefs of Staff is currently $249,844, with the highest salary at $389,471. Further, P.L.111-163 legislation provided special pay between $10,000 and $100,000 for Nurse Executives that is added to their base pay and is included in their retirement computation. The current

mean base salary for Nurse Executives is $135,943. The average salary for the Nurse Executive is $151,994 with the top salary of $201,700. For GS-15 Associate Directors, the average annual salary now stands at $135,584 with the highest salary at $157,100.

There is little to no financial incentive to progress to the position of Medical Center Director with the scope and responsibility inherent in these positions. Candidates from the ranks of Associate Directors, Chiefs of Staff and Nurse Executives are fewer and fewer because there are minimal financial incentives associated with the disruption of a geographical move and the much broader managerial span of control and responsibility.

There is also a lack of an appropriate pay differential when considering the position of VISN Network Director. Network Directors managing the largest and most complex organizations in health care with an average employment of 12,893 and annual budgets averaging $1.1 billion, earn the same, or in some cases far less, than their direct reports.

After reviewing data it has been determined that since 2012 the average salary of a person entering the SES is $152,559, with the highest salary of $181,500. The SES pay system provides for no pay differential based on the locality of the position so that in many cases, a "promotion" into the SES provides little to no actual increase in available income.

Losses due to retirement. The average age of a VHA Medical Center Director is 55, with more than 27 years of service. Fifty-two percent of Medical Center Directors/VISN Directors are now eligible for retirement. Many are several years beyond retirement eligibility, with little financial incentive for continued service to the government because of retirement benefits. Within the next two to five years, 74 percent will be eligible to retire and most will likely do so as they reach eligibility.

VHA must create competitive compensation that attracts private sector health care executives, current VHA health care executives, and VHA Title 38 clinical executives. In doing so, VHA will expand the succession pipeline and afford a bench strength that can be relied upon to fill current and future health care executive positions.

Private sector pay for comparable positions. Growing pay disparities between VHA and private sector entities make it more difficult to attract experienced individuals. Public sector executive pay is dramatically below the private sector for comparable positions. This fact is nowhere more apparent than in the health care industry where VHA competes directly with private sector health care organizations for the same labor pool.

The Healthcare Compensation Survey conducted by the Hay Group for 2013 reflects individuals holding the position of Chief Executive Officer (CEO) in private sector health care systems receive on average $731,800 annual cash compensation. CEOs of a single facility within an overall system receive an average of $393,100. SES pay rates, maximum compensation for VHA senior executives is $181,500 for 2014.

Under this proposal, compensation would continue to remain far less than that of CEOs in private sector health care systems; however, increasing the compensation of VHA

Network Directors and Medical Center Directors would acknowledge and recognize the clinical and health care expertise and experience that these health care executives provide to our Nation's Veterans.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations............	$8,813	$9,472	$9,464	$9,456	$9,451	$46,656
Collections............						
Appropriations......	$8,813	$9,472	$9,464	$9,456	$9,451	$46,656

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations............	$9,442	$9,434	$9,429	$9,420	$9,412	$93,793
Collections............						
Appropriations......	$9,442	$9,434	$9,429	$9,420	$9,412	$93,793

Veterans Transportation Service (VTS) - Transportation of Individuals to and from Facilities of the Department of Veteran Affairs

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($1,720)	$0	($1,720)	0

Proposed Program Change in Law:

VA proposes legislation to extend the authority in 38 U.S.C. 111A(a) for VA to transport any person to or from a VA facility or other place in connection with certain services and treatment. This authority was enacted in January 2013 in section 202 of Public Law 112-260 of the Dignified Burial and Other Veterans' Benefits Improvement Act of 2012. Section 401 of Public Law 114-58 recently extended this authority to December 31, 2016. This proposal would extend the authority for three years.

Current Law or Practice:

Under 38 U.S.C. 111A(a), the Secretary has the authority to transport any person to or from a VA facility or other place in connection with vocational rehabilitation, counseling, or for the purpose of examination, treatment, or care. This provision authorizes use of paid VA staff to transport Veterans and caregivers.

Justification:

Through the VTS initiative, local VA facilities have hired staff and purchased vehicles to complement existing access to care provided by volunteers. With increasing numbers of transportation-disadvantaged Veterans, there simply are not enough volunteers in all regions of the country to sustain the current level of service. Without the proposed extension to Section 111A(a), transportation of Veterans will be significantly reduced or curtailed, particularly in rural areas of the country.

During 2013, VTS provided more than 280,000 trips that totaled more than 15 million miles. The average length of a round trip is almost 60 miles—a considerable distance in some rural communities, and a prohibitive distance for those with poor health if transportation was not available.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations...........	($1,720)	($2,135)	($5,142)	$0	$0	($8,997)
Collections............						
Appropriation......	($1,720)	($2,135)	($5,142)	$0	$0	($8,997)

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations...........	$0	$0	$0	$0	$0	($8,997)
Collections............						
Appropriation......	$0	$0	$0	$0	$0	($8,997)

38 U.S.C Section 7675, Which Defines Liability for Breach of Agreement Under the Employee Incentive Scholarship Program (EISP)

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($42)	$0	($42)	$0

Proposed Program Change in Law:

VA proposes to amend 38 U.S.C Section 7675, which defines liability for breach of agreement under the Employee Incentive Scholarship Program (EISP). This proposal would amend the current public law to provide that full-time student participants in EISP would have the same liability as part-time students for breaching an agreement by leaving VA employment.

Current Law or Practice:

The current statute limits liability to part-time student participants who leave VA employment prior to completion of their education program. This allows a scholarship participant who meets the definition of full-time student to leave VA employment prior to completion of the education program and breach the agreement with no liability.

38 U.S.C Chapter 76 Section 7675 Subchapter VI as currently written states:
Breach of agreement: liability

(b) Liability during Course of Education or Training

(E) In the case of a participant who is a part-time student, the participant fails to maintain employment, while enrolled in the course of training being pursued by the participant, as a Department employee.

Justification:

This proposal would provide the same liability for both full-time and part-time students who breach their scholarship agreement by leaving VA employment. All other employee recruitment/retention incentive programs have a service obligation and liability component. This proposal would result in cost savings for the Department by recovering the education funds provided to employees who leave VA employment prior to fulfilling their agreement.

Additionally, by promoting employee retention, the costs used to recruit and train replacement employees would be avoided. The proposal provides a direct positive impact on the provision of care for Veterans by health care professionals as it retains those individuals for service in VHA.

In accordance with 38 U.S.C. Section 7671, the purpose of EISP is to "assist, through the establishment of an incentive program for individuals employed in the Veterans Health

Administration, in meeting the staffing needs of the Veterans Health Administration for health professional occupations for which recruitment or retention of qualified personnel is difficult." The current statute does not support this purpose, as it allows participants who elect full-time student status to receive the education funds and then leave VA employment with no liability for those funds. In contrast, participants who are in part-time student status, and leave VA employment, are held liable for repayment of the education funds received.

10-Year Cost Table:

$ in thousands	**2017**	**2018**	**2019**	**2020**	**2021**	**5 Year**
Obligations............	($42)	($43)	($45)	($46)	($47)	($223)
Collections............						
Appropriation.......	($42)	($43)	($45)	($46)	($47)	($223)

$ in thousands	**2022**	**2023**	**2024**	**2025**	**2026**	**10 Year**
Obligations............	($48)	($48)	($49)	($50)	($51)	($469)
Collections............						
Appropriation.......	($48)	($48)	($49)	($50)	($51)	($469)

VA Payment for Medical Foster Home (MFH)

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($8,732)	$0	($8,732)	$0

Proposed Program Change in Law:

VA proposes legislation to give VA authority to pay for Veterans' care (room, board, and caregiver services) in VA-approved Medical Foster Homes (MFHs), for Veterans who would otherwise need nursing home care. This proposal is limited in scope and is intended to cover only VA-approved MFH caregivers serving three Veterans or fewer per home. This proposal does not create general authority to cover Veterans who reside in assisted living facilities.

Current Law or Practice:

Currently, all Veterans in VA's MFH program must pay for MFH. VA does not have authority to pay for assisted living facilities except in two limited situations: the assisted living pilot program for certain Veterans with TBI authorized by section 1705 of Public Law 110-181 (38 U.S.C. 1710C note) and the authority in 38 U.S.C. 1720(g) to provide assisted living to certain Veterans with traumatic brain injury).

VA currently has authority to pay for nursing home level of care only in a nursing home that is either VA-owned or community-based. VA does not presently have the authority to pay for nursing home level of care in non-nursing home settings.

Justification:

Authorizing VA to pay for certain MFH care would result in Veterans receiving long-term care in a preferred setting, with substantial reductions in costs to the Government.

MFHs merge traditional adult foster care with comprehensive care provided in the home by a VA interdisciplinary team that includes a physician, nurse, social worker, rehabilitation therapist, mental health provider, dietitian and pharmacist. In 2000, VA launched the MFH initiative as an alternative to traditional long-stay nursing home care. So far, MFHs have demonstrated significant success in 43 states and are in development in another three states. Presently, over 600 VA-approved caregivers provide MFH care in their homes to over 700 Veterans daily nationwide, albeit paid by the Veterans themselves. For all current Veterans served in MFHs, their care needs are fundamentally no different whether they reside in a MFH or in a nursing home; however, their care needs can be met at substantially lower costs in a MFH than in a long-stay nursing home. MFH is a proven alternative in the community that allows Veterans who are referred for or currently reside in nursing homes to receive this care in a community MFH. Many more service-connected Veterans referred to or residing in nursing homes would choose MFH if

VA paid the costs for MFH. Instead, they presently choose nursing home care because VA pays the full cost of nursing home care but not for the cost of Veterans' care in a MFH.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations.............	($8,732)	($10,433)	($12,466)	($14,895)	($17,490)	($64,016)
Collections.............						
Appropriations.......	($8,732)	($10,433)	($12,466)	($14,895)	($17,490)	($64,016)

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations.............	($20,717)	($24,540)	($29,067)	($34,430)	($40,782)	($213,552)
Collections.............						
Appropriations.......	($20,717)	($24,540)	($29,067)	($34,430)	($40,782)	($213,552)

Smoke-Free Environment

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
($7,863)	$0	($7,863)	$0

Proposed Program Change in Law:

The proposal would repeal the requirement for designated smoking areas at certain VA medical facilities, as required by Public Law (P.L.) 102-585. It would also prohibit smoking on the grounds of all VA health care facilities in order to make them completely smoke-free.

Current Law or Practice:

Section 526 of P.L. 102-585, enacted in 1992, requires the Veterans Health Administration (VHA) to provide suitable smoking areas, either an indoor area or detached building, for patients who desire to smoke tobacco products.

Justification:

Currently, there are no VA health care facilities with smoke-free grounds because in 1992, P.L. 102-585 required designated smoking areas for patients. Because of this requirement, the Department of Veterans Affairs continues to fall far behind the public and private sectors in promoting smoke-free facilities. As a result, Veterans, VHA health care providers, and visitors do not have the same level of protection from the hazardous effects of secondhand smoke exposure as patients and employees in other health care systems.

For example, as of November 19, 2015, there are over 3,822 local and/or state/territory/commonwealth hospitals, health care systems and clinics and four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation) in the United States that have adopted 100 percent smoke-free policies that extend to all their facilities, grounds, and office buildings. In July 2013, the state of New York enacted a law requiring 100 percent smoke-free grounds on general hospitals and nationally, 33 municipalities have enacted laws requiring 100 percent smoke-free hospital grounds. Numerous Department of Defense (DoD) medical treatment facilities have become tobacco-free as well. In addition, on July 1, 2011, the U. S. Department of Health and Human Services (HHS) adopted a policy banning the use of all tobacco products (including cigarettes, cigars, pipes, smokeless tobacco, or any other tobacco products, and e-cigarettes) at all times on its grounds, making all facilties tobacco free. With this, HHS became the first Federal Department to implement a tobacco-free policy.

Fifty years after the landmark 1964 Surgeon General Report on the health effects of smoking, tobacco use remains the leading cause of preventable death and disease in the

United States, accounting for more deaths than HIV/AIDS, alcohol and drug abuse, automobile accidents, fires, homicides and suicides combined. Smoking is responsible for 1 in every 5 deaths or nearly 480,000 preventable deaths in the United States each year, including deaths due to secondhand smoke exposures (U.S. Surgeon General Report 2006; U.S. Surgeon General Report 2010; U.S. Surgeon General Report 2014).

Research on the health effects of secondhand smoke has greatly increased in the last two decades. In 1992, the Environmental Protection Agency (EPA) designated secondhand smoke as a Class A carcinogen and the 2006 U.S. Surgeon General Report was the first to conclude that "there is no risk-free level of exposure to secondhand smoke" (U.S. Surgeon General Report, 2006). It is estimated that exposures to secondhand smoke account for more than 3,000 deaths from lung cancer, approximately 46,000 deaths from coronary heart disease, and 430 newborn deaths from sudden infant death syndrome (SIDS) in the United States each year (U.S. Surgeon General Report, 2010).

The U.S. Surgeon General issued its 30th tobacco-related Surgeon General Report since 1964, *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease* (December 9, 2010). This report concluded that "exposure to tobacco smoke-even occasional smoking or secondhand smoke…causes immediate damage to your body that can lead to serious illness or death." The U.S. Surgeon General Report reviewed the body of clinical research to date and reported that even brief exposures to secondhand smoke can "cause cardiovascular disease and could trigger acute cardiac events, such as health attack," by causing damage to blood vessels and increased clotting.

As the Nation's largest single health caresystem and a national leader in health care, VHA has fallen far behind the health care community in this regard. This was not the case in 1992 when VHA led nationally on smoke-free policies. The medical research since that time has demonstrated the serious and sometime life-threatening consequences of secondhand smoke exposures. In a 2009 Institute of Medicine (IOM) Report, *Combating Tobacco Use in Military and Veteran Populations,* an IOM expert committee stated the requirement for smoking areas at VA health care facilities "has precluded VA from going entirely smoke-free" and it "prevents VA from protecting its patients, employees, and visitors from exposure to tobacco smoke and also hinders efforts to encourage tobacco cessation." The IOM Committee recommended that Congress provide legislation to allow VHA health care facilities to adopt smoke-free grounds.

While in the past there had been resistance to smoke-free policies, there have been a number of successes in adopting policies that may not have been accepted a decade ago. A notable example is that of North Carolina, a state that has long been recognized as a home to the tobacco industry and tobacco farming. As of July 6, 2009, all public and private hospitals in North Carolina became smoke-free. A December 2009 publication authored by policy leaders at The Joint Commission noted that at the end of 2009, the majority of U.S. hospitals would have a smoke-free campus. The article noted the Department of Veterans Affairs health care system as an exception because of legislation

that "makes it virtually impossible for VA hospitals to adopt a completely smoke-free campus" (Williams, Hafner et al. 2009).

The provisions of P.L. 102-585 that require smoking areas are not consistent with nearly two decades of medical and scientific literature that followed. An October 2009 IOM Report, *Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*, reviewed U.S. and international evidence and concluded that secondhand smoke exposure increased the risk of coronary health disease and heart attacks by 25 to 30 percent and that smoking bans reduce heart attacks. The IOM Report concluded, "Given the prevalence of heart attacks, and the resultant deaths, smoking bans can have a substantial impact on public health. The savings, as measured in human lives, is undeniable."

The clear health benefits of smoke-free policies have been supported by numerous studies to date. For example, an Indiana University study found that after a countywide smoking ban was implemented, hospital admissions for non-smokers with no other risk factors for acute myocardial infarction (MI) or heart attack dropped by 70 percent (Seo & Torabi, 2007). In addition, additional studies have found significant decreases in the rates of total admissions for heart attacks following smoke-free policies in Helena, Montana and Pueblo, Colorado. International studies have also found similar effects following the implementation of smoke-free policies in Scotland and Italy (Pell et al., 2008; Cesaroni et al., 2008; U.S. Surgeon General Report 2014).

Because of the increasing knowledge about the health effects of secondhand smoke, there have also been a number of cases where nonsmoker employees who have been harmed by such exposures have successfully filed lawsuits or disability claims against their employers. In 1995, a widower of an employee of a VA hospital was awarded a death benefit on the grounds that his wife's fatal lung cancer was caused by exposure to secondhand smoke while treating patients (CDC, 2006).

Legislation to make the grounds of all VA health care facilities smoke-free would be a Veteran-centric measure that would serve to protect the right and health of the large majority of Veterans who do not smoke. Currently, approximately 20 percent of Veterans enrolled in VA health care are smokers, while approximately 80 percent are non-smokers (VHA, 2015). Many of the non-smokers are also older Veterans, a population that may be at higher risk for underlying cardiac conditions that could make them even more vulnerable to the cardiovascular events associated with secondhand smoke exposures (CDC, 2010). As with patients of other health care systems, Veteran patients have a right to be protected from secondhand smoke exposures when seeking health care at a VA facility. For Veterans who are inpatients, nicotine replacement therapy is currently available so they would not have to experience nicotine withdrawal during hospital admissions.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Obligations...........	($7,863)	($8,013)	($8,176)	($8,345)	($8,521)	($40,918)
Collections............						
Appropriations.....	($7,863)	($8,013)	($8,176)	($8,345)	($8,521)	($40,918)

$ in thousands	2022	2023	2024	2025	2026	10 Year
Obligations...........	($8,704)	($8,894)	($9,092)	($9,297)	($9,510)	($86,415)
Collections............						
Appropriations.....	($8,704)	($8,894)	($9,092)	($9,297)	($9,510)	($86,415)

Expand VA's Income Verification Matching Authority

Dollars in Thousands ($000)			
Obligations	Collections	Appropriation	FTE
$0	$16,436	$0	$0

Proposed Program Change in Law:

The proposal would amend title 38 U.S.C. 5317 to expand VA's Income Verification Matching authority allowing VA to verify self-reported income of service-connected Veterans whom are granted waiver of deductibles for purposes of beneficiary travel under 38 CFR 70.31(c)(2) or for service-connected Veterans granted medication copayment exemption under the provisions of 38 CFR 17.110(c)(3). VA proposes inserting the following lanquage to subsection (c)(3), "section 111; and subsection (a)(3)(C) of section 1722A" before "of this title." VA also proposes amending subclause (III) of section 6103(l)(7)(D)(viii) of Internal Revenue Code of 1986 by striking, "and 1710(b) of such title" and inserting "1710(b), 111, and 1722A(a)(3)(C) of title 38, United States Code" before "; and."

Current Law or Practice:

VA currently matches self-reported income for Veterans as described in 38 USC 5317 (b)(3); "Health-care services furnished under subsections (a)(2)(G), (a)(3), and (b) of section 1710 of this title."

Justification:

Improper payments are defined as payments made in an incorrect amount, payments that should not have been made at all, or payments made to an ineligible recipient or for an ineligible purpose. The Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA; P.L. 112-248), signed into law on January 10, 2013, addressed some of the weaknesses in agency improper payment prevention controls and recovery audit

programs. IPERIA requires agencies to improve the quality of oversight for high-dollar and high risk programs and it mandates that agencies share data regarding recipient eligibility and payment amounts. In addition, IPERIA requires the Office of Management and Budget to examine the rates and amounts of improper payments that agencies have recovered and establish targets for increasing those amounts. VA's Beneficiary Travel program is a high risk program for IPERIA purposes. This expanded authority would allow VA to potentially reduce the volume of improper payments related to the beneficiary travel program.

10-Year Cost Table:

$ in thousands	2017	2018	2019	2020	2021	5 Year
Collections............	$16,436	$16,765	$17,100	$17,442	$17,791	$85,534

$ in thousands	2022	2023	2024	2025	2026	10 Year
Collections............	$18,147	$18,510	$18,878	$19,238	$19,643	$179,950

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VHA Performance Plan

Mission

Honor America's Veterans by providing exceptional health care that improves their health and well-being.

Vision

Veterans Health Administration (VHA) will continue to be the benchmark of excellence and value in healthcare and benefits by providing exemplary services that are both patient-centered and evidence-based.

This care will be delivered by engaged, collaborative teams in an integrated environment that supports learning, discovery, and continuous improvement.

It will emphasize prevention and population health and contribute to the Nation's well-being through education, research, and service in national emergencies.

Clientele

VHA serves Veterans and their families.

National Contribution

VHA supports the public health of the Nation through medical, surgical, and mental health care, medical research, medical education, and training. VHA also plays a key role in homeland security by serving as a resource in the event of a national emergency or natural disaster.

Stakeholders

Numerous stakeholders have a direct interest in VHA's delivery of health care, medical research and medical education. They include:

Veterans and their families	Academic affiliates
The White House Administration and Congress	Health care professional trainees
DoD and other Federal Agencies	Researchers
Veteran Service Organizations	Contract providers
State/County Veterans offices	VA employees
State Veterans homes	Public-at-large
Local communities	

VHA Strategic Framework

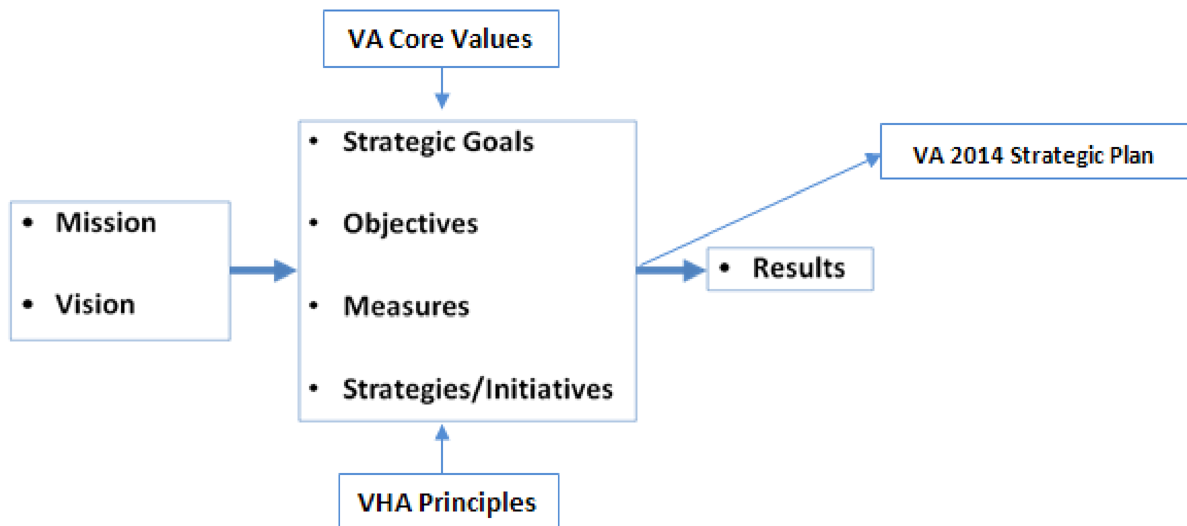
Overview

VHA's National Leadership Council (NLC) developed a strategic planning framework to accomplish its mission and achieve VA's vision, as cited above.

Strategic Framework

The VHA Strategic Framework shown below guides planning and decision-making to enable VA to provide Veterans with health care that is personalized, proactive, and patient-drive. The framework is informed by VA's Core Values of **I**ntegrity, **C**ommitment, **A**dvocacy, **R**espect, and **E**xcellence (ICARE). The framework also utilizes VHA's Principles of being Patient-Centered, Team-Based, Data-Driven/Evidence-Based and focusing on Prevention/Population Health, Providing Value, and Continuously Improving.

VHA STRATEGIC FRAMEWORK
2016-2020



Goals

VHA is charting a deliberate course to guide strategic change to assure a health care system that will define excellence in the 21st Century. The following strategic goals represent VA's strategy over the next four years to focus on personalized health care that will deliver sustained value to Veterans.

Strategic Goal #1: EMPOWER VETERANS TO IMPROVE THEIR WELL-BEING.

Strategic Goal #2: ENHANCE AND DEVELOP TRUSTED PARTNERSHIPS.

Strategic Goal #3: MANAGE AND IMPROVE VA OPERATIONS TO DELIVER SEAMLESS AND INTEGRATED SUPPORT.

Performance Measures

VHA's performance measurement system is the final component of the strategic planning framework. Fourteen performance measures have been identified that meet the strategic intent of VA's mission and vision. The performance measures cover a range of clinical, administrative, and financial actions required to support VHA's Strategic Framework.

To be included, the measure will meet the mandatory criteria:

1. Specific interest to the public

   AND

2. Collectively cover a substantial portion of the organization's budget request. The performance measures contained in the 2017 VHA Performance Plan have been screened and determined to satisfy the above criteria and are an appropriate platform for assessing VHA health care services and programs.

Performance Indicators, Historical Milestones & Agency Priority Goals	Performance Results & History			Fiscal Year Targets			Strategic Target
	2013	2014	2015	2016 (Final)	2017	2018	2021 (Target)
Medical Care – Existing Measures							
Percentage of Veterans reporting employment at a discharge from VA homeless residential programs	N/Av	42%	45%	45%	45%	TBD	TBD
Percent of participants at risk for homelessness (Veterans and their households) served in SSVF that were prevented from becoming homeless	88%	90%	84%	85%	85%	85%	85%
Percent of patients who responded "yes" on Patient Centered Medical Home survey questions that contribute to the Self-Management Support Composite (providers support you in taking care of your own health)	N/Av	57%	58%	58%	58%	59%	64%
The average patients rating VA health care on a scale from 0 to 10 (Inpatient)	N/Av	N/Av	8.6	8.75	8.8	8.8	9.03
Percent of patients who responded "Always" regarding their ability to get an appointment for needed care right away (Patient Centered Medical Home Survey)	N/Av	44%	44%	47%	48%	49%	59%
Percent of patients who respond "Always" regarding their ability to get an appointment for a routine checkup as soon as needed (Patient Centered Medical Home Survey)	N/Av	53%	52%	56%	57%	58%	67%
The average patients rating VA primary care provider on a scale from 0 to 10 on the Patient Centered Medical Home Survey	N/Av	N/Av	8.46	8.65	8.7	8.75	8.95
Mental Health Balanced Scorecard (New)	N/Av	N/Av	N/Av	(Baseline)	90% of facilities at/or above target	95% of facilities at/or above target	98% of facilities at/or above target

N/Av – Not Available ***SSVF- Supportive Services for Veterans Families***

Medical Care – New Measures							
The average patients rating VA specialty care provider on a scale from 0 to 10 on the Specialty Care Survey	N/Av	N/Av	N/Av	N/Av	(Baseline)	TBD	TBD
Percent of Specialty Care patients who responded "Always" regarding their ability to get an appointment for needed care right away	N/Av	N/Av	N/Av	N/Av	(Baseline)	TBD	TBD
Percent of Primary Care patients who responded "Always" regarding their ability to get an appointment for needed care right away	N/Av	N/Av	N/Av	N/Av	(Baseline)	TBD	TBD
Percent of Primary Care patients who respond "Always" regarding their ability to get an appointment for a routine checkup as soon as needed	N/Av	N/Av	N/Av	N/Av	(Baseline)	TBD	TBD
Percent of Specialty Care patients who respond "Always" regarding their ability to get an appointment for a routine checkup as soon as needed	N/Av	N/Av	N/Av	N/Av	(Baseline)	TBD	TBD
Patient Safety Indicator (PSI) 90	N/Av	N/Av	N/Av	TBD	TBD	TBD	TBD

N/Av – Not Available

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Selected Program Highlights

Introduction

This section provides narrative descriptions of the selected programs supported by the Veterans Health Administration (VHA). The funding levels presented in this chapter highlight these programs to provide a better understanding of programmatic services provided to Veterans. However, some programs overlap and therefore cannot be added together to determine the overall funding amount.

Selected Program Highlights

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)								
AIDS	$1,056,012	$890,747	$1,110,200	$958,820	$1,166,500	$1,225,800	$56,300	$59,300
Education and Training	$1,894,295	$1,816,718	$1,806,000	$1,924,000	$1,876,000	$1,972,000	$70,000	$96,000
Energy / Green Management	$52,310	$140,000	$46,659	$100,000	$45,000	$0	($1,659)	($45,000)
Comp. Emerg. Mgmt. Prog. (CEMP)	$147,250	$152,551	$134,580	$152,551	$138,700	$140,580	$4,120	$1,880
Gulf War Programs	$2,496,700	$2,638,669	$2,770,800	$2,940,768	$3,081,100	$3,428,000	$310,300	$346,900
Health Care Sharing:								
Services Purchased by VA	$1,060,451	$1,260,660	$1,102,869	$1,311,086	$1,146,984	$1,192,864	$44,115	$45,880
Services Provided by VA	$50,142	$53,455	$52,148	$55,594	$54,234	$56,403	$2,086	$2,169
VA/DoD Sharing:								
Services Purchased from DoD	$95,300	$108,000	$100,000	$105,000	$111,200	$110,300	$11,200	($900)
Services Provided by VA	$107,000	$114,300	$104,500	$102,400	$112,000	$100,400	$7,500	($11,600)
Health Professional Educ. Asst. Prog	$36,757	$58,736	$55,807	$64,136	$70,349	$81,485	$14,542	$11,136
Income Verification Match (IVM)	$16,540	$19,754	$18,843	$20,322	$19,079	$19,320	$236	$241
OEF/OIF/OND/OIR	$4,386,368	$4,872,900	$5,025,900	$5,485,500	$5,665,600	$6,338,400	$639,700	$672,800
Rural Health:								
Rural Health Initiative	$218,639	$250,000	$270,000	$250,000	$250,000	$250,000	($20,000)	$0
Rural Care and Outreach	$18,727,225	$19,354,594	$19,283,638	$19,826,846	$19,947,883	$20,607,250	$664,245	$659,367
Telehealth	$1,050,636	$1,223,859	$1,114,127	$1,371,974	$1,170,504	$1,225,718	$56,377	$55,215
Traumatic Brain Injury (TBI):								
TBI - All Vets	$256,169	$231,800	$271,800	$233,200	$284,100	$293,700	$12,300	$9,600
TBI - OEF/OIF/OND/OIR	$63,268	$59,300	$73,600	$59,800	$77,600	$81,500	$4,000	$3,900
Electronic Health Record/VistA	$58,652	$159,596	$90,000	$208,265	$40,000	$0	($50,000)	($40,000)
Women Veterans Health Care:								
Gender Specific Health Care	$438,825	$446,100	$475,000	$481,700	$515,400	$557,200	$40,400	$41,800
Total Care	$4,185,501	$4,659,400	$4,691,900	$5,222,200	$5,263,700	$5,890,400	$571,800	$626,700

AIDS/HIV

	2015	2016		2017		2018	Increase / Decrease	
	Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)..	$1,056,012	$890,747	$1,110,200	$958,820	$1,166,500	$1,225,800	$56,300	$59,300

The VA National Human Immunodeficiency Virus (HIV) Program ensures that Veterans with HIV infection receive the highest quality comprehensive clinical care, including diagnosis of their infection, timely linkage to care, treatment of co-morbidities, and reduction in HIV-related health disparities. The program also promotes evidence-based HIV preventive services.

In December 2015, the President updated the National HIV/Acquired Immunodeficiency Syndrome (AIDS) Strategy (NHAS). As one of the Federal agencies required to implement this strategic plan by 2020, VA has utilized the HIV Care Continuum model to assess gaps in care, from diagnosis of HIV infection and active linkage to and retention in care to initiation of antiretroviral therapy (ART) and eventual viral suppression, meaning that no detectable virus is present in the blood. As such, VA's National HIV Program, within VHA's Office of Patient Care Services, has implemented a VA-specific plan to meet the President's goals, with a particular focus on increasing HIV testing and improving linkage to care for difficult to reach patients through the use of telehealth and other technologies.

It is VHA policy that all Veterans be offered HIV testing at least once in their lifetime, with testing offered at least annually to those who have on-going risk of exposure. Multiple published studies have shown that individuals who are aware that they have HIV infection are less likely to transmit infection to others. HIV-positive individuals who are aware of their diagnosis are more likely to change their high-risk behaviors, decreasing disease transmission. Since 2009, HIV testing has almost quadrupled among Veterans in VA care to reach 35.4 percent of all Veterans in 2014, with 99 percent of those newly diagnosed getting linked to care within 90 days of their diagnosis. VA will continue to expand HIV testing, particularly for Veterans at high risk, and maintain effective linkage to care efforts.

In 2014, following regulatory action by the Food and Drug Administration and guidance from the U.S. Centers for Disease Control and Prevention, VA's Pharmacy Benefits Management Service (PBM) added the use of HIV Pre-exposure Prophylaxis (PrEP) in VA to PBM's Criteria for Use for the combination medication emtricitabine/tenofovir, which was already on the VA National Formulary. An Under Secretary for Health Information Letter providing clinical guidance on PrEP is under development and will be distributed to VA providers in early 2016. As of August 2015, over half of VA facilities offer PrEP. VA will promote the broader use of PrEP across the system and will continue to promote HIV prevention by making both male and female condoms available to all Veterans in care. VA will also encourage implementation of evidence-based HIV prevention strategies among HIV–negative Veterans, and among HIV-positive Veterans to reduce the risk of transmission to others.

VA's National HIV Program will continue to work to ensure that all Veterans diagnosed with HIV infection in VA are not only linked to care in a timely manner but are also retained in care and engaged in treatment. Under VA policy, VA providers are expected to follow U.S. Department of Health and Human Services treatment guidelines to ensure that all HIV-positive Veterans receive high quality care. All anti-retroviral medications approved by the FDA will be made available to Veterans with HIV infection.

Veterans with HIV infection suffer from high rates of medical and psychiatric co-morbidities, including mental health and substance use disorders, cardiovascular disease, renal dysfunction, and metabolic disorders. VA will continue to ensure that all Veterans with HIV infection not only receive the care they need for these conditions but also attain or exceed the standard of care in their communities. To this end, VA's National HIV Program will continue to collaborate with the VA's Office of Academic Affiliations to support a training program for clinical psychology postdoctoral fellows, with an emphasis on integrated mental health services as part of HIV and liver disease care. VA's National HIV Program will also continue to ensure that educational opportunities regarding the management and treatment of HIV infection and related co-morbidities are made available to all VA providers. Through annual data reports, the program will provide feedback to VA providers, leadership, and the public on quality indicators of HIV/AIDS care delivered to Veterans.

All HIV-positive Veterans will have equal access to ART, appropriate laboratory testing, and HIV support services. VA's National HIV Program will continue to support integrated care models that address HIV prevention, care, treatment of co-morbidities, and routine vaccination for all Veterans infected with HIV. HIV care will be provided in a manner consistent with the Patient Aligned Care Team (PACT) model being promoted in VHA.

In addition, VA's National HIV Program will work with other VA and VHA program offices to improve HIV screening rates and educational efforts in primary care, women's health, mental health and substance use programs, homelessness and jail re-entry programs, and in community-based outpatient clinics. VA's National HIV Program will also work with VHA's Office of Health Equity to reduce disparities in care for Veterans with or at risk for HIV infection. The program will also promote the use of a point-of-care clinical reminder that prompts VA providers to offer HIV testing to all Veterans.

VA's HIV Program will also support pilot quality improvement projects at VA medical facilities to develop best practices for improving HIV testing, education, and care in a variety of VA health care settings. These resources and programs will be evaluated over the next year, and those projects that achieve the intended goals will be further developed and disseminated to other facilities in VHA over the next five years.

VA's National HIV Program is committed to collaborating with other Federal agencies to ensure that HIV-positive Veterans are linked to the appropriate providers in a timely manner and receive the highest standard of care. These resources will help VHA remain a leader among health care organizations in responding to the challenges posed by the HIV/AIDS epidemic.

Education and Training - Health Care Professionals

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)								
Education and Training Support[1]	$1,043,295	$908,359	$903,000	$962,000	$938,000	$986,000	$35,000	$48,000
Trainees[2]	$851,000	$908,359	$903,000	$962,000	$938,000	$986,000	$35,000	$48,000
Total	$1,894,295	$1,816,718	$1,806,000	$1,924,000	$1,876,000	$1,972,000	$70,000	$96,000
Health Profs. Individuals Rotating thru VA								
Physician Residents & Fellows	41,534	41,682	41,888	41,871	42,200	42,400	312	200
Medical Students	22,931	21,851	22,314	22,314	22,400	22,500	86	100
Nursing Students	27,275	28,982	28,200	30,110	28,300	28,500	100	200
Associated Health Residents & Students	28,663	28,272	28,786	28,768	29,000	29,200	214	200
Total	120,403	120,787	121,188	123,063	121,900	122,600	712	700

[1] Educational supplement to the Veterans Equitable Resource Allocation (VERA) model in support of the indirect costs of VA medical centers that have clinical training programs. These funds help offset costs such as faculty time, education office staffing, accreditation costs, and space and equipment needs.

[2] Special Purpose funds that are allocated in the President's Budget to directly fund the stipends and benefits of VA clinical trainees who rotate through VA medical centers during the year.

In order to carry out the primary patient care function of VHA and to assist in providing an adequate supply of health personnel to the Nation, VA is authorized by Title 38 Section 7302 to provide clinical education and training programs for developing health professionals. VA conducts these programs in partnership with the Nation's academic institutions, and plays a leadership role in defining the education of future healthcare professionals to meet the changing needs of U.S. healthcare delivery.

In 2015, over 120,000 trainees, representing more than 40 health care disciplines, received all or part of their clinical training in VA health care facilities. Health professional trainees contribute substantially to VA's ability to deliver cost-effective, high-quality patient care for Veterans. Nearly a third of currently employed VA health professionals have received some or all of their clinical training in VA. To continue to meet its workforce needs while providing innovative, 'state of the art' Veteran care, VA has identified and expanded clinical training programs in critical areas of need as defined by the VA and VHA strategic plans, VA Secretary's priorities and the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act).

VA's physician education program is conducted in collaboration with 135 of 141 allopathic medical schools and 35 of 40 locations for osteopathic medical schools. VA is the second largest Federal supporter (after the Centers for Medicare & Medicaid Services) of education for health care professionals. In addition, more than 40 other health professions are represented by affiliations with over 1,800 unique colleges and universities. Among these institutions are Hispanic Serving Institutions, Historically Black Colleges and Universities, Asian American and Native American Pacific Islander Serving Institutions, and Native American Serving Institutions.

Energy / Green Management Program

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Advance Approp.	2017 Revised Estimate	2018 Advance Approp.	Increase / Decrease 2016-2017	Increase / Decrease 2017-2018
Obligations ($000)..	$52,310	$140,000	$46,659	$100,000	$45,000	$0	($1,659)	($45,000)

A series of Greening the Government laws and executive orders since the 1990s accelerated the need to coordinate energy, environment, vehicle fleet, and sustainable buildings policies and programs at the Department level. VA integrated these areas under the Green Management Program (GMP) Service within the Office of Asset Enterprise Management in 2006. This integration is essential in helping VA optimize and prioritize "green" investments, as well as meet requirements of laws, executive orders, and presidential memoranda. VA will reassess funding for this program during the 2018 budget cycle.

In 2015, VA successfully carried out a green management program, including the following accomplishments[1]:

- Awarded 10 energy projects for design, construction, and installation. These projects included solar and combined heat and power plants; and
- Undertook 35 contracts for commissioning, energy audits, environmental assessments, and other requirements.

From 2016 to 2018, VA plans to focus on energy-saving performance contracts and utility energy services contracts, as these require little to no up-front investment. VA will also conduct feasibility studies and implement additional renewable and alternative energy projects as funding permits. Renewable energy and combined heat and power projects will compete for appropriated funds through the Strategic Capital Investment Planning (SCIP) program. Other planned initiatives include:

- Completion of building retro-commissioning in 25 percent of VA facilities;
- Energy assessments of 25 percent of VA facilities;
- Improvements to the functionality of VA's national metering data collection and analysis system;
- Obtaining green building certification to meet sustainable building goals;
- Continued funding of facility energy managers and regional-level environmental coordinators; and
- Continued focus on Presidential goals enumerated in Executive Order 13693, such as using 30 percent renewable energy by 2025 and continued development of energy performance contracts.

[1] A total of $80 million in 2015 and $92.4 million in 2016 originally budgeted for the Green Management Program were redirected to support VA construction in 2015 and 2016.

See Chapter 9.2, Green Management Program, in Volume 4, for additional program information.

Comprehensive Emergency Management Program (CEMP)

	2015	2016		2017		2018	Increase / Decrease	
	Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)...	$147,250	$152,551	$134,580	$152,551	$138,700	$140,580	$4,120	$1,880

VA is committed to achieving the readiness necessary to meet its health care responsibilities in national emergencies in times of disaster or attack and ensuring continuity of care to its patients during any emergency. Emergency Management Strategic Health Care Group (EMSHG) manages, coordinates, and implements VHA's Comprehensive Emergency Management Program (CEMP) to help VA meet these mission requirements. CEMP includes preparedness and response actions as mandated through various Federal laws and regulations to ensure continuity of care and operation, supporting the DoD medical system in wartime, providing medical backup for national emergencies through the National Disaster Medical System, and providing support as requested under the National Response Framework.

The major components of the VHA medical emergency preparedness budget include performance improvement funds to the VA medical facilities to meet the identified gaps in emergency preparedness, provide pharmaceutical supplies, support the decontamination program, provide personal protective equipment, ensure the availability of deployable clinics and environmental safety specialists/emergency coordinators, meet training needs, and secure the continuity of operations plans for essential functions and personnel.

The major initiatives are recent programs that include Veterans Integrated Service Networks (VISN)-based patient evacuation capabilities, a Federal emergency regional coordination program, field evaluation, and contingency support for CEMP.

Challenges**:**

The Department of Veterans Affairs is experiencing a critical shortage of VA police officers throughout the health care system. Currently, the officer shortfall is 740 employees, representing sixteen percent of the full authorized force of 4,500. A review of police personnel attributed VA police staff shortages to salaries that were lower than those in other federal agencies and the private sector. In a high proportion of cases, following training and a few years of experience, VA police officers leave VA. Therefore, VA Medical Center Directors were authorized to use special pay incentives to retain current trained and qualified police staff and to hire new staff. VA hopes to strategically deploy these incentives in 2017 in order to reduce turnover and ultimately avoid some of the $27-35 million cost VA pays annually to recruit and train new VA Police positions or the $20 million VA paid in police officers' mandatory overtime in fiscal year 2015.

Gulf War Programs

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)...	$2,496,700	$2,638,669	$2,770,800	$2,940,768	$3,081,100	$3,428,000	$310,300	$346,900

VA's Gulf War Veteran programs provide a range of services, including Priority Level 6 eligibility for health care and no-cost clinical registry evaluations for Gulf War Veterans to access VA clinical care and the Gulf War Registry Program. The programs provide special clinical and diagnostic evaluations for combat Veterans with difficult-to-diagnose illnesses and world-class research on Veteran health issues. VA works to meet the special medical needs of Gulf War Veterans who served in Southwest Asia and are concerned about depleted uranium munitions or other forms of embedded-fragment wounds during combat. VA also conducts surveys of Gulf War Veterans to determine if they have any adverse health effects related to their deployment and develops effective outreach and educational tools for Gulf War Veterans with health concerns related to potential environmental exposures and their deployment.

Health Care Sharing

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Services Purchased by VA:								
Obligations ($000)...	$1,060,451	$1,260,660	$1,102,869	$1,311,086	$1,146,984	$1,192,864	$44,115	$45,880
Services Provided by VA:								
Reimbursements ($000)...	$50,142	$53,455	$52,148	$55,594	$54,234	$56,403	$2,086	$2,169

VA has been procuring health care resources with affiliated institutions and community providers based on authority included in title 38 United States Code (U.S.C.), section 8153, enacted in 1966 and last amended by the Veterans Health Care Eligibility Reform Act of 1996, Public Law (P.L.) 104-262. VA also procures health care resources using Federal Supply Schedules. These authorities are the contracting mechanism of choice for VHA and non-Department of Defense (DoD) health care entities, including medical specialists and the shared use of medical equipment. This authority, along with the use of competitive procurements, allows VHA facilities to maximize the effective use of internal and community resources to eliminate any diminution of services to Veterans. Procurements with affiliated institutions, such as medical schools, medical practice groups, and academic institutions, allow quality service and support VHA goals in education and training in accordance with 38 U.S.C. 7302. The primary goal of the VA health care system is to furnish high quality medical care to our Veterans on a timely basis and at a fair and reasonable price. All revenue generated from the sale of services is used to enhance care for enrolled Veterans.

VA/DoD Sharing

	2015	2016		2017		2018	Increase / Decrease	
	Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
VA Services Purchased from DoD:								
Obligations ($000)...	$95,300	$108,000	$100,000	$105,000	$111,200	$110,300	$11,200	($900)
VA/DoD Sharings Svcs, VA Provided:								
Reimbursements ($000)..................................	$107,000	$114,300	$104,500	$102,400	$112,000	$100,400	$7,500	($11,600)

Section 721 of the 2003 National Defense Authorization Act (NDAA), P.L. 107-314, required DoD and VA to establish a joint incentive program to identify, implement, fund, and evaluate creative coordination and sharing initiatives at the facility, intraregional, and national levels. Title 38 U.S.C., Section 8111 authorizes VA and DoD to enter into sharing agreements for the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by VHA and the Military Health System to the beneficiaries of both Departments. The obligations and reimbursements shown here are the result of over 140 sharing agreements between VA and DoD facilities; they do not reflect the funding that the two Departments contribute to the two joint VA-DOD accounts, the DoD-VA Health Care Sharing Incentive Fund and the Joint DoD-VA Medical Facility Demonstration Fund. For more information on the joint accounts, see Part 2 of this Volume.

Health Professionals Educational Assistance Program (HPEAP)

	2015	2016		2017		2018	Increase / Decrease	
	Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)								
Education Debt Reduction Program (EDRP)...	$10,500	$27,400	$23,000	$27,400	$37,400	$45,000	$14,400	$7,600
Employee Incentive Scholarship Program (EISP)......................................	$2,204	$2,000	$2,000	$2,000	$1,000	$2,000	($1,000)	$1,000
VA Nursing Education for Employees Program (VANEEP)....................	$7,944	$12,287	$12,287	$12,287	$12,287	$12,287	$0	$0
Nat'l Nursing Education Initiative (NNEI)..	$16,031	$17,049	$17,049	$17,049	$17,049	$17,049	$0	$0
Health Professional Scholarship Program (HPSP)/1................................	$0	$0	$571	$5,400	$1,713	$4,249	$1,142	$2,536
Visual Impairment Education Assistance Program (VIOMPSP)..............	$78	$0	$900	$0	$900	$900	$0	$0
Total..	$36,757	$58,736	$55,807	$64,136	$70,349	$81,485	$14,542	$11,136

1/Obligations in 2015 and 2016 for this program are funded through the Veterans Choice Act, Sec. 801

The Education Debt Reduction Program (EDRP) was authorized by the Veterans Programs Enhancement Act of 1998, P.L. 105-368 and implemented in 2002. The statute was amended by the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135), the Caregivers and Veterans Omnibus Health Service Act of 2010 (P.L. 111-163), the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146), and the Department of Veteran Affairs Expiring Authorities Act of 2014 (P.L. 113-175). P.L. 113-146 allows EDRP participants to receive education debt reduction payments up to a maximum of $120,000 for up to five years. As a result of P.L. 111-163, there is allowance for the Secretary to grant waivers to the maximum loan amount, which was extended in P.L. 113-146 from $60,000 to $120,000, for certain critical hires. In

addition, P.L. 113-175 authorizes VA to pay the lender directly on behalf of EDRP participants.

The VHA Workforce Succession and Strategic Plan ranks physicians and nurses, along with other allied health professionals, among the top ten occupations experiencing the greatest shortages, which should receive priority attention from the agency in recruitment and retention efforts. Recruitment for these positions is highly competitive nationally due to significant increased demand, insurance reform initiatives, accelerated retirements of the baby boomer cohorts, and a decreased applicant pool size.

EDRP serves as both a recruitment and retention tool. When recruitment and retention of qualified personnel is difficult, VHA has the authority to offer education debt reduction payments for employees who are in difficult to recruit/retain healthcare positions and who are providing direct patient care services or services incident to direct patient care. Local facilities prioritize hard-to-recruit and -retain occupations based on facility needs. The local facilities identify top occupations as part of the facility/VISN workforce succession strategic planning process. Currently, at the conclusion of each 12-month service period, payments are made to EDRP participants equal to the student loan payments made by the participant during the service period not to exceed the award amount for that service period. Participants receive education debt reduction payments while they remain employed by VHA in the position that was approved for EDRP for up to five years, thereby acting as a significant retention incentive. P.L. 113-175, however, authorizes VA to pay the lender directly. VHA is exploring options for automating and enhancing the program infrastructure to support direct lender payments, including the possibility of a shared service agreement with other government entities that have the existing capabilities.

While sufficient funding was available in prior years, P.L. 113-146 increased the overall limit per participant from $60,000 to $120,000. EDRP has since been heavily promoted by VA and VHA leadership to aid with hiring additional providers. To meet VHA's access needs, the Office of Workforce Management and Consulting (WMC) enrolled 969 new participants in 2015, an increase of 50 percent over the previous year's new awards and nearly 250 percent more than the new awards in 2013. In order to offer the new maximum award amount to attract critical healthcare providers and sustain the commitments to current participants, the EDRP baseline budget must be increased over the next several fiscal years to ensure sufficient funding is available.

Employee Incentive Scholarship Program (EISP) was established by title VIII of P.L. 105-368, the Department of Veterans Affairs Health Care Personnel Incentive Act of 1998, and codified in sections 7671-7675 of Title 38 U.S.C. The statute was amended by P.L. 107-135, the Department of Veterans Health Care Programs Enhancement Act of 2001, P.L. 108-170, the Veterans Health Care, Capital Asset, And Business Improvement Act of 2003, and P.L. 108-422, the Veterans Health Programs Improvement Act of 2004. EISP authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. The National Nursing Education Initiative (NNEI) and the VA Nursing Education for

Employees Program (VANEEP) are policy-derived programs that stem from the legislative authority of EISP.

EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this program includes education and training programs in fields leading to appointments or retention in title 38 or Hybrid title 38 health care positions listed in 38 U.S.C. section 7401. The maximum amount of a scholarship that may be awarded to an employee enrolled in a full-time curriculum is $38,248 for the equivalent of three years of full-time coursework. Title 38 U.S.C. section 7631 allows for periodic adjustments in the amount of assistance whenever there is a general Federal pay increase. As of September 30, 2015, VA has awarded 16,530 scholarships to EISP, NNEI, and VANEEP participants since the program started in 2000. Educational assistance awarded to date totals $246 million, which includes future obligations of $25 million through 2020.

VA Health Professional Scholarship Program (HPSP) and the Visual Impairment and Orientation and Mobility Professional Scholarship Program (VIOMPSP) were authorized under P.L. 111-163. This legislation allows VA to provide scholarship awards to VA and non-VA employees in exchange for committing to a minimum two-year service obligation with VHA in a permanent, full-time position. Section 302 directs the Secretary to institute a Visual Impairment Professional Education Assistance Program, to provide financial assistance to individuals pursuing a program of study leading to a degree or certificate in visual impairment or orientation and mobility. For VIOMPSP, each scholarship recipient would receive tuition (up to $15,000) for each year of a degree program (not to exceed a total of $45,000). HPSP allows VA to provide tuition assistance, a monthly stipend, and other required education fees for students pursuing education/training that would lead to an appointment in a title 38 or Hybrid title 38 occupation. For HPSP, each scholarship recipient would receive tuition, stipend, and other reasonable costs for each year of a graduate/training program. Regulations pertaining to VIOMPSP and HPSP became effective on September 19, 2013. Section 302 of P.L. 113-146, the Veterans Choice Act, extended the HPSP sunset date until December 31, 2019. Initial scholarships were awarded for VIOMPSP during 2015, and we anticipate continued growth in 2016. The initial offering of scholarships for HPSP will occur during 2016.

Income Verification Match (IVM)

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)								
VHA Support	$10,337	$12,640	$12,640	$13,208	$12,876	$13,117	$236	$241
IT Support 1/	$6,203	$7,114	$6,203	$7,114	$6,203	$6,203	$0	$0
Total	$16,540	$19,754	$18,843	$20,322	$19,079	$19,320	$236	$241

1/ The IT support dollars come from the Office of Information Technology (OIT) Appropriation fund.

Eligibility for VA health care services, co-pay status, and enrollment priority is based, in part, on the Veteran's financial status. VA's Health Eligibility Center Income Verification

Division verifies a Veterans' self-reported gross household income to determine their eligibility for VA health benefits. Computer-matching agreements with Internal Revenue Service (IRS) and the Social Security Administration (SSA) authorize VA to receive Federal tax information for the income verification process.

If a co-pay-exempt Veteran's income is verified as being above the applicable income threshold, the Veteran and the site(s) where the Veteran received care are notified and the Veteran is billed for co-pays for medical care received during that particular income year. Additionally, the Veteran's enrollment status may be impacted as a result.

Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) / Operation New Dawn (OND) / Operation Inherent Resolve (OIR)

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)	$4,386,368	$4,872,900	$5,025,900	$5,485,500	$5,665,600	$6,338,400	$639,700	$672,800
Unique Patients	770,452	844,695	849,327	916,292	922,664	995,196	73,337	72,532
Cost Per Patient	$5,693	$5,769	$5,918	$5,987	$6,140	$6,369	$223	$229

Note: OEF/OIF/OND/OIR obligations reflect the total cost of medical care, including outreach services that are documented as medical encounters. These obligations do not include benefits or Readjustment Counseling.

VA provides medical care to military personnel who served in OEF/OIF/OND/OIR. Veterans deployed to combat zones are entitled to five years of eligibility for VA health care services following their separation from active duty, even if they are not otherwise eligible to enroll in VA. VA is committed to ensuring a continuum of care for our injured Servicemembers and supports ongoing efforts to continuously improve this process while providing the necessary care to these returning Servicemembers. VA's outreach network ensures that returning Servicemembers receive full information about VA benefits and services. Each medical center and benefits office now has a point of contact assigned to work with returning OEF/OIF/OND/OIR Veterans who represent 13 percent of the overall VA patients served.

Rural Health

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)								
Rural Health Initiative	$218,639	$250,000	$270,000	$250,000	$250,000	$250,000	($20,000)	$0
Rural Care and Outreach	$18,727,225	$19,354,594	$19,283,638	$19,826,846	$19,947,883	$20,607,250	$664,245	$659,367

Rural Health Initiative obligations are intended to improve the delivery of health care services to Veterans living in rural areas of the United States. These funds may be allocated as specific purpose funding for the Office of Rural Health (ORH), whose mission is to improve the health and well-being of rural Veterans by increasing their access to care and services.

ORH focuses on four strategic goals:

1) Promote health and well-being in the rural Veteran population;
2) Generate and diffuse knowledge regarding rural Veteran health;
3) Strengthen community health care infrastructure where rural Veterans reside; and,
4) Inform health care policy that impacts rural Veterans and rural health care delivery.

The attainment of these goals has resulted in the identification and implementation of:

- Workforce recruitment and retention initiatives;
- Expanding the use of distance learning for providers who care for rural and highly rural Veterans;
- Accelerating and expanding Telehealth opportunities through enterprise-level solutions such as the National Teleradiology Program, Tele-Intensive Care and comprehensive TeleStroke care;
- Operating the Veterans Rural Health Resource Centers to support rural care delivery innovations, studies, and the mentored implementation of Rural Promising Practices; and,
- Collaborating with Federal and non-federal community partners to expand access to care for rural Veterans.

Rural Health Funding Plan

Obligations by Activity ($000)	FY 2016	FY 2017
Enterprise Wide Rural Access Solutions	$48,950	$72,500
ORH Rural Promising Practices	$8,500	$9,500
Rural Innovation in Delivery of Care	$161,800	$161,000
Sustainment of ORH Veterans Rural Health Resource Centers	$6,400	$7,000
Other*	$44,350	$0
Total	**$270,000**	**$250,000**

*Includes Project Access Received Closer to Home (ARCH), Study and Grants for Construction of State Extended Care Facilities and Impact Analysis Study of the Veterans Choice Program.

Enterprise-Wide Rural Access Solutions

ORH funds these projects in collaboration with other VHA Program offices, pursuing system-wide innovation to increase access to care and services for Veterans living in rural areas of the United States.

ORH Rural Promising Practices

ORH identifies Rural Promising Practices based on ORH-funded pilot programs that successfully innovated in the delivery of care and services to rural Veterans. ORH Rural Promising Practices demonstrate increased rural access to care while maintaining or increasing quality of care for rural Veterans.

ORH will support the USH initiative to identify Promising Practices in access improvements at facilities serving rural Veterans through mentored implementation by USH Promising Practices Fellows.

In 2016, 6 Rural Promising Practices will be implemented at over 60 sites nationwide. ORH Rural Promising Practices are aggressively disseminated through mentored implementation by ORH's Veterans Rural Health Resource Centers, who provide project management, technical guidance, subject matter expertise and practice adoption materials for each participating site. The 6 ORH Rural Promising Practices funded for mentored implementation in 2016 are:

1) Telephone-Based Home Cardiac Rehabilitation is a program in which rural Veterans with heart disease are contacted by an exercise physiologist weekly and counseled on exercise, nutrition, smoking cessation, medication adherence, stress management, and steps towards leading a heart healthy lifestyle.

2) Telehealth Collaborative Care for Rural Veterans With HIV Infection integrates local primary care with specialized HIV care delivered via clinical video Telehealth (CVT), creating a shared care delivery model.

3) CVT to Provide Comprehensive Care to Rural Veterans with Multiple Sclerosis (MS) delivers comprehensive care, including physical therapy by CVT, to rural Veterans with MS, thus improving Veterans access to the most effective treatment available for this disease.

4) The Rural Clergy Training Program educates rural community clergy about the physical, mental, and social challenges faced by returning Veterans and their families. Through these training sessions, clergy learn how to create a Veteran support network in their community and how to refer Veterans to the VA for health care services and benefits.

5) The Geriatric Scholars Program is collaboration among ORH, the Geriatric Research Education Clinical Centers (GRECC), the Office of Geriatrics/Extended Care, the VHA Employee Education System (EES), the Indian Health Service (IHS), and academic affiliates. The Geriatric Scholars Program provides a longitudinal, blended format, multi-modal education and training experience to develop geriatric service competencies in VA's rural primary care workforce.

6) Connecting Older Veterans to Community or Veteran Eligible Resources Program provides older, rural Veterans and their caregivers with information on VA benefits, eligibility, application processes, and application process assistance.

Rural Innovation in Delivery of Care

Existing ORH-funded innovation projects that were previously reviewed, approved, and funded under the fiscal year 2015 Request for Proposals (RFP) process were eligible to apply for sustainment funding in 2016 and 2017. Projects entering their second, third, or fourth year of funding that demonstrated satisfactory project progress and reporting compliance were considered for sustainment funding to further explore innovative models of clinical care delivery to improve access for rural Veterans.

These projects support VA's enterprise-wide effort to support field innovation in health care delivery through a network of Innovation Sites and innovation technical assistance via the VA Center for Innovation.

Sustainment of ORH Veterans Rural Health Resource Centers

ORH Veterans Rural Health Resource Centers (VRHRC) are required by Public Law 112-154, section 110 to perform the following functions:

1) Improve understanding of the challenges faced by Veterans living in rural areas;
2) Identify disparities in the availability of health care to Veterans living in rural areas;
3) Formulate practices or programs to enhance the delivery of health care to Veterans living in rural areas; and
4) Develop special practices and products for the benefit of Veterans living in rural areas and for implementation of such practices and products in the Department system-wide.

To accomplish these functions in fiscal years 2016 and 2017, ORH VRHRCs collaborate with stakeholder organizations serving rural Veterans within rural communities; conduct studies to identify and understand challenges to and disparities in rural Veteran care and services in order to inform national-level policy; innovate rural access solutions; and provide project management, technical assistance and implementation mentoring to assist VA sites across the country in adopting ORH Rural Promising Practices.

In 2017, ORH will continue to address the unique needs of approximately three million enrolled Veterans living in rural and highly rural areas, who make up 33 percent of all Veteran enrollees. ORH collaborates with a range of internal and external stakeholders to implement and evaluate enterprise-level rural access solutions through ORH's Rural Promising Practices program and other national-level innovations in rural care and services delivery. Through these data-driven and collaborative processes, ORH translates study findings and best practices into policy and facilitates broader execution among established VA program offices.

ORH continues to collaborate internally with a broad range of partners, including the Office of Academic Affiliations, Office of Connected Health, Office of Specialty Care Transformation, Office of Geriatrics and Extended Care, Veterans Transportation Program, Center for Women Veterans, and others to improve the provision of primary and specialty care to Veterans living in rural and highly rural areas, as well as enhance educational opportunities for providers and medical staff in rural communities. ORH collaborates with other federal agencies, including the U.S. Department of Agriculture and the Department of Health and Human Services to extend and improve access to health care services to rural and highly rural Veterans.

Telehealth

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)								
Home Telehealth /1	$218,208	$227,529	$227,630	$239,104	$239,414	$247,528	$11,784	$8,114
Rural Telehealth Services Projects (Specific Purpose)	$71,747	$73,204	$73,204	$73,204	$73,204	$73,204	$0	$0
Rural Telehealth Medical Services /2	$254,794	$357,630	$277,843	$416,946	$300,117	$323,651	$22,274	$23,534
Non-Rural Telehealth Medical Services /2	$256,450	$309,604	$279,557	$386,828	$301,877	$325,443	$22,319	$23,567
Telehealth	$208,945	$213,187	$213,187	$213,187	$213,187	$213,187	$0	$0
Other Specific Purpose (Telehealth) /3	$10,492	$10,705	$10,705	$10,705	$10,705	$10,705	$0	$0
Teleradiology (Diagnostic Services)	$30,000	$32,000	$32,000	$32,000	$32,000	$32,000	$0	$0
Total Telehealth	**$1,050,636**	**$1,223,859**	**$1,114,127**	**$1,371,974**	**$1,170,504**	**$1,225,718**	**$56,377**	**$55,215**

1/ Also displayed under Non-Institutional Long-Term Services and Supports in the Medical Services chapter.

2/ Includes primary care, health promotion, mental health, specialty care, diabetes and retinal screening, dermatology, EKG, and other clinical Telehealth.

3/ Palo Alto Telehealth Centers.

Telehealth delivers health care services remotely to patients, from clinicians situated at different geographic locations. Its value proposition lies in: increasing access to care, especially in rural and remote locations; making expert advice more available to Veterans; and reducing the costs and inconvenience of their travel. VA increasingly uses Telehealth to reach Veterans in rural communities that are medically underserved. In 2015, VHA Telehealth Services provided 2.1 million consultations to more than 677,000 Veterans, 45 percent of whom were in rural areas. In addition to direct support of ambulatory care services for Veterans in rural clinics, Telehealth maintains the viability of many small rural VA medical centers, ones where core services would be impossible to sustain without access to remote expertise such as Tele-Intensive Care, TeleAudiology, TelePathology, TeleRetinal Imaging, TeleTransplant, TeleDermatology and TeleMental Health. Telehealth funding supports the critical clinical, technological, and administrative infrastructures necessary for VA to successfully deliver this volume of virtual care services to Veterans safely and cost-effectively. In 2017, VA expects to deliver Telehealth-based services to 762,000 Veterans.

Priorities

The program office responsible for Telehealth in VA is VHA's Telehealth Services, within the Office of Patient Care Services. In 2017, priorities for Telehealth Services are: serving 762,000 Veterans by sustaining and expanding services developed in 2016;

creating innovative new programs; an ongoing focus on increasing access to underserved rural populations; and monitoring the quality of clinical care to ensure its continued excellence. Currently Telehealth services in VA are provided via three modalities that are distinguishable by the care they offer, and the technology platforms that support them. These modalities are: Clinical Video Telehealth (CVT), Home Telehealth (HT) and Store and Forward Telehealth (SFT).

Areas of clinical care that new Telehealth program development in 2017 will focus on to address priority areas of Veteran care include:

- TeleMental Health, including National Specialist Networks (see TeleMental Health subsection under Strategy)
- Clinical Video Telehealth expansion to Veterans in their homes
- TeleAudiology
- TelePathology
- TeleICU Services
- TeleStroke
- TeleWound Care
- Home Telehealth model for Veterans with low-complexity healthcare needs
- Women's Telehealth for gynecology, reproductive health and mental health
- TelePulmonology, including TeleSpirometry
- TeleRetinal Imaging for macular degeneration
- TeleTransplant
- TeleSurgery for pre- and post-operative care
- TeleCardiology
- TeleNeurology
- Telehealth expansion with non-VA sites to improve Veterans' access to care, to include but not limited to the DoD and Indian Health Service.

Through its sustainment/expansion of existing Telehealth services, and focus on new service development, VHA expects 12 percent of Veterans to receive an element of their healthcare via Telehealth (CVT, HT and SFT) during 2017.

Overall Telehealth Strategy

Accomplishing VA's Telehealth goals requires complex coordination of the associated clinical, technology, telecommunications, training and other supportive arrangements. VHA Telehealth Services monitors and project manages areas of routine operations and development to ensure Telehealth programs deliver high quality services on robust infrastructures appropriate to expected levels of patient care. Core functions VHA Telehealth Services performs in support of this are:

- Strategic planning for Telehealth;
- Integration of telehealth with other virtual care modalities;
- Enterprise program management;

- National contracting and technology support, to include national service and warranty agreements for Telehealth equipment;
- National telehealth training, operations manuals, support for competency testing and related resources;
- Organizational development support for Telehealth programs;
- National quality and performance management, business processes and related reports; and
- Enterprise-level coordination with other VA/VHA program offices and internal and external organizations.

Traumatic Brain Injury (TBI) and Polytrauma

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)								
TBI - All Veterans	$256,169	$231,800	$271,800	$233,200	$284,100	$293,700	$12,300	$9,600
TBI-OEF/OIF/OND/OIR	$63,268	$59,300	$73,600	$59,800	$77,600	$81,500	$4,000	$3,900
Unique Patients - TBI-All Veterans	79,991	85,362	89,197	92,550	97,728	106,473	8,531	8,745
Unique Patients - TBI-OEF/OIF/OND/OIR	36,726	38,758	42,727	41,766	47,137	52,043	4,410	4,906

*VA estimates the ten-year cost (2017-2026) to be $3.3 billion for TBI-All Veterans and $0.9 billion for TBI-OEF/OIF/OND/OIR Veterans.

VA's Polytrauma System of Care (PSC) is the largest integrated system of care dedicated to the medical rehabilitation of Veterans and Servicemembers with combat and non-combat related traumatic brain injuries (TBI) and polytrauma. PSC encompasses specialized rehabilitation programs at 110 medical facilities across the VA. These programs are organized into a four-tier system that ensures access to the appropriate level of rehabilitation services based on the needs of the Veteran and Servicemember.

PSC has five regional Polytrauma Rehabilitation Centers (PRC) that serve as regional referral centers for acute medical and rehabilitation care and as hubs for research and education; 23 Polytrauma Network Sites that coordinate polytrauma services within the Veterans Integrated Service Networks; 87 Polytrauma Support Clinic Teams (PSCTs) providing specialized evaluation, treatment, and community re-integration services within their catchment areas; and, 39 Polytrauma Points of Contact (PPOC) that provide a more limited range of rehabilitation services and facilitate referrals to the other PSC programs, as necessary.

VA's medical rehabilitation services for TBI and polytrauma are provided in partnership with Veterans and their families, and address the goals of recovery and community re-integration. They include:

- Mandatory TBI Screening for possible TBI for all Veterans of combat operations in Iraq and Afghanistan, upon their initial entry into VA for services – Veterans with positive screening results are offered referral for a comprehensive evaluation with specialty providers.

- Veterans with TBI requiring rehabilitation services receive an Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care – the computerized IRCR Plan of Care documents physical, cognitive, mental health and vocational problems that may affect the Veteran's progress toward successful community re-integration and outlines Veteran-directed goals for addressing those issues. The functional status of Veterans with an IRCR Plan of Care is measured using a validated tool that allows rehabilitation teams to track changes and to provide appropriate interventions at the right time to maximize the Veteran's independence and restore physical and cognitive function.

- Integrated interdisciplinary team approach to care – VA includes specialists from psychiatry, nursing, psychology, social work, physical therapy, occupational therapy, speech-language pathology, recreational therapy, and other disciplines, as appropriate for the individual needs of the patient.

- Collaborative decision-making process – decisions regarding the provision of rehabilitation services are made by the medical provider in collaboration with the Veteran and his/her family based on their individually-assessed needs.

- VA rehabilitation outcomes meet or exceed benchmarks – outcomes data collected in PSC programs show that Veterans with TBI and polytrauma that receive rehabilitation in VA meet or exceed external non-Veteran benchmarks in functioning, community participation, and satisfaction with life. These outcomes reflect the outstanding rehabilitative care, prosthetic services, benefits, and adaptive modifications to the home and automobile that help Veterans with these severe disabilities overcome common obstacles to achieve personal independence, positive life adjustment, and opportunities in meaningful areas of life.

- PSC partners with other VA services – PSC provides access to a broad continuum of rehabilitation services for TBI and polytrauma, from acute inpatient rehabilitation to sub-acute and transitional rehabilitation, outpatient care, adult day programs, home based care, and community living centers.

- PSC collaborates with specialists in the DoD, academia, and private sector to develop and deploy clinical practice guidelines, consensus positions and guidance on best practices – VA/DoD Clinical Practice Guidelines (CPG) for the management of mild TBI have been widely disseminated to VA rehabilitation providers through educational and training opportunities and reinforced through information technology solutions in the computerized medical record. These CPGs were updated in 2015 and will be disseminated in 2016.

PSC leads the Nation in advancing rehabilitation care for TBI and polytrauma. Recent developments in the PSC include:

- Integration with the VA Amputation System of Care to provide acute and long-term medical, rehabilitation and prosthetic needs for individuals with amputations;
- Assistive Technology Labs at the PRCs offering comprehensive evaluation, prescription and training for the use of technology to optimize the Veterans' independence and community participation goals;
- Emerging Consciousness Programs at the PRCs serving Veterans and Servicemembers who are slow to recover consciousness after severe brain injuries; and,
- Expanding Tele-rehabilitation services to include standardized protocols for remote TBI evaluation, devices for in-home monitoring of TBI symptoms, and the upcoming release of the TBI Coach, an app for the self-management of TBI symptoms.

Since 1982, VA has provided acute rehabilitation services for Veterans and military Servicemembers with TBI, amputations, and severe complex injuries secondary to accidents and service-connected incidents (e.g., combat operations, other missions, training, etc.). As current combat operations subside, VA will continue to maintain the PSC to provide comprehensive evidenced-based rehabilitation services to improve and maintain the physical and cognitive function of all patients in its care. VA continues to study the results of the pilot program providing assisted living services to eligible Veterans with TBI, as authorized by P.L. 110-181 and extended by the Choice Act. This study will assess how the pilot impacted rehabilitation, quality of life, and community reintegration of Veterans with TBI.

Electronic Health Record Interoperability and Veterans Integrated System Technology Architecture (VistA) Evolution

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)..	$58,652	$159,596	$90,000	$208,265	$40,000	$0	($50,000)	($40,000)

VistA Evolution is a joint program of the VA Office of Information and Technology (OI&T) and VHA, supporting VA providers delivering Veteran-centric, team-based, quality-driven care. Through coordinated improvements to VA's electronic health record system, scheduling system, population health and operational analytics, and point of care workflows, VistA Evolution is focused on optimizing access to care based on Veteran preference and clinical need. Tools delivered by the program will also help VA care teams work more efficiently, creating greater elasticity to respond to demand for VA services.

VistA 4 Vision:

VA established the VistA Evolution program to deliver modernized VistA capabilities based on open standard, open architecture, non-proprietary designs. VistA 4 is the first segment of the program, with deliverables through 2018. VistA 4 leverages open standards endorsed by the Office of the National Coordinator, and adheres to key open

architecture tenets such as open transport formats, open interface specifications, and design patterns enabling robust, scalable solutions. VistA 4 will deliver interoperable, effective, safe, and efficient health information technology that improves the lives of Veterans.

The enterprise Health Management Platform (eHMP) is a key deliverable for VistA 4. eHMP is a new clinical data services and application platform for VistA, which integrates Veterans' health information from all available VA, DoD and community health partner sources. eHMP will provide modern decision support, activity management, support for interoperable care plans, and other advanced features in a Veteran-centric record. eHMP will ultimately replace the Computerized Patient Record System (CPRS) as VA's primary point of care application.

VistA 4 will provide support for new models of care. Historically, VA has employed a physician-centric, locally oriented, face-to-face encounter model of care. This model has been effective in many respects, and Veterans in the system are typically satisfied with the quality of care they receive. Limitations of this model include systemic inefficiencies in maximizing the potential of all care team members, resource bottlenecks created by physician-centric encounters, and limited application of population health management strategies. These limitations have led VA to develop new models of care, centered on patient-aligned care teams. In order to manage access based on clinical need, VA needs to fully implement these new models. This includes adopting a Veteran-centric, team-based, quality-driven model, supported by appropriate enabling technology.

VistA 4 will enable a team-based care model. Over the past several years, VA has moved slowly toward full implementation of a team-based care model, in which care team members work together to engage Veterans using multiple encounter modalities. These modalities include traditional face-to-face visits, but may also include secure messaging, phone calls, Telehealth encounters, text messaging, and other technology enabled communications. For the team to work effectively, team members need the appropriate technology to communicate with each other and Veterans (Veterans are key members of their own care team), and assign and follow up on team tasks.

VistA 4 will provide software to support interoperable, Veteran-centric care plans. Effective implementation of team-based care also requires a Veteran-centric care plan. The care plan ensures Veterans' goals and preferences are identified and respected, and helps the team coordinate care on appropriate clinical pathways. The care plan must be interoperable between all VA facilities, and ideally between VA, DoD, and community providers as well. This ensures continuity of care regardless where a Veteran is seen, and helps VA provide consistent, high quality services.

Modern decision support is critical for efficient, optimal administration of best practices and quality care, and will be provided in the VistA 4 program through eHMP. Modern decision support tools incorporated into VA's Health Information Technology (HIT) platforms will ensure Veteran care is managed on appropriate evidence based clinical pathways. Sophisticated decision support and clinical information content services can be used together to proactively assist team members in providing high quality care. Errors of

omission, or "misses," such as necessary follow-up activities based on test results or evidence based guidelines, can be substantially reduced or eliminated.

VA seeks to adopt "lean" models of excellence, and requires software to support clinical process modernization, and enable efficiencies. Realizing maximum benefit and efficiency from new models of care requires creating a health care system in which resources (providers, facilities, and clinical time) are optimally provisioned. Reflecting key clinical priorities in both individual and cohort care across the national VA system requires close integration between clinical workflow, reasoning systems, and analytics in the HIT platform. These integrated capabilities must be optimized using Lean Six Sigma type processes to increase point-of-care efficiency and clinical capacity. Software development efforts within eHMP and other VistA 4 projects will support Lean management objectives.

There is currently no capability that allows appointments to be effectively prioritized. All appointments are treated with the same level of urgency, which is not conducive to providing the most critical need patients with immediate care, and more appropriately scheduling patients who do not require immediate attention. Clinical prioritization will allow for better care management, and better management of scarce resources. Development in VistA 4 will support access prioritization based on clinical need.

There is considerable variability across the dimensions of access (geographic, timeliness, financial, digital, and cultural) for care in VA today. There is no mechanism for communicating best practices, or consistently identifying and standardizing best practices of care. No tools exist for population health management, or identification of optimal interventions. It is not uncommon for unique service-related conditions, which do not as commonly affect general civilian populations, to manifest in large groups of Veterans. Many times, best practices, new interventions, therapies, and treatments evolve as generations of Servicemembers and Veterans begin exhibiting symptoms. Communities of care providers treating these conditions, such as PTSD, TBI, poly-trauma, amputated limbs, Agent Orange-related conditions, should have a means of communicating care paths among an individual's care team. Successful initiatives should be shared enterprise wide, and in the worldwide community seeking to help patients with similar conditions. Development investment in eHMP, and clinical terminology, and business process reengineering and training will support platforms enabling communication and implementation of best practices.

2015 Accomplishments:

- ***Enterprise Health Management Platform (eHMP), major milestones:***
  - Completed development work for the enhanced viewer with condition-based analysis and user-defined workspaces;
  - Initiated development of the next version (v. 1.3), which will offer basic outpatient encounter write-back with patient-centric goals and data;
  - Conducted and delivered Immunization Gap analysis for the eHMP

  - project; and
  - Initiated Data Cache Optimization Architectural Design analysis.

- ***Enterprise Messaging Infrastructure (eMI):***
  - Successful deployment of the system at the Captain James A. Lovell Federal Health Care Center (JAL FHCC); and
  - Achieved Full Operating Capability (FOC), establishing JAL FHCC as the first site to successfully use eMI in production.

- ***VistA Enhancements (VSE):***
  - Tested a Graphical User Interface (GUI) for the Legacy VistA Scheduling Enhancements at 10 sites;
  - Completed standardization and enhancements of nationally-deployed VistA Immunization code; and
  - Established a method for automatic review of test results based on lab-established set of boundaries (Rules).

- ***File Manager:***
  - Agile planning was completed for security enhancements (role-based and context-based access), enhanced meta-data dictionary, and the use of extensible data types.

***<u>2016 Goals</u>*:**

1) Achieve interoperability consistent with the requirements of 2014 National Defense Authorization Act (NDAA).

2) Deliver enhanced EHR consistent with FY2014 NDAA.

3) Complete enhancements in the following areas:
   - *Medication Order Check Healthcare Application (MOCHA 2), Full Operating Capability* – The MOCHA Clinical Decision Support system provides enhanced order checking functionality for orders placed through the Computerized Patient Record System (CPRS) and VistA Pharmacy.

   - *Pharmacy Enterprise Customization System (PECS), Full Operating Capability* – The PECS component provides the tools for customization of the drug database information to enable improvements in patient safety.

   - *Safety Updates for Medication Prescription Management (SUMPM), Full Operating Capability* – The SUMPM project specifically addresses enhancement requests related to Pharmacy Legacy applications. The enhancements provided by this project address patient safety issues, legislative/ regulatory changes, and user/site requested changes that enhance productivity, reduce costs, and/or improve the ability to provide care.

- *Pharmacy Safety Updates, Additive and IV Strength, Full Operating Capability* **–** This project addresses patient safety issues relating to VistA Outpatient and Inpatient Pharmacy by associating the appropriate IV additive with the correct orderable item and dosage strength property, and by providing the capability within VistA Pharmacy to allow a greater than 90-day fill for specified medications.

- *VistA Immunizations Enhancements (VIMM 2.0), Initial Operating Capability Exit* **–** VIMM 2.0 will modify existing Immunization functions enabling VA to quickly and reliably document and exchange standardized immunization information on beneficiaries across services and departments. Additionally, modifications will support read/write/exchange with decision support for vaccines capability for coded immunizations data that is integrated into eHMP and certification for Meaningful Use (C/MU).

- *VistA Application Programming Interface (API) Exposure 2.0, Full Operating Capability* – This project is an infrastructure support project developing and testing Service Oriented Architecture (SOA) compliant enterprise.

- *VistA Services Assembler (VSA) Phase 2, Enterprise Availability* – VSA provides the basic functionality and infrastructure necessary to support development, deployment and operations of VistA services.

- *VistA Scheduling Enhancements, Full Operating Capability* – This project provides critical, near-term enhancements to VA's existing scheduling system.

Women Veterans Health Care

		2016		2017		2018	Increase / Decrease	
	2015 Actual	Budget Estimate	Current Estimate	Advance Approp.	Revised Estimate	Advance Approp.	2016-2017	2017-2018
Obligations ($000)								
Gender-Specific Health Care	$438,825	$446,100	$475,000	$481,700	$515,400	$557,200	$40,400	$41,800
Total Care	$4,185,501	$4,659,400	$4,691,900	$5,222,200	$5,263,700	$5,890,400	$571,800	$626,700
Gender-Specific Unique Patients*	258,516	268,594	271,133	281,226	285,068	298,723	13,935	13,655
Women Veterans Total Unique Patients	447,333	476,353	474,367	505,282	502,863	532,004	28,496	29,141

*Included in Women Veterans Total Unique Patients.

Women comprise 15 percent of today's active duty military forces and 18 percent of National Guard and Reserves. Correspondingly, women are enrolling for VA health care at record levels: the number of women Veterans using VA health care has doubled since 2001. Based on the upward trend of women in all service branches, the continued withdrawal of troops from Afghanistan, the decision to allow women in combat roles, and the increased number of women choosing VA for healthcare, the expected number of women Veterans using VA health care will rise rapidly, the complexity of injuries of

returning troops is likely to increase, and the cost associated with their care will grow accordingly.

VA is improving access, services, resources, facilities, and workforce capacity to make health care more accessible, more sensitive to gender-specific needs, and of the highest quality for the women Veterans of today and tomorrow. VA specifically wants to ensure that every eligible woman Veteran receives high-quality comprehensive care that includes reproductive health care (such as maternity and gynecology care) and treatment for all gender-specific conditions and disorders, as well as mental health care, basic preventive care, acute care, and chronic disease management.

Most importantly, deployed women are sustaining injuries similar to those of their male counterparts, both in severity and complexity. VA is anticipating and preparing not only for the increase in the number of women Veterans but also for the accompanying complexity and longevity of treatment needs they will bring with them. Security and privacy for women Veterans is a high priority for VA. VA is training providers and other clinical staff, enhancing facilities to meet the needs of women Veterans, and reaching out to inform women Veterans about VA services. VA has implemented women's health care delivery models of care that ensure women receive equitable, timely, high-quality primary health care from a single primary care provider and team, thereby decreasing fragmentation and improving quality of care for women Veterans.

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*Fiscal Years include Medical Services, Medical Support & Compliance, Medical Facilities, VACAA Sections 801 and 802 unless otherwise noted.

2015 Obligations by Object

(dollars in thousands)

Description	Services Non 801/802	Services VACAA 801	Subtotal Services	S&C Non 801/802	S&C VACAA 801	Subtotal S&C	Facilities Non 801/802	Facilities VACAA 801	Subtotal S&C	Total Non 801/802	Total VACAA 801	Medical Care Total	VACAA 802 Total	Grand Total
10 Personnel Compensation and Benefits:														
Physicians	$5,492,742	$187,521	$5,680,263	$178,604	$96	$178,700	$10	$0	$10	$5,671,356	$187,617	$5,858,973	$0	$5,858,973
Dentists	$247,526	$5,329	$252,855	$3,634	$0	$3,634	$0	$0	$0	$251,160	$5,329	$256,489	$0	$256,489
Registered Nurses	$6,290,627	$130,316	$6,420,943	$371,838	$4	$371,842	$118	$0	$118	$6,662,583	$130,320	$6,792,903	$150	$6,793,053
LP Nurse/LV Nurse/Nurse Assistant	$1,637,811	$25,774	$1,663,585	$4,233	$0	$4,233	$324	$0	$324	$1,642,368	$25,774	$1,668,142	$0	$1,668,142
Non-Physician Providers	$1,831,219	$62,132	$1,893,351	$30,841	$0	$30,841	$18	$0	$18	$1,862,078	$62,132	$1,924,210	$0	$1,924,210
Health Technicians/Allied Health	$6,126,249	$82,575	$6,208,824	$118,091	$0	$118,091	$7,303	$0	$7,303	$6,251,643	$82,575	$6,334,218	$0	$6,334,218
Wage Board/Purchase & Hire	$313,192	$155	$313,347	$58,315	$0	$58,315	$1,229,812	$0	$1,229,812	$1,601,319	$155	$1,601,474	$0	$1,601,474
All Other	$2,214,436	$68,566	$2,283,002	$3,701,332	$310	$3,701,642	$386,593	$0	$386,593	$6,302,361	$68,876	$6,371,237	$2,085	$6,373,322
Permanent Change of Station	$4,076	$50	$4,126	$8,030	$0	$8,030	$840	$0	$840	$12,946	$50	$12,996	$0	$12,996
Employee Compensation Pay	$155,402	$149	$155,551	$39,760	$0	$39,760	$33,622	$0	$33,622	$228,784	$149	$228,933	$0	$228,933
Subtotal	$24,313,280	$562,567	$24,875,847	$4,514,678	$410	$4,515,088	$1,658,640	$0	$1,658,640	$30,486,598	$562,977	$31,049,575	$2,235	$31,051,810
21 Travel & Transportation of Persons:														
Employee	$32,099	$2	$32,101	$40,716	$2	$40,718	$2,741	$0	$2,741	$75,556	$4	$75,560	$0	$75,560
Beneficiary	$852,797	$0	$852,797	$56	$0	$56	$20	$0	$20	$852,873	$0	$852,873	$10,303	$863,176
Other	$29,742	$0	$29,742	$3,407	$0	$3,407	$30,286	$0	$30,286	$63,435	$0	$63,435	$0	$63,435
Subtotal	$914,638	$2	$914,640	$44,179	$2	$44,181	$33,047	$0	$33,047	$991,864	$4	$991,868	$10,303	$1,002,171
22 Transportation of Things	$18,027	$26	$18,053	$10,034	$0	$10,034	$14,058	$0	$14,058	$42,119	$26	$42,145	$0	$42,145
23 Rent, Communications, and Utilities:														
Rental of Equipment	$134,209	$484	$134,693	$43,215	$0	$43,215	$4,794	$0	$4,794	$182,218	$484	$182,702	$0	$182,702
Communications	$188,308	$0	$188,308	$71,880	$0	$71,880	$2,669	$0	$2,669	$262,857	$0	$262,857	$0	$262,857
Utilities	$102	$0	$102	$1	$0	$1	$533,042	$0	$533,042	$533,145	$0	$533,145	$0	$533,145
GSA Rent	($3)	$0	($3)	$17	$0	$17	$26,122	$76	$26,198	$26,136	$76	$26,212	$0	$26,212
Other Real Property Rental	$531	$0	$531	$803	$0	$803	$491,049	$29,007	$520,056	$492,383	$29,007	$521,390	$0	$521,390
Subtotal	$323,147	$484	$323,631	$115,916	$0	$115,916	$1,057,676	$29,083	$1,086,759	$1,496,739	$29,567	$1,526,306	$0	$1,526,306
24 Printing & Reproduction:	$14,359	$0	$14,359	$12,300	$0	$12,300	$177	$0	$177	$26,836	$0	$26,836	$4,169	$31,005
25 Other Contractual Services:														
Care in the Community Outpatient Dental Care	$124,410	$126	$124,536	$2	$0	$2	$1	$0	$1	$124,413	$126	$124,539	$67,102	$191,641
Contract Dentist Outpatient Dental Care	$9,225	$0	$9,225	$0	$0	$0	$0	$0	$0	$9,225	$0	$9,225	$0	$9,225
Medical and Nursing Care in the Community	$1,314,255	$17	$1,314,272	$3,259	$0	$3,259	$75	$0	$75	$1,317,589	$17	$1,317,606	$743,173	$2,060,779
Contract Medical and Nursing Care	$253,280	$0	$253,280	$0	$0	$0	$0	$0	$0	$253,280	$0	$253,280	$0	$253,280
Repairs to Furniture/Equipment	$227,553	$0	$227,553	$2,526	$0	$2,526	$17,244	$0	$17,244	$247,323	$0	$247,323	$0	$247,323
Maintenance & Repair Contract Services	$31,882	$59	$31,941	$628	$0	$628	$196,840	$13	$196,853	$229,350	$72	$229,422	$0	$229,422
Care in the Community Hospital Care	$1,671,428	$0	$1,671,428	$4	$0	$4	$0	$0	$0	$1,671,432	$0	$1,671,432	$739,149	$2,410,581
Community Nursing Homes	$585,314	$0	$585,314	$0	$0	$0	$0	$0	$0	$585,314	$0	$585,314	$211,158	$796,472
Repairs to Prosthetic Appliances	$241,384	$0	$241,384	$0	$0	$0	$0	$0	$0	$241,384	$0	$241,384	$2	$241,386
Home Oxygen	$183,222	$0	$183,222	$0	$0	$0	$0	$0	$0	$183,222	$0	$183,222	$0	$183,222
Personal Services Contracts	$91,759	$12	$91,771	$5,885	$0	$5,885	$4,028	$0	$4,028	$101,672	$12	$101,684	$4,169	$105,853
House Staff Disbursing Agreement	$633,943	$1,527	$635,470	$434	$0	$434	$0	$0	$0	$634,377	$1,527	$635,904	$0	$635,904
Scarce Medical Specialists	$115,934	$191	$116,125	$135	$0	$135	$0	$0	$0	$116,069	$191	$116,260	$0	$116,260
Other Medical Contract Services	$3,136,299	$106	$3,136,405	$12,858	$0	$12,858	$13,993	$0	$13,993	$3,163,150	$106	$3,163,256	$964,366	$4,127,622
Administrative Contract Services	$639,388	$101	$639,489	$898,672	$0	$898,672	$395,990	$1,651	$397,641	$1,934,050	$1,752	$1,935,802	$318,053	$2,253,855
Training Contract Services	$38,529	$81	$38,610	$10,497	$0	$10,497	$1,115	$0	$1,115	$50,141	$81	$50,222	$0	$50,222
CHAMPVA	$1,131,521	$0	$1,131,521	$0	$0	$0	$0	$0	$0	$1,131,521	$0	$1,131,521	$0	$1,131,521
Subtotal	$10,429,326	$2,220	$10,431,546	$934,900	$0	$934,900	$629,286	$1,664	$630,950	$11,993,512	$3,884	$11,997,396	$3,047,172	$15,044,568

2015 Obligations by Object
(dollars in thousands)

Description	Services Non 801/802	Services VACAA 801	Subtotal Services	S&C Non 801/802	S&C VACAA 801	Subtotal S&C	Facilities Non 801/802	Facilities VACAA 801	Subtotal S&C	Total Non 801/802	Total VACAA 801	Medical Care Total	VACAA 802 Total	Grand Total
26 Supplies & Materials:														
Provisions	$123,612	$0	$123,612	$4,366	$0	$4,366	$20	$0	$20	$127,998	$0	$127,998	$0	$127,998
Drugs & Medicines	$6,053,336	$1,652	$6,054,988	$2	$0	$2	$4	$0	$4	$6,053,342	$1,652	$6,054,994	$417,120	$6,472,114
Blood & Blood Products	$58,498	$2	$58,500	$0	$0	$0	$0	$0	$0	$58,498	$2	$58,500	$0	$58,500
Medical/Dental Supplies	$1,508,551	$12,698	$1,521,249	$728	$0	$728	$923	$0	$923	$1,510,202	$12,698	$1,522,900	$6	$1,522,906
Operating Supplies	$141,251	$253	$141,504	$22,323	$0	$22,323	$121,180	$2,823	$124,003	$284,754	$3,076	$287,830	$0	$287,830
Maintenance & Repair Supplies	$28,681	$6	$28,687	$491	$0	$491	$139,157	$0	$139,157	$168,329	$6	$168,335	$0	$168,335
Other Supplies	$114,030	$595	$114,625	$59,981	$0	$59,981	$48,515	$0	$48,515	$222,526	$595	$223,121	$1	$223,122
Prosthetic Appliances	$2,219,631	$0	$2,219,631	$0	$0	$0	$0	$0	$0	$2,219,631	$0	$2,219,631	$411	$2,220,042
Home Respiratory Therapy	$37,203	$0	$37,203	$0	$0	$0	$0	$0	$0	$37,203	$0	$37,203	$0	$37,203
Subtotal	$10,284,793	$15,206	$10,299,999	$87,891	$0	$87,891	$309,799	$2,823	$312,622	$10,682,483	$18,029	$10,700,512	$417,538	$11,118,050
31 Equipment	$843,670	$29,210	$872,880	$22,166	$0	$22,166	$69,129	$0	$69,129	$934,965	$29,210	$964,175	$0	$964,175
32 Lands & Structures:														
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$803,050	$485,419	$1,288,469	$803,050	$485,419	$1,288,469	$0	$1,288,469
All Other Lands & Structures	$802	$0	$802	$179	$0	$179	$139,693	$26,472	$166,165	$140,674	$26,472	$167,146	$0	$167,146
Subtotal	$802	$0	$802	$179	$0	$179	$942,743	$511,891	$1,454,634	$943,724	$511,891	$1,455,615	$0	$1,455,615
41 Grants, Subsidies & Contributions:														
State Home	$1,141,718	$0	$1,141,718	$0	$0	$0	$0	$0	$0	$1,141,718	$0	$1,141,718	$0	$1,141,718
Grants	$539,995	$0	$539,995	$34	$0	$34	$11	$0	$11	$540,040	$0	$540,040	$0	$540,040
Subtotal	$1,681,713	$0	$1,681,713	$34	$0	$34	$11	$0	$11	$1,681,758	$0	$1,681,758	$0	$1,681,758
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$194	$0	$194	$194	$0	$194	$0	$194
Subtotal	$48,823,755	$609,715	$49,433,470	$5,742,277	$412	$5,742,689	$4,714,760	$545,461	$5,260,221	$59,280,792	$1,155,588	$60,436,380	$3,481,417	$63,917,797
Prior Year Recoveries	$574,411	$0	$574,411	$589	$0	$589	$10,654	$0	$10,654	$585,654	$0	$585,654	$0	$585,654
Financial Statement Audit Adjustment	($149,222)	$0	($149,222)	$0	$0	$0	$0	$0	$0	($149,222)	$0	($149,222)	($1,700,000)	($1,849,222)
Obligations Total	$49,248,944	$609,715	$49,858,659	$5,742,866	$412	$5,743,278	$4,725,414	$545,461	$5,270,875	$59,717,224	$1,155,588	$60,872,812	$1,781,417	$62,654,229

* VACAA 802 excludes Information Technology
** VACAA 801 excludes Minor Construction and Information Technology

2016 Obligations by Object
(dollars in thousands)

Description	Services Non 801/802	Services VACAA 801	Subtotal Services	S&C Non 801/802	S&C VACAA 801	Subtotal S&C	Facilities Non 801/802	Facilities VACAA 801	Subtotal S&C	Total Non 801/802	Total VACAA 801	Medical Care Total	VACAA 802 Total	Grand Total
10 Personnel Compensation and Benefits:														
Physicians	$5,852,298	$443,664	$6,295,962	$187,276	$4,215	$191,491	$0	$0	$0	$6,039,574	$447,879	$6,487,453	$0	$6,487,453
Dentists	$267,174	$12,608	$279,782	$3,604	$0	$3,604	$0	$0	$0	$270,778	$12,608	$283,386	$0	$283,386
Registered Nurses	$6,623,054	$308,320	$6,931,374	$401,922	$176	$402,098	$0	$0	$0	$7,024,976	$308,496	$7,333,472	$0	$7,333,472
LP Nurse/LV Nurse/Nurse Assistant	$1,717,200	$60,980	$1,778,180	$4,927	$0	$4,927	$0	$0	$0	$1,722,127	$60,980	$1,783,107	$0	$1,783,107
Non-Physician Providers	$1,903,237	$147,001	$2,050,238	$37,228	$0	$37,228	$0	$0	$0	$1,940,465	$147,001	$2,087,466	$0	$2,087,466
Health Technicians/Allied Health	$6,427,612	$195,368	$6,622,980	$113,987	$0	$113,987	$7,643	$0	$7,643	$6,549,242	$195,368	$6,744,610	$0	$6,744,610
Wage Board/Purchase & Hire	$325,077	$367	$325,444	$63,890	$0	$63,890	$1,274,760	$857	$1,275,617	$1,663,727	$1,224	$1,664,951	$0	$1,664,951
All Other	$2,311,354	$162,223	$2,473,577	$3,913,969	$13,609	$3,927,578	$415,007	$0	$415,007	$6,640,330	$175,832	$6,816,162	$0	$6,816,162
Permanent Change of Station	$4,159	$118	$4,277	$8,193	$0	$8,193	$857	$0	$857	$13,209	$118	$13,327	$0	$13,327
Employee Compensation Pay	$158,557	$353	$158,910	$40,567	$0	$40,567	$34,305	$0	$34,305	$233,429	$353	$233,782	$0	$233,782
Subtotal	$25,589,722	$1,331,002	$26,920,724	$4,775,563	$18,000	$4,793,563	$1,732,572	$857	$1,733,429	$32,097,857	$1,349,859	$33,447,716	$0	$33,447,716
21 Travel & Transportation of Persons:														
Employee	$20,139	$0	$20,139	$44,294	$1,000	$45,294	$2,822	$0	$2,822	$67,255	$1,000	$68,255	$0	$68,255
Beneficiary	$888,200	$0	$888,200	$0	$0	$0	$0	$0	$0	$888,200	$0	$888,200	$0	$888,200
Other	$18,661	$0	$18,661	$3,706	$0	$3,706	$31,178	$0	$31,178	$53,545	$0	$53,545	$0	$53,545
Subtotal	$927,000	$0	$927,000	$48,000	$1,000	$49,000	$34,000	$0	$34,000	$1,009,000	$1,000	$1,010,000	$0	$1,010,000
22 Transportation of Things	$21,000	$0	$21,000	$13,000	$0	$13,000	$15,000	$0	$15,000	$49,000	$0	$49,000	$0	$49,000
23 Rent, Communications, and Utilities:														
Rental of Equipment	$143,285	$0	$143,285	$43,930	$0	$43,930	$4,641	$0	$4,641	$191,856	$0	$191,856	$0	$191,856
Communications	$201,042	$0	$201,042	$73,070	$0	$73,070	$2,584	$0	$2,584	$276,696	$0	$276,696	$0	$276,696
Utilities	$0	$0	$0	$0	$0	$0	$516,001	$0	$516,001	$516,001	$0	$516,001	$0	$516,001
GSA Rent	$0	$0	$0	$0	$0	$0	$28,830	$748	$29,578	$28,830	$748	$29,578	$0	$29,578
Other Real Property Rental	$0	$0	$0	$0	$0	$0	$541,945	$284,857	$826,802	$541,945	$284,857	$826,802	$0	$826,802
Subtotal	$344,327	$0	$344,327	$117,000	$0	$117,000	$1,094,001	$285,605	$1,379,606	$1,555,328	$285,605	$1,840,933	$0	$1,840,933
24 Printing & Reproduction:	$23,000	$0	$23,000	$15,000	$0	$15,000	$0	$0	$0	$38,000	$0	$38,000	$0	$38,000
25 Other Contractual Services:														
Care in the Community Outpatient Dental Care	$155,579	$1,532	$157,111	$0	$0	$0	$0	$0	$0	$155,579	$1,532	$157,111	$0	$157,111
Contract Dentist Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$1,643,517	$207	$1,643,724	$3,219	$0	$3,219	$0	$0	$0	$1,646,736	$207	$1,646,943	$0	$1,646,943
Contract Medical and Nursing Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$284,562	$0	$284,562	$2,495	$0	$2,495	$22,820	$0	$22,820	$309,877	$0	$309,877	$0	$309,877
Maintenance & Repair Contract Services	$39,869	$718	$40,587	$0	$0	$0	$260,489	$0	$260,489	$300,358	$718	$301,076	$0	$301,076
Care in the Community Hospital Care	$2,090,173	$0	$2,090,173	$0	$0	$0	$0	$0	$0	$2,090,173	$0	$2,090,173	$0	$2,090,173
Community Nursing Homes	$969,603	$0	$969,603	$0	$0	$0	$0	$0	$0	$969,603	$0	$969,603	$0	$969,603
Repairs to Prosthetic Appliances	$256,600	$0	$256,600	$0	$0	$0	$0	$0	$0	$256,600	$0	$256,600	$0	$256,600
Home Oxygen	$194,800	$0	$194,800	$0	$0	$0	$0	$0	$0	$194,800	$0	$194,800	$0	$194,800
Personal Services Contracts	$114,747	$146	$114,893	$5,812	$0	$5,812	$5,330	$0	$5,330	$125,889	$146	$126,035	$0	$126,035
House Staff Disbursing Agreement	$792,765	$18,572	$811,337	$0	$0	$0	$0	$0	$0	$792,765	$18,572	$811,337	$0	$811,337
Scarce Medical Specialists	$144,979	$2,323	$147,302	$0	$0	$0	$0	$0	$0	$144,979	$2,323	$147,302	$0	$147,302
Other Medical Contract Services	$3,923,273	$1,289	$3,924,562	$12,699	$778	$13,477	$0	$0	$0	$3,935,972	$2,067	$3,938,039	$3,331,264	$7,269,303
Administrative Contract Services	$799,575	$1,228	$800,803	$887,735	$0	$887,735	$525,357	$0	$525,357	$2,212,667	$1,228	$2,213,895	$0	$2,213,895
Training Contract Services	$48,182	$985	$49,167	$10,367	$0	$10,367	$1,476	$0	$1,476	$60,025	$985	$61,010	$0	$61,010
CHAMPVA	$255,009	$0	$255,009	$102,873	$0	$102,873	$5,750	$0	$5,750	$363,632	$0	$363,632	$0	$363,632
Subtotal	$11,713,233	$27,000	$11,740,233	$1,025,200	$778	$1,025,978	$821,222	$0	$821,222	$13,559,655	$27,778	$13,587,433	$3,331,264	$16,918,697

2016 Obligations by Object
(dollars in thousands)

Description	Services Non 801/802	Services VACAA 801	Subtotal Services	S&C Non 801/802	S&C VACAA 801	Subtotal S&C	Facilities Non 801/802	Facilities VACAA 801	Subtotal S&C	Total Non 801/802	Total VACAA 801	Medical Care Total	VACAA 802 Total	Grand Total
26 Supplies & Materials:														
Provisions	$179,498	$0	$179,498	$0	$0	$0	$0	$0	$0	$179,498	$0	$179,498	$0	$179,498
Drugs & Medicines	$6,908,868	$1,956	$6,910,824	$0	$0	$0	$0	$0	$0	$6,908,868	$1,956	$6,910,824	$0	$6,910,824
Blood & Blood Products	$66,766	$2	$66,768	$0	$0	$0	$0	$0	$0	$66,766	$2	$66,768	$0	$66,768
Medical/Dental Supplies	$2,190,574	$15,031	$2,205,605	$0	$0	$0	$0	$0	$0	$2,190,574	$15,031	$2,205,605	$0	$2,205,605
Operating Supplies	$205,111	$299	$205,410	$26,038	$0	$26,038	$222,917	$0	$222,917	$454,066	$299	$454,365	$0	$454,365
Maintenance & Repair Supplies	$0	$7	$7	$0	$0	$0	$0	$0	$0	$0	$7	$7	$0	$7
Other Supplies	$165,583	$704	$166,287	$69,962	$0	$69,962	$88,717	$0	$88,717	$324,262	$704	$324,966	$0	$324,966
Prosthetic Appliances	$2,360,000	$0	$2,360,000	$0	$0	$0	$0	$0	$0	$2,360,000	$0	$2,360,000	$0	$2,360,000
Home Respiratory Therapy	$39,600	$0	$39,600	$0	$0	$0	$0	$0	$0	$39,600	$0	$39,600	$0	$39,600
Subtotal	$12,116,000	$17,999	$12,133,999	$96,000	$0	$96,000	$311,634	$0	$311,634	$12,523,634	$17,999	$12,541,633	$0	$12,541,633
31 Equipment	$887,700	$39,000	$926,700	$25,000	$0	$25,000	$74,000	$0	$74,000	$986,700	$39,000	$1,025,700	$0	$1,025,700
32 Lands & Structures:														
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$417,838	$591,448	$1,009,286	$417,838	$591,448	$1,009,286	$0	$1,009,286
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$180,162	$0	$180,162	$180,162	$0	$180,162	$0	$180,162
Subtotal	$0	$0	$0	$0	$0	$0	$598,000	$591,448	$1,189,448	$598,000	$591,448	$1,189,448	$0	$1,189,448
41 Grants, Subsidies & Contributions:														
State Home	$1,230,000	$0	$1,230,000	$0	$0	$0	$0	$0	$0	$1,230,000	$0	$1,230,000	$0	$1,230,000
Grants	$515,000	$0	$515,000	$0	$0	$0	$0	$0	$0	$515,000	$0	$515,000	$0	$515,000
Subtotal	$1,745,000	$0	$1,745,000	$0	$0	$0	$0	$0	$0	$1,745,000	$0	$1,745,000	$0	$1,745,000
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$53,366,982	$1,415,001	$54,781,983	$6,114,763	$19,778	$6,134,541	$4,680,429	$877,910	$5,558,339	$64,162,174	$2,312,689	$66,474,863	$3,331,264	$69,806,127
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment	$149,222	$0	$149,222	$0	$0	$0	$0	$0	$0	$149,222	$0	$149,222	$0	$149,222
Obligations Total	$53,516,204	$1,415,001	$54,931,205	$6,114,763	$19,778	$6,134,541	$4,680,429	$877,910	$5,558,339	$64,311,396	$2,312,689	$66,624,085	$3,331,264	$69,955,349

* VACAA 802 excludes Information Technology
** VACAA 801 excludes Minor Construction and Information Technology

2017 Obligations by Object
(dollars in thousands)

Description	Services Non 801/802	Services VACAA 801	Subtotal Services	S&C Non 801/802	S&C VACAA 801	Subtotal S&C	Facilities Non 801/802	Facilities VACAA 801	Subtotal S&C	Total Non 801/802	Total VACAA 801	Medical Care Total	VACAA 802 Total	Medical Community Care Total	Grand Total
10 Personnel Compensation and Benefits:															
Physicians	$6,567,954	$258,331	$6,826,285	$197,231	$3,512	$200,743	$0	$0	$0	$6,765,185	$261,843	$7,027,028	$0	$0	$7,027,028
Dentists	$303,141	$7,341	$310,482	$3,907	$0	$3,907	$0	$0	$0	$307,048	$7,341	$314,389	$0	$0	$314,389
Registered Nurses	$7,258,043	$179,525	$7,437,568	$410,457	$146	$410,603	$0	$0	$0	$7,668,500	$179,671	$7,848,171	$0	$0	$7,848,171
LP Nurse/LV Nurse/Nurse Assistant	$1,849,179	$35,507	$1,884,686	$5,043	$0	$5,043	$0	$0	$0	$1,854,222	$35,507	$1,889,729	$0	$0	$1,889,729
Non-Physician Providers	$2,076,325	$85,594	$2,161,919	$38,263	$0	$38,263	$0	$0	$0	$2,114,588	$85,594	$2,200,182	$0	$0	$2,200,182
Health Technicians/Allied Health	$6,943,189	$113,756	$7,056,945	$116,443	$0	$116,443	$7,750	$0	$7,750	$7,067,382	$113,756	$7,181,138	$0	$0	$7,181,138
Wage Board/Purchase & Hire	$339,642	$214	$339,856	$64,872	$0	$64,872	$1,286,862	$0	$1,286,862	$1,691,376	$214	$1,691,590	$0	$0	$1,691,590
All Other	$2,518,580	$94,457	$2,613,037	$4,099,114	$11,342	$4,110,456	$419,790	$0	$419,790	$7,037,484	$105,799	$7,143,283	$0	$0	$7,143,283
Permanent Change of Station	$4,243	$69	$4,312	$8,359	$0	$8,359	$874	$0	$874	$13,476	$69	$13,545	$0	$0	$13,545
Employee Compensation Pay	$161,776	$205	$161,981	$41,391	$0	$41,391	$35,001	$0	$35,001	$238,168	$205	$238,373	$0	$0	$238,373
Subtotal	$28,022,072	$774,999	$28,797,071	$4,985,080	$15,000	$5,000,080	$1,750,277	$0	$1,750,277	$34,757,429	$789,999	$35,547,428	$0	$0	$35,547,428
21 Travel & Transportation of Persons:															
Employee	$19,880	$0	$19,880	$45,216	$1,262	$46,478	$2,822	$0	$2,822	$67,918	$1,262	$69,180	$0	$0	$69,180
Beneficiary	$923,700	$0	$923,700	$0	$0	$0	$0	$0	$0	$923,700	$0	$923,700	$0	$0	$923,700
Other	$18,420	$0	$18,420	$3,784	$0	$3,784	$31,178	$0	$31,178	$53,382	$0	$53,382	$0	$0	$53,382
Subtotal	$962,000	$0	$962,000	$49,000	$1,262	$50,262	$34,000	$0	$34,000	$1,045,000	$1,262	$1,046,262	$0	$0	$1,046,262
22 Transportation of Things	$22,000	$0	$22,000	$13,000	$0	$13,000	$15,000	$0	$15,000	$50,000	$0	$50,000	$0	$0	$50,000
23 Rent, Communications, and Utilities:															
Rental of Equipment	$148,684	$0	$148,684	$45,057	$0	$45,057	$5,117	$0	$5,117	$198,858	$0	$198,858	$0	$0	$198,858
Communications	$208,618	$0	$208,618	$74,943	$0	$74,943	$2,849	$0	$2,849	$286,410	$0	$286,410	$0	$0	$286,410
Utilities	$0	$0	$0	$0	$0	$0	$568,933	$0	$568,933	$568,933	$0	$568,933	$0	$0	$568,933
GSA Rent	$0	$0	$0	$0	$0	$0	$42,332	$0	$42,332	$42,332	$0	$42,332	$0	$0	$42,332
Other Real Property Rental	$0	$0	$0	$0	$0	$0	$795,770	$0	$795,770	$795,770	$0	$795,770	$0	$0	$795,770
Subtotal	$357,302	$0	$357,302	$120,000	$0	$120,000	$1,415,001	$0	$1,415,001	$1,892,303	$0	$1,892,303	$0	$0	$1,892,303
24 Printing & Reproduction:	$23,000	$0	$23,000	$15,000	$0	$15,000	$0	$0	$0	$38,000	$0	$38,000	$0	$0	$38,000
25 Other Contractual Services:															
Care in the Community Outpatient Dental Care	$59,391	$0	$59,391	$0	$0	$0	$0	$0	$0	$59,391	$0	$59,391	$0	$0	$59,391
Contract Dentist Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$627,403	$0	$627,403	$3,919	$0	$3,919	$0	$0	$0	$631,322	$0	$631,322	$0	$0	$631,322
Contract Medical and Nursing Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$108,630	$0	$108,630	$3,037	$0	$3,037	$23,821	$0	$23,821	$135,488	$0	$135,488	$0	$0	$135,488
Maintenance & Repair Contract Services	$15,220	$0	$15,220	$0	$0	$0	$271,915	$0	$271,915	$287,135	$0	$287,135	$0	$0	$287,135
Care in the Community Hospital Care	$797,912	$0	$797,912	$0	$0	$0	$0	$0	$0	$797,912	$0	$797,912	$0	$0	$797,912
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,012,378	$1,012,378
Repairs to Prosthetic Appliances	$328,200	$0	$328,200	$0	$0	$0	$0	$0	$0	$328,200	$0	$328,200	$0	$0	$328,200
Home Oxygen	$249,100	$0	$249,100	$0	$0	$0	$0	$0	$0	$249,100	$0	$249,100	$0	$0	$249,100
Personal Services Contracts	$43,804	$0	$43,804	$7,076	$0	$7,076	$5,564	$0	$5,564	$56,444	$0	$56,444	$0	$0	$56,444
House Staff Disbursing Agreement	$302,634	$0	$302,634	$0	$0	$0	$0	$0	$0	$302,634	$0	$302,634	$0	$0	$302,634
Scarce Medical Specialists	$55,345	$0	$55,345	$0	$0	$0	$0	$0	$0	$55,345	$0	$55,345	$0	$0	$55,345
Other Medical Contract Services	$1,498,409	$0	$1,498,409	$15,460	$0	$15,460	$0	$0	$0	$1,513,869	$0	$1,513,869	$4,819,819	$3,643,019	$9,976,707
Administrative Contract Services	$305,233	$0	$305,233	$1,079,330	$0	$1,079,330	$548,550	$0	$548,550	$1,933,113	$0	$1,933,113	$0	$0	$1,933,113
Training Contract Services	$18,393	$0	$18,393	$12,621	$0	$12,621	$1,540	$0	$1,540	$32,554	$0	$32,554	$0	$0	$32,554
CHAMPVA	$96,518	$0	$96,518	$109,334	$0	$109,334	$6,034	$0	$6,034	$211,886	$0	$211,886	$0	$1,504,506	$1,716,392
Subtotal	$4,506,192	$0	$4,506,192	$1,230,777	$0	$1,230,777	$857,424	$0	$857,424	$6,594,393	$0	$6,594,393	$4,819,819	$6,159,903	$17,574,115

2017 Obligations by Object
(dollars in thousands)

Description	Services Non 801/802	Services VACAA 801	Subtotal Services	S&C Non 801/802	S&C VACAA 801	Subtotal S&C	Facilities Non 801/802	Facilities VACAA 801	Subtotal S&C	Total Non 801/802	Total VACAA 801	Medical Care Total	Total Non 801	Medical Community Care Total	Grand Total
26 Supplies & Materials:															
Provisions	$173,371	$0	$173,371	$0	$0	$0	$0	$0	$0	$173,371	$0	$173,371	$0	$0	$173,371
Drugs & Medicines	$7,598,976	$1,956	$7,600,932	$0	$0	$0	$0	$0	$0	$7,598,976	$1,956	$7,600,932	$0	$0	$7,600,932
Blood & Blood Products	$73,435	$2	$73,437	$0	$0	$0	$0	$0	$0	$73,435	$2	$73,437	$0	$0	$73,437
Medical/Dental Supplies	$2,116,992	$14,630	$2,131,622	$0	$0	$0	$0	$0	$0	$2,116,992	$14,630	$2,131,622	$0	$0	$2,131,622
Operating Supplies	$198,110	$299	$198,409	$26,851	$0	$26,851	$231,647	$0	$231,647	$456,608	$299	$456,907	$0	$0	$456,907
Maintenance & Repair Supplies	$0	$7	$7	$0	$0	$0	$0	$0	$0	$0	$7	$7	$0	$0	$7
Other Supplies	$159,931	$704	$160,635	$72,149	$0	$72,149	$92,129	$0	$92,129	$324,209	$704	$324,913	$0	$0	$324,913
Prosthetic Appliances	$3,017,777	$0	$3,017,777	$0	$0	$0	$0	$0	$0	$3,017,777	$0	$3,017,777	$0	$0	$3,017,777
Home Respiratory Therapy	$50,600	$0	$50,600	$0	$0	$0	$0	$0	$0	$50,600	$0	$50,600	$0	$0	$50,600
Subtotal	$13,389,192	$17,598	$13,406,790	$99,000	$0	$99,000	$323,776	$0	$323,776	$13,811,968	$17,598	$13,829,566	$0	$0	$13,829,566
31 Equipment	$989,000	$29,000	$1,018,000	$28,000	$0	$28,000	$83,000	$15,512	$98,512	$1,100,000	$44,512	$1,144,512	$0	$0	$1,144,512
32 Lands & Structures:															
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$1,057,473	$0	$1,057,473	$1,057,473	$0	$1,057,473	$0	$0	$1,057,473
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$186,527	$0	$186,527	$186,527	$0	$186,527	$0	$0	$186,527
Subtotal	$0	$0	$0	$0	$0	$0	$1,244,000	$0	$1,244,000	$1,244,000	$0	$1,244,000	$0	$0	$1,244,000
41 Grants, Subsidies & Contributions:															
State Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,336,278	$1,336,278
Grants	$515,000	$0	$515,000	$0	$0	$0	$0	$0	$0	$515,000	$0	$515,000	$0	$0	$515,000
Subtotal	$515,000	$0	$515,000	$0	$0	$0	$0	$0	$0	$515,000	$0	$515,000	$0	$1,336,278	$1,851,278
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$48,785,758	$821,597	$49,607,355	$6,539,857	$16,262	$6,556,119	$5,722,478	$15,512	$5,737,990	$61,048,093	$853,371	$61,901,464	$4,819,819	$7,496,181	$74,217,464
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Obligations Total	$48,785,758	$821,597	$49,607,355	$6,539,857	$16,262	$6,556,119	$5,722,478	$15,512	$5,737,990	$61,048,093	$853,371	$61,901,464	$4,819,819	$7,496,181	$74,217,464

* VACAA 802 excludes Information Technology
** VACAA 801 excludes Minor Construction and Information Technology

2018 Obligations by Object
(dollars in thousands)

Description	Services	S&C	Facilities	Medical Care Total	Medical Community Care Total	Grand Total
10 Personnel Compensation and Benefits:						
Physicians	$6,802,445	$208,521	$0	$7,010,966	$0	$7,010,966
Dentists	$290,250	$4,271	$0	$294,521	$0	$294,521
Registered Nurses	$7,079,167	$421,082	$0	$7,500,249	$0	$7,500,249
LP Nurse/LV Nurse/Nurse Assistant	$1,841,097	$5,198	$0	$1,846,295	$0	$1,846,295
Non-Physician Providers	$2,156,801	$39,553	$0	$2,196,354	$0	$2,196,354
Health Technicians/Allied Health	$6,808,325	$119,477	$7,901	$6,935,703	$0	$6,935,703
Wage Board/Purchase & Hire	$331,083	$66,184	$1,305,466	$1,702,733	$0	$1,702,733
All Other	$2,553,017	$4,191,689	$426,512	$7,171,218	$0	$7,171,218
Permanent Change of Station	$4,329	$8,529	$892	$13,750	$0	$13,750
Employee Compensation Pay	$165,060	$42,231	$35,712	$243,003	$0	$243,003
Subtotal	$28,031,574	$5,106,735	$1,776,483	$34,914,792	$0	$34,914,792
21 Travel & Transportation of Persons:						
Employee	$22,900	$46,500	$2,800	$72,200	$0	$72,200
Beneficiary	$960,700	$0	$0	$960,700	$0	$960,700
Other	$19,400	$3,900	$32,300	$55,600	$0	$55,600
Subtotal	$1,003,000	$50,400	$35,100	$1,088,500	$0	$1,088,500
22 Transportation of Things	$26,100	$13,400	$15,400	$54,900	$0	$54,900
23 Rent, Communications, and Utilities:						
Rental of Equipment	$159,900	$47,800	$5,300	$213,000	$0	$213,000
Communications	$205,500	$74,900	$2,800	$283,200	$0	$283,200
Utilities	$0	$0	$585,300	$585,300	$0	$585,300
GSA Rent	$0	$0	$41,009	$41,009	$0	$41,009
Other Real Property Rental	$0	$0	$770,891	$770,891	$0	$770,891
Subtotal	$365,400	$122,700	$1,405,300	$1,893,400	$0	$1,893,400
24 Printing & Reproduction:	$25,100	$15,400	$0	$40,500	$0	$40,500
25 Other Contractual Services:						
Care in the Community Outpatient Dental Care	$63,900	$0	$0	$63,900	$0	$63,900
Contract Dentist Outpatient Dental Care	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$627,400	$4,000	$0	$631,400	$0	$631,400
Contract Medical and Nursing Care	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$111,800	$3,100	$23,800	$138,700	$0	$138,700
Maintenance & Repair Contract Services	$15,700	$0	$279,700	$295,400	$0	$295,400
Care in the Community Hospital Care	$849,000	$0	$0	$849,000	$0	$849,000
Community Nursing Homes	$0	$0	$0	$0	$1,064,090	$1,064,090
Repairs to Prosthetic Appliances	$303,900	$0	$0	$303,900	$0	$303,900
Home Oxygen	$230,700	$0	$0	$230,700	$0	$230,700
Personal Services Contracts	$45,100	$7,300	$5,600	$58,000	$0	$58,000
House Staff Disbursing Agreement	$311,300	$0	$0	$311,300	$0	$311,300
Scarce Medical Specialists	$55,300	$0	$0	$55,300	$0	$55,300
Other Medical Contract Services	$2,086,688	$15,900	$0	$2,102,588	$5,493,484	$7,596,072
Administrative Contract Services	$314,000	$1,059,532	$699,765	$2,073,297	$0	$2,073,297
Training Contract Services	$18,400	$13,000	$1,500	$32,900	$0	$32,900
CHAMPVA	$437,446	$115,367	$6,333	$559,146	$1,641,412	$2,200,558
Subtotal	$5,470,634	$1,218,199	$1,016,698	$7,705,531	$8,198,986	$15,904,517

2018 Obligations by Object
(dollars in thousands)

Description	Services	S&C	Facilities	Total Non 801/802	Medical Community Care Total	Grand Total
26 Supplies & Materials:						
Provisions	$179,500	$0	$0	$179,500	$0	$179,500
Drugs & Medicines	$6,783,631	$0	$0	$6,783,631	$0	$6,783,631
Blood & Blood Products	$65,555	$0	$0	$65,555	$0	$65,555
Medical/Dental Supplies	$2,241,500	$0	$0	$2,241,500	$0	$2,241,500
Operating Supplies	$200,600	$26,900	$242,300	$469,800	$0	$469,800
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0
Other Supplies	$164,500	$72,100	$92,100	$328,700	$0	$328,700
Prosthetic Appliances	$2,794,759	$0	$0	$2,794,759	$0	$2,794,759
Home Respiratory Therapy	$46,800	$0	$0	$46,800	$0	$46,800
Subtotal	$12,476,845	$99,000	$334,400	$12,910,245	$0	$12,910,245
31 Equipment	$542,000	$14,000	$44,000	$600,000	$0	$600,000
32 Lands & Structures:						
Non-Recurring Maintenance	$0	$0	$ 600,000	$600,000	$0	$600,000
All Other Lands & Structures	$0	$0	$186,500	$186,500	$0	$186,500
Subtotal	$0	$0	$786,500	$786,500	$0	$786,500
41 Grants, Subsidies & Contributions:						
State Home	$0	$0	$0	$0	$1,460,132	$1,460,132
Grants	$258,034	$0	$0	$258,034	$0	$258,034
Subtotal	$258,034	$0	$0	$258,034	$1,460,132	$1,718,166
43 Imputed Interest	$0	$0	$0	$0	$0	$0
Subtotal	$48,198,687	$6,639,834	$5,413,881	$60,252,402	$9,659,118	$69,911,520
Prior Year Recoveries	$0	$0	$0	$0	$0	$0
Financial Statement Audit Adjustment	$0	$0	$0	$0	$0	$0
Obligations Total	$48,198,687	$6,639,834	$5,413,881	$60,252,402	$9,659,118	$69,911,520

* VACAA 801 and 802 ended in FY 2017

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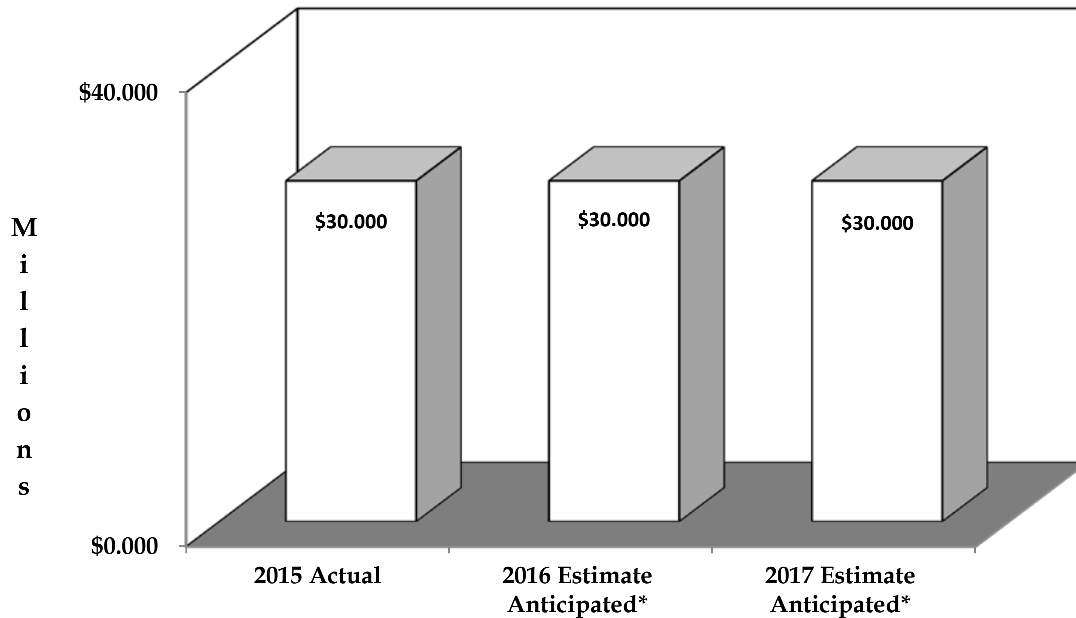
DoD-VA Health Care Sharing Incentive Fund

DoD-VA Health Care Sharing Incentive Fund
Budget Authority



*Funding contributions anticipated from VA and DoD.

Program Description

Congress created the DoD-VA Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF), between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to encourage development of sharing initiatives at the facility, intra-regional and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefit both VA and DoD.

Through the JIF, there is a minimum of $30,000,000 available annually to enable VA and DoD to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels. Section 8111(d) of title 38, United States Code (U.S.C.) requires each Secretary to contribute a minimum of $15,000,000 from the funds appropriated to that Secretary's Department. The DoD-VA Health Care Sharing

Incentive Fund became effective on October 1, 2003. Public Law 114-92, the National Defense Authorization Act for 2016, section 722, amended section 8111(d)(3) of title 38, U.S.C. to extend the program to September 30, 2020. This is a no-year account.

Extension of the JIF authority will ensure the continued development and implementation of joint projects that will benefit the delivery of health care to beneficiaries of both departments.

Program Highlights
(dollars in thousands)

Description	2015 Actual*	2016 Budget Estimate	2016 Current Estimate*	2017 Estimate*	Increase/ Decrease
Transfer from Medical Services	$15,000	$15,000	$15,000	$15,000	$0
Transfer from DoD	$15,000	$15,000	$15,000	$15,000	$0
Budget Authority Total	$30,000	$30,000	$30,000	$30,000	$0
Rescissions, P.L. 113-235, P.L. 114-113 (From Unobligated Balance)	($15,000)	$0	($30,000)	$0	$30,000
Total Budgetary Resources	$30,000	$30,000	$30,000	$30,000	$0
Obligations	$84,560	$70,000	$59,853	$74,435	$14,582
FTE**	57	44	57	57	0

*Anticipates VA and DoD will each transfer the required minimum of $15 million to this fund.
**Data source: VA Financial Management System (FMS). VA assumes a steady-state number of FTEs through the budget years.

Administrative Provision

An administrative provision related to the JIF will be included in the VA chapter of the President's Budget Appendix:

> SEC. 222. Of the amounts available in this title for ''Medical Services'', ''Medical Support and Compliance'', and ''Medical Facilities'', a minimum of $15,000,000 shall be transferred to the DOD–VA Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, to remain available until expended, for any purpose authorized by section 8111 of title 38, United States Code.

Governance and Accountability

The VA-DoD Joint Executive Council delegated the implementation of the fund to the Health Executive Council (HEC). VHA administers the fund under the policy guidance and direction of the HEC and executes funding transfers for projects approved by the HEC. The VHA Chief Financial Officer (CFO) provides periodic status reports of the financial balance of the Fund to the Defense Health Agency (DHA) CFO and to the HEC.

2016 JIF Projects

The regularly scheduled call for the 2016 JIF project proposals was cancelled for 2016, due to the rescission of $30,000,000 from the JIF program's unobligated balance. A call for the 2017 JIF project proposals is being prepared for DoD-VA interdepartmental release.

DoD-VA Health Care Sharing Incentive Fund Crosswalk
(dollars in thousands)

Description	2015 Actual*	2016 Budget Estimate	2016 Current Estimate*	2017 Estimate*	Increase/ Decrease
Transfer from Medical Services	$15,000	$15,000	$15,000	$15,000	$0
Transfer from DoD	$15,000	$15,000	$15,000	$15,000	$0
Subtotal	$30,000	$30,000	$30,000	$30,000	$0
Budget Authority	$30,000	$30,000	$30,000	$30,000	$0
Adjustments to Obligations:					
Unobligated Balance (SOY):					
No-Year	$195,593	$140,593	$137,730	$91,000	($46,730)
Rescissions, P.L. 113-235, P.L. 114-113 (From Unobligated Balance)	($15,000)	$0	($30,000)	$0	$30,000
Unobligated Balance (EOY):					
No-Year	($137,730)	($100,593)	($91,000)	($61,000)	$30,000
Change in Unobligated Balance (Non-Add)	$42,863	$40,000	$16,730	$30,000	$13,270
Recovery Prior Year Obligations	$11,697	$0	$13,123	$14,435	$1,312
Obligations	$84,560	$70,000	$59,853	$74,435	$14,582
Outlays:					
Obligations	$84,560	$70,000	$59,853	$74,435	$14,582
Obligated Balance (SOY)	$73,184	$113,184	$69,937	$94,167	$24,230
Obligated Balance (EOY)	($69,937)	($160,684)	($94,167)	($146,667)	($52,500)
Recovery Prior Year Obligations	($11,697)	$0	($13,123)	($14,435)	($1,312)
Outlays, Net	$76,110	$22,500	$22,500	$7,500	($15,000)
FTE**	57	44	57	57	0

*Anticipates VA and DoD will each transfer the required minimum of $15 million to this fund.
**Data source: VA Financial Management System (FMS). VA assumes a steady-state number of FTEs through the budget years.

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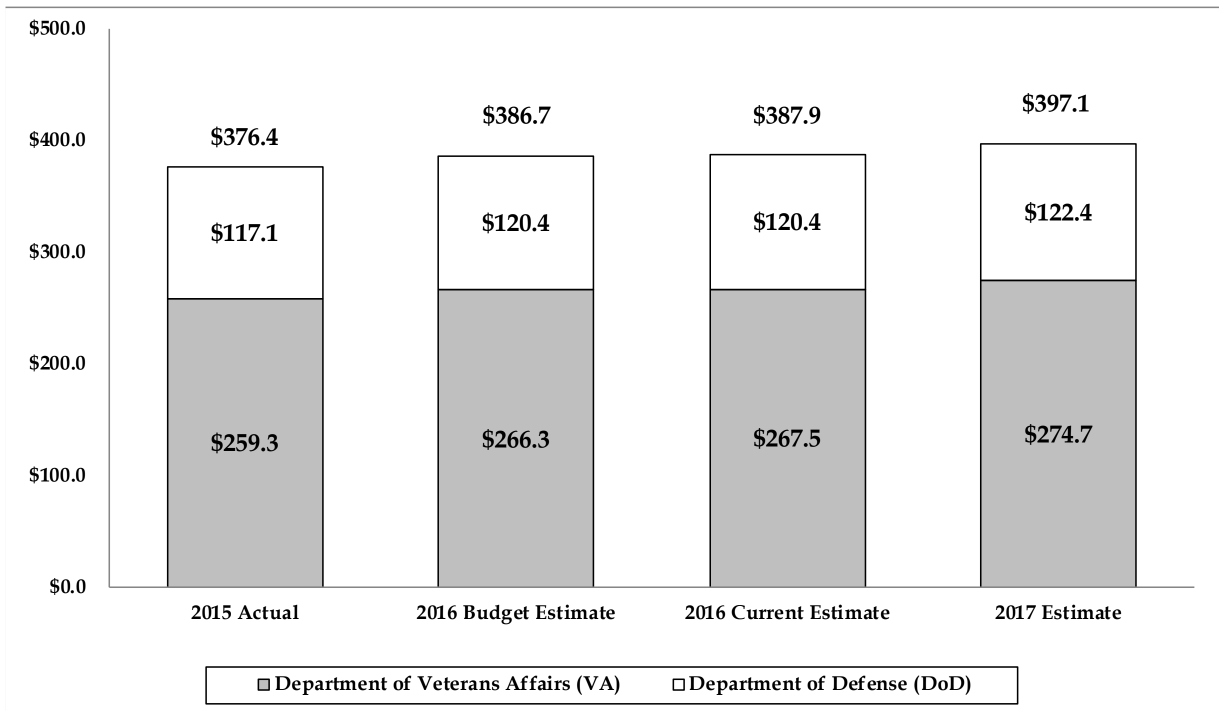
Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund



Financial Highlights

(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate 3/	2017 Estimate 3/	2016-2017 Increase/ Decrease
Appropriation, Transfers From:					
Medical Services	$190,185	$195,358	$196,323	$201,604	$5,281
Medical Support & Compliance	$26,608	$27,332	$27,405	$28,206	$801
Medical Facilities	$35,490	$36,455	$36,635	$37,620	$985
VA Information Technology	$6,968	$7,158	$7,158	$7,301	$143
Subtotal, VA Contribution	$259,251	$266,303	$267,521	$274,731	$7,210
Department of Defense (DoD) 1/	$117,125	$120,387	$120,387	$122,375	$1,988
Other DoD Contributions:					
MERHCF DoD reimbusement	$3,483	$3,615	$3,615	$3,615	$0
DoD "Stay Navy" (non-add) 2/	$14,695	$14,980	$14,980	$15,383	$403
Subtotal, DoD Contribution	$135,303	$138,982	$138,982	$141,373	$2,391
Total /4	$376,376	$386,690	$387,908	$397,106	$9,198
Collections 5/	$22,330	$21,110	$22,102	$22,316	$214
Reimbursements 6/	$7,487	$8,500	$8,500	$8,500	$0
Unobl Bal (SOY)	$5,950	$5,000	$8,008	$5,000	($3,008)
Unobl Bal (EOY)	($8,008)	($5,000)	($5,000)	($5,000)	$0
Lapse	($7,993)				
Obligations	$396,142	$416,300	$421,518	$427,922	$6,404
FTE:					
Civilian	2,127	2,167	2,167	2,172	5
DoD Uniformed Military 7/	928	836	836	836	0
Total FTE	3,055	3,003	3,003	3,008	5

1/The actual amount of the MERHCF reimbursement will impact DoD transfer amount.

2/ Non-add for Personal Services Contract funded by DoD for the East Campus.

3/FY 2016 and 2017 estimates are based upon the best available information at the time of the development. of the budget. These estimates are subject to revision as operational estimates are refined for the Captain James A. Lovell Federal Healthcare Center (FHCC). These estimates are in compliance with Public Law 111-84 which established this fund.

4/Total does not include the Stay Navy contribution or MERHCF reimbursement.

5/Collections estimate provided by the Chief Business Office.

6/Includes estimated MERHCF reimbursement from DoD.

7/FY 2015 is based on estimates from the Navy Manning Plan in FY 2015, and no change is expected in FY 2016. Estimates do not reflect the number of DoD Uniform Military FTE subject to Reconciliation in the FHCC Joint Areas.

Program Description

On May 27, 2005, the Department of Veterans Affairs (VA)/Department of Defense (DoD) Health Executive Council signed an agreement to integrate the North Chicago VA Medical Center (NCVAMC) and the Navy Health Clinic Great Lakes (NHCGL). This landmark agreement created an organization composed of all the medical and dental components on both VA and Navy property under the leadership of a VA Senior Executive Service (SES) Medical Center Director and a Navy Captain (O-6) Deputy Director. The leadership functions in concert with an Interagency Advisory Board and a local Stakeholder Advisory Board. To support the integration of NHCGL and NCVAMC, a $118 million DoD construction project was awarded to construct a new federal ambulatory care clinic and parking facilities co-located with NCVAMC. The project was completed on September 27, 2010, and the first multiple specialty clinic opened on December 20, 2010. The approved Governance Model, with VA as the Lead Partner, relies on an extensive Resource Sharing Agreement (RSA) between the current NCVAMC and NHCGL. This RSA ensures strict adherence to the title 38 requirement that one entity may not endanger the mission of the other entity engaged in a RSA.

The integrated organization – the Captain James A. Lovell Federal Health Care Center (FHCC) – is comprised of two campuses. The West Campus has 48 buildings on 107-acres of land between Green Bay Road and Buckley Road in North Chicago, Illinois. The East Campus has four medical facilities on Naval Station Great Lakes, Illinois. There are two Community Based Outpatient Clinics (CBOCSs) in Evanston and McHenry, Illinois, and one in Kenosha, Wisconsin. The FHCC has 376 available beds and treated 959,339 outpatients and 4,645 inpatient admissions in 2015.

The FHCC began using a single unified budget in 2011 to operate the integrated facility and execute funding using the VA Financial Management System (FMS). An account under the Department of Veterans Affairs, "Joint Department of Defense - Department of Veterans Affairs Medical Facility Demonstration Fund" (referred to as the "Fund"), was effective beginning in 2011 (4th Quarter).

VA and DoD determine the FHCC expenses that can be attributed to VA and DoD, based on cost, workload, and the consumption of resources by each Department's beneficiaries. This reconciliation model is used as the basis for preparing future budgets. The reconciliation methodology uses agreed-upon full costing methods and execution data to determine the costs attributable to each Department. The reconciliation methodology uses industry standard measurements such as Relative Value Units (RVUs) and Relative Weighted Products (RWPs) for the determinations of workload values to be compared to VA's Decision Support System (DSS) full costs. Both Departments will continue to work together to improve upon an equitable reconciliation process and ensure respective Department financial controls are implemented.

Per statute, the Secretary of Defense, in consultation with the Secretary of the Navy, and the Secretary of Veterans Affairs shall jointly provide for an annual independent review of the Fund at least three years after the date of the enactment of National Defense Authorization Act (NDAA) of 2010, Public Law 111-84.

In addition, Public Law 111-84 requires the Secretaries to jointly submit a final report on the exercise of the authorities in the law not later than 180 days after the fifth anniversary of the date of the execution of the executive agreement. The report must include the following:

a. A comprehensive description and assessment of the exercise of the authorities in NDAA 2010.

b. The recommendation of the Secretaries as to whether the exercise of the authorities of NDAA 2010 should continue.

The Departments anticipated submitting this report to the appropriate committees of Congress in March 2016.

The authorities to use this Fund shall terminate on September 30, 2017.

Administrative Provisions

VA is proposing continuing the following administrative provisions in accordance with Public Law 111-84, NDAA 2010, for 2017, as included in the President's Budget:

SEC. 219. Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2017 for ''Medical Services'', ''Medical Support and Compliance'', ''Medical Facilities'', ''Construction, Minor Projects'', and ''Information Technology Systems'', up to $274,731,000, plus reimbursements, may be transferred to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 3571) and may be used for operation of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): *Provided*, That additional funds may be transferred from accounts designated in this section to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress: *Provided further,* That section 223 of Title II of Division J of Public Law 114-113 is repealed.

SEC. 221. Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, for healthcare provided at facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500) shall also be available: (1) for transfer to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 3571); and (2) for operations of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National

Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500).

Also in accordance with Public Law 111-84, NDAA 2010, DoD is proposing the following general provision, for 2017, as included in the President's Budget:

> Section 8098. From within the funds appropriated for operation and maintenance for the Defense Health Program in this Act, up to $122,375,000 shall be available for transfer to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund in accordance with the provisions of section 1704 of the National Defense Authorization Act for Fiscal Year 2010, Public Law 111-84: Provided, That for purposes of section 1704(b), the facility operations funded are operations of the integrated Captain James A. Lovell Federal Health Care Center, consisting of the North Chicago Veterans Affairs Medical Center, the Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility as described by section 706 of Public Law 110-417: Provided further, That additional funds may be transferred from funds appropriated for operation and maintenance for the Defense Health Program to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Defense to the Committees on Appropriations of the House of Representatives and the Senate.

Justification for VA Administrative Provisions:

The first VA provision (Sec. 222) is required to permit the transfer of funds from specific VA appropriations to the Fund, which was established by Public Law 111-84, section 1704. Section 1704(a)(2)(A) and (B) specify that the Fund will consist of amounts transferred from amounts authorized and appropriated for the DoD and VA specifically for the purpose of providing resources for this Fund.

The VA's 2017 budget request includes funding to be appropriated and transferred to the Fund within the appropriations request for Medical Services, Medical Support and Compliance, Medical Facilities, and Information Technology Systems.

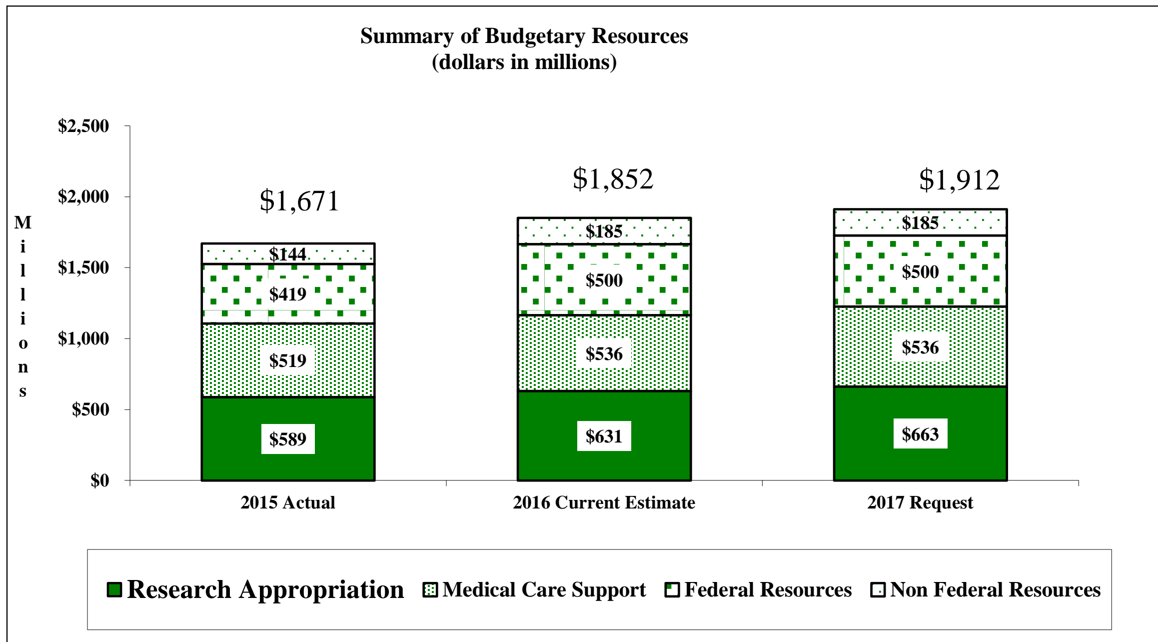
The second provision (Sec. 224) will permit the transfer of funds from the Medical Care Collections Fund to the Fund. Section 1704 of Public Law 111-84 allows VA and DoD to deposit medical care collections to this Fund. Section 1704(b)(2) specifies that the availability of funds transferred to the Fund under subsection (a)(2)(C) shall be subject to the provisions of 1729A of title 38, United States Code (U.S.C). Title 38, U.S.C., section 1729A(e), requires that: (e) amounts recovered or collected under the provisions of law referred to in subsection (b) shall be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901, 902) as offsets to discretionary appropriations to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified in subsection (c).

To treat the collections as offsets to discretionary appropriations, language is needed in the appropriations act regarding the authority to use collections to pay for the expenses of

furnishing health care at the Captain James A. Lovell Federal Health Care Center located in North Chicago, Illinois.

Medical and Prosthetic Research

Leading 21st Century Medical Research/ Transforming VA Care



Appropriation Language

For necessary expenses in carrying out programs of medical and prosthetic research and development as authorized by chapter 73 of title 38, United States Code, [$630,735,000] *$663,366,000* plus reimbursements, shall remain available until September 30, [2017] *2018.*

Executive Summary

VA Research is transforming VA into a learning health care system through integration with health delivery systems that facilitates improved outcomes and cost management. VA research achieves superior results because of effective collaboration among engaged Veterans and families, dedicated clinician-scientists, and an unparalleled national health care system. Although VA research is dedicated to improving the lives of current and future American Veterans, it benefits health care worldwide. Most VA researchers are also clinicians and providers who treat patients. Thus, VA research arises from the desire to heal, rather than pure scientific curiosity and yields remarkable returns. A VA clinical trial that compared angioplasty to best medical therapy alone for coronary artery disease, for example, led to a significant reduction in the use of unnecessary angioplasty, with

savings to the public of hundreds of millions of dollars annually. Similarly, VA research also showed that many patients with rheumatoid arthritis can be treated with an older, inexpensive drug and achieve clinical outcomes comparable to treatments costing tens of thousands of dollars each year – a finding that continues to save money over time.

VA research continually rebalances its portfolio to meet the most pressing needs of Veterans, setting priorities with input from department and administration leadership, clinical leaders, Veterans and Veterans Service Organizations (VSO), and the President. In 2017 and 2018, VA's research priorities focus on ensuring world-class care for Veterans throughout their lives, emphasizing personalized precision medicine approaches to improve clinical outcomes, and developing a Learning Health Care System. Health services research will continue to advance implementation of improved treatments in the VA health care system and optimize systems approaches to care delivery. VA will advance engineering research and development to improve the lives of disabled Veterans by personalizing prosthetic systems that replace lost limbs or activate remaining nerves and muscles.

Building on the Million Veteran Program (MVP) to advance the President's Precision Medicine Initiative (PMI) is a major goal for VA research in 2017 and 2018. MVP, a groundbreaking genomic research program, seeks to collect genetic samples and general health information from 1 million Veterans. This program will use genetic analysis to show how to improve treatments by understanding individual patients, thus improving care for Veterans and the Nation. MVP has enrolled more than 438,000 Veterans. An initial genetic analysis is ongoing; some data are now available to investigators who are beginning studies on posttraumatic stress disorder, schizophrenia, bipolar disorder, and Gulf War Illness. VA research is committed to ensuring the success of the President's PMI , and in 2017 will reprioritize program spending to provide additional support to this initiative.

Research to benefit Gulf War Veterans remains a priority. Over the past several years the number of projects funded and the level of funding have increased each year. As directed by Senate Report 111-40, the VA research program ensures that no less than $15 million is available for Gulf War research each year; the actual amount spent on such research depends on the quantity and quality of research proposals. VA has worked to develop Gulf War researchers to ensure that research proposals of high scientific merit are submitted. Funding increased from $9.7 million in 2014, to $10.5 million in 2015, $12.5 million in 2016, with a 2017 estimate of $15 million.

VA is expanding research efforts to improve women Veterans' health, by studying how VA provides for women Veterans' general and gender-specific health care needs, and understanding military experiences of women Veterans as well as later health risk factors.

VA works closely with other federal agencies to assure effective use of scarce taxpayer resources in executing its research mission. We conduct joint programmatic reviews with the Department of Defense (DoD) and National Institutes of Health (NIH) to ensure that our research efforts are well coordinated. Under the President's National Research Action

Plan (NRAP), VA and DoD created research consortia for traumatic brain injury and Post-Traumatic Stress Disorder (PTSD), investing $107 million over five years. High level coordination has become routine for all three agencies, benefiting Veterans and the American public.

To fulfill our commitment to provide superior health care to Veterans, VA requests $663 million in direct appropriations in 2017, which is an increase of $33 million, or 5 percent, over 2016. The VA research program is enhanced by private and federal grants awarded to VA-investigators. These other Federal and non-Federal resources, from organizations including NIH, DoD, and Centers for Disease Control and Prevention (CDC), are estimated at $1.2 billion. VA estimates total resources will exceed $1.9 billion in 2017. The estimated direct research program and reimbursable employment is estimated to be 3,521 full-time equivalents (FTEs); all VA researchers are VA employees. The budget request and table below reflect a civilian pay raise of 1.3 percent for 2017. We estimate that VA research and development will support 2,234 projects during 2017. This slight decrease in supported projects is the result of rebalancing the portfolio and investing available dollars to expand the Genomic database to support future research in Precision Medicine.

Appropriation and Other Federal Resources
(dollars in thousands)

	2015 Actual	2016 PB	2017 Request	% Change 2016-2017 PB to Req.
Medical and Prosthetic Research	$588,513	$630,735	$663,366	5%
Medical Care Support	$519,393	$536,125	$563,861	5%
Other Federal and Non-Federal Resources	$563,384	$685,000	$685,000	0%
Reimbursements	$32,751	$40,000	$40,000	0%
Total Budgetary Resources	$1,704,041	$1,891,860	$1,952,227	3%
FTE	3,521	3,551	3,521	-1%

Appropriation Highlights - Medical and Prosthetic Research
(dollars in thousands)

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Request	2016-2017 Inc/Dec
Appropriation	$588,513	$621,813	$630,735	$663,366	$32,631
Obligations	$661,590	$661,813	$673,374	$703,366	$29,992
Total Projects	2,224	2,254	2,254	2,234	(20)
Average Employment	3,491	3,551	3,551	3,551	0
Employment Distribution					
Direct FTE	3,380	3,410	3,410	3,380	(30)
Reimbursable FTE	141	141	141	141	0
Total	3,521	3,551	3,551	3,521	(30)

Net Change
Medical and Prosthetic Research
2017 Summary of Resource Requirements
(dollars in thousands)

Description	Budget Authority
Original FY 2016 President's Budget	$621,813
Omnibus Budget Increase	$8,922
Adjusted FY 2016 Budget Estimate	$630,735
2017 Request:	
Pay Raise (1.3%) Starting January 1, 2017	$3,779
Biomedical Research and Development Price Index (2.7%)	$7,339
Current Program Reprioritization	($43,486)
Strategic Initatives	$65,000
Subtotal	$32,631
2017 Budget Estimate	$663,366

Promoting the President's Precision Medicine Initiative:
Clinical Precision Medicine

> *We must move these discoveries from the lab bench to the clinic and into Veterans' hands.*

VA's Million Veteran Program provides a rich platform for discovering the relationships among genes, environmental exposures, and health. More than 438,000 Veterans have provided DNA specimens, military exposure information, and access to their health records (by authorized researchers) to facilitate studies on topics ranging from the causes of Gulf War illness and PTSD to functional impairment in schizophrenia and bipolar disorder. While studies like these will elucidate the biological pathways of disease and ideally lead to improved diagnostics and new drugs, they are not sufficient to realize the full range of potential benefits of precision medicine for those who have served our country. To do this, we must move these discoveries from the lab bench to the clinic and into Veterans' hands.

Among the many conditions associated with military service and combat exposure, the constellation of chronic pain, PTSD, depression, and substance abuse looms large. These conditions frequently occur together and are difficult to treat adequately. Patients develop tolerance to opioids, a mainstay of pain therapy, reducing their effect. Paradoxically, this tolerance may be accompanied with enhanced pain perception in some patients. Inability to find adequate pain relief may contribute to the development of depression, which is highly associated with PTSD and substance abuse. For those for whom the first medication is ineffective in treating depression or PTSD or pain, the current approach is to try a second drug, or a third, or a combination, thus increasing the risk of complications without necessarily treating adequately. Recently, we have begun to understand some of the genetic factors that may cause one medication to work better than another in a specific patient, but there has been no effort as of yet to evaluate the effectiveness of genomically-informed medication selection for these conditions within a large health care system.

We therefore propose to investigate the impact of pharmacogenomic strategies for drug selection in up to 21,500 Veterans with PTSD, depression, pain and/or substance abuse over the next five years. These studies will evaluate the effectiveness of providing pharmacogenomic information to patients and providers for improving treatment of pain, PTSD, depression, and substance abuse in Veterans. The studies will also evaluate the impact of this approach on cost and staffing requirements in primary care and specialty clinics. If these strategies prove effective, the research will lead to the formulation of a plan for system-wide implementation, truly advancing the goals of precision medicine.

The Department plans to invest $15 million to support this new initiative. The $15 million will come from an internal reprioritization of supported research.

Promoting the President's Precision Medicine Initiative:
Sequencing the Genome of Veterans in the Million Veteran Program

Using the VA Vietnam Era Twins Registry, VA scientists have studied the factors influencing susceptibility and resilience to PTSD. Comparing combat-experienced identical and fraternal twins showed that about a third of the likelihood of developing PTSD can be explained by genetic factors alone. Although subsequent VA studies have identified a few possible candidate genes for PTSD susceptibility, our understanding is far from complete. Ongoing analysis of PTSD patients among the more than 438,000 MVP Veterans whose genome has been partially characterized using "MVP chip" analysis is expected to further improve this understanding, but newer technologies to sequence the genome promise significantly greater information for improving treatments.

We propose, therefore, to use "next generation sequencing" to sequence, in up to 100,000 MVP Veterans, the part of the genome that codes for proteins (the exome). To do so requires extensive effort and resources, but at great reward: More detailed genetic analysis of Veterans with PTSD, and those with frequently co-occurring conditions such as depression, pain, and substance abuse, will shed light on the molecular changes in the brain that cause or increase the risk for these illnesses. Such studies provide hope not only for improved diagnosis, but also for more effective drugs, based on the individual genetic characteristics of the Veterans who suffer lingering effects of war.

The Department will invest $50 million for the sequencing effort.

Update on FY2016 Initiatives

VA is transforming care for Veterans and thus increasing the need for care coordination with the private sector, while improving the Veteran experience, access, and timeliness of care wherever it is obtained. Implementing new models of care under the Veterans Health Administration (VHA) Blueprint for Excellence requires us to excel as a Learning Health Care System. To this end, VA Research began in 2016 to support five interlocking research streams: measurement science, operations research, point of care research, studies of provider behavior, and randomized program implementation:

1. **Measurement science:** Current systems for assessing system performance may not uniformly assess gaps in care. VA studies have developed predictive analytic measures to assess clinical severity, and critically evaluated validity of chronic disease performance measures to prevent inappropriate, potentially harmful, treatment. A current study applies cost estimation to Hepatitis C treatment to determine cost-effectiveness and cost-benefit over time. We will build on this work to further validate and deploy patient-centered measures of care including access, care experience, and adherence.
2. **Operations research**: Veterans should experience seamless services at any healthcare facility. We are building on the measurement science work stream to develop mathematical models of health systems functions and improve health care timeliness and efficiency. Special focus is on supply chain management and industrial engineering techniques to optimize the delivery of medical care and improve care quality/safety (e.g., combatting antimicrobial resistance-CARB).
3. **Point of Care Research**: In Point of Care (POC) Research, VA is exploring a new approach to answer comparative effectiveness questions by embedding research

methods into delivery of usual patient care. Alternative treatments are offered randomly at the first patient encounter by the patient's usual healthcare provider; the VA medical record shows the outcome of the treatment, without a patient having to complete other research related visits. VA is starting a multisite POC trial of two widely used diuretics, with a goal to enroll more than 10,000 patients. The effort will advance knowledge regarding which diuretic is more effective, and ideally demonstrate that this type of work can be accomplished with the VA electronic medical record infrastructure on a national level.

4. **Provider behavior**: Health care providers may vary widely in test ordering and treatment recommendations, with the result that clinical services may be overused, underused, or applied to the wrong patients. This initiative extends VA research on care variation to new areas: use of cognitive science to understand variation in decision-making and information needs of clinicians; studies on how to de-implement established practices that are proven ineffective; influence of patients on provider behavior and use of patient interventions to promote appropriate decisions; impact of innovative ways of presenting information; use of "big data" methods to identify patterns of individual clinical decision making -- e.g. medication prescribing, test ordering, visit frequency, referral patterns; and the influence of performance measurement of provider behavior.
5. **Randomized Program Implementation**: VA research also tests new ways to do rigorous evaluation of new VA programs or policies. OMB strongly supports use of rigorous methods to assess the effectiveness of new VA programs or policies. Randomized program evaluations ask not only "does the program work?" but also "what makes it work?" and "how can we make it work in the real world?" Randomized evaluations of clinical programs or policies implemented nationally produce more effective strategies that prevent wasted effort and expense on ineffective rollouts, and ultimately produce greater returns. VA research will focus on developing large-scale randomized program evaluations to determine effectiveness of new programs or practices for improving access and outcomes of care, especially for those that seek care across different treatment settings, such as VA and non-VA facilities.

Executive Office Activities

National Research Action Plan for Mental Health

Since August 2012, federal agencies have worked together to address the mental health needs of Veterans through the NRAP. The plan was developed by VA, DoD, the Department of Health and Human Services (HHS), and the Department of Education (DoE) in response to Executive Order 13625. It outlines a vision for research on PTSD, Traumatic Brain Injury (TBI), and suicide prevention, and describes a goal-driven vision to improve treatment for PTSD and TBI. In the most recent NRAP progress report, all actions to improve mental health care were either on-track or completed.

One major result of the plan has been the establishment of new research consortia devoted to studying PTSD and TBI. These consortia, jointly developed by VA and DoD, were established and approved for five years of funding in 2014. The overall funding level is

estimated at $107 million from the two departments. The Consortium to Alleviate PTSD has begun five studies focusing on potential biomarkers and advanced brain imaging for PTSD. The Chronic Effects of Neurotrauma Consortium is conducting studies designed to fill gaps in knowledge about mild TBI, to determine mild TBI's effects on older Veterans, and to identify the most effective treatment strategies.

Cross-Agency Priority Goals

Under the Performance.gov Cross Agency Priority Goals effort, VA has worked with DoD and the National Institutes of Health to advance mental health research for service members and Veterans. The agencies have published common data elements for PTSD studies and suicide-prevention research and have completed a complete research portfolio analysis for suicide prevention. These efforts will advance scientific queries and enhance data-sharing.

The National Alzheimer's Project Act (NAPA)

NAPA creates an important opportunity to leverage federal efforts to help change the trajectory of Alzheimer's disease and dementia care for Veterans and other Americans. VA is working with HHS, the National Science Foundation, and DoD to accelerate the development of treatments, improve early diagnosis and coordination of care, reduce ethnic and racial disparities, and coordinate with international efforts to fight these conditions. VA research applications focusing on the NAPA initiative have doubled within the past year.

I. Care for Returning Service Members

> *"The Department of Veterans Affairs' Medical and Prosthetic Research Service is very productive in advancing medical knowledge and improving health care for Veterans and all other citizens."*—Resolution No. 148 of the 96th annual convention (2014) of the American Legion.

VA researchers are addressing Iraq and Afghanistan Veterans' most pressing mental and physical health issues, including PTSD, TBI, traumatic limb loss, sensory dysfunction, pain, and polytrauma. This work also benefits Veterans of all ages with similar issues.

Military Occupational Exposures

Military personnel serving in Iraq and Afghanistan between October 2001 and December 2014 were at risk for exposure to high levels of airborne particulate matter (PM), predominantly from burn pits. These potential hazards were reviewed in an October 2011 Institute of Medicine report, which recommended a prospective study of the long-term health effects of deployment-related exposures in military personnel. As a result, VA investigators have designed a study that aims to assess the link between land-based deployment in Iraq, Afghanistan, Kuwait, or Qatar with current pulmonary health among a representative sample of Army, Marines and Air Force military personnel.

A related effort will assess association of airborne exposures during deployment with current respiratory health among Veterans who served in Iraq and Afghanistan, testing

whether exposure to PM during military service is associated with worse respiratory health.

VA investigators are also pursuing innovative studies to improve the immune system and inflammatory responses to bacterial, viral, and fungal pulmonary infections from military occupational exposures and from opportunistic infections. Several common pathogens that have been found in the lungs of Veterans are being studied to understand the mechanisms of infection, in hopes of improving clinical care. Understanding how bacterial infection influences the worsening of chronic obstructive pulmonary disease (COPD) has led to the identification of vaccine candidates and biomarkers, as well as to changes in international guidelines for the use of antibiotics in COPD.

Pneumonia is a major cause of illness and death among Veterans, and has been associated with service in the Middle East. In pneumonia, significant inflammation in the lung, caused by the release of proteins called cytokines, can result in death. Various VA studies are examining the pathways that lead to cytokine production in pneumonia in hopes of identifying new drug targets. Also, VA is conducting a phase 3 clinical trial of the drug methylprednisolone to determine if it can be an effective early treatment for severely ill patients with community–acquired pneumonia (pneumonia acquired outside of a hospital or long-term care facility.

VA researchers are also working to identify factors that are critical in the early immune response to tuberculosis (TB) infection. Another study is exploring white blood cells that identify lung cells infected with Mycobacterium tuberculosis, the causative agent of TB. The cells do this by taking advantage of a protein called MR1 that alerts the immune system to cells that harbor the bacteria. VA's goal is to develop MR1 as a potential target for a vaccine and diagnostic test. Other investigators are working to develop new biomarkers to quickly identify treatment failures in clinical trials for new TB drugs, and to monitor drug resistance among TB patients.

Mental Health

VA studies mental health conditions that may affect the Veteran population, particularly post-deployment concerns such as PTSD, depression, anxiety, substance abuse, and suicide. Researchers aim to:

- understand the basic mechanisms of mental disorders, including individual risk factors and their impact on health outcomes;
- develop and test novel and improved treatments; and
- develop models of care that will deliver effective treatments more quickly, widely, and reliably to Veterans in need.

Suicide

A national surveillance system for data management relating to suicide, attempted suicide, and suicide re-attempts has been developed by VA and DoD personnel. The framework for characterizing risk and protective factors for suicidal behavior among Veterans is thus available for program evaluation and research purposes. The systems are already being used to support large-scale epidemiology research on suicide risk. Separately, a large

clinical trial has been launched to determine whether lithium is effective in preventing suicide attempts among those who have previously made an attempt. The trial began enrolling participants in 2015.

A recently completed VA study followed up on a previous finding that about half of those who commit suicide had contact with primary care clinicians in the month before they died. The study found that Veterans who died by suicide were more likely to have had documented functional decline (decreases in their physical or cognitive functioning or both), sleep disturbance, expressions of anger, and thoughts of suicide. The odds of dying by suicide were greatest among Veterans with anxiety diagnoses and functional decline. A diagnosis of PTSD was not significantly associated with suicide, nor was a pain diagnosis or the presence of other medical illnesses. Another recent study, however, has found that in Veterans with polytrauma, PTSD *was* associated with an increased risk of suicide. VA researchers are working to further clarify these associations so that risks for targeted treatment are identified.

Self-harm and suicide risk—Non-suicidal self-injury (NSSI)—that is, purposefully hurting oneself without conscious suicidal intent—is relatively common among Iraq and Afghanistan Veterans, according to a recent VA study. The research included 151 such Veterans, 14 percent of whom reported a history of NSSI. Moreover, the study found that those who deliberately hurt themselves were more likely to engage in suicidal behavior. The researchers hope that NSSI could serve as a marker for identifying which Veterans are most likely to attempt suicide. The same study team found that more than half of 214 male Iraq and Afghanistan Veterans seeking treatment for PTSD reported engaging in NSSI during their lifetime.

Posttraumatic Stress Disorder (PTSD)

VA clinical trials provided much of the evidence that cognitive processing therapy (CPT) and prolonged exposure therapy are effective treatments for PTSD. In 2013, VA researchers demonstrated that Veterans using either therapy not only showed reductions in their PTSD symptoms, but also used VA's mental health services considerably less often than in the year before they began therapy. Now, an important comparative effectiveness trial of CPT and prolonged exposure therapy is underway to learn more about which type of treatment may be better overall, or for specific types of patients. Enrollment is ongoing.

VA PTSD research includes studies of complementary and alternative treatments, such as meditation and yoga, and studies to improve Veterans' access to and engagement in evidence-based PTSD treatments. Current efforts promise to provide new insight into factors that could prevent or mitigate PTSD's onset following traumatic exposure. As part of these efforts, VA scientists are also investigating the genetic risk factors for PTSD in combat-exposed Veterans using MVP data.

VA is conducting a clinical trial on the benefit of service dogs for PTSD. Eligible Veterans are provided with an emotional support dog or a service dog specifically trained to perform tasks to mitigate PTSD. Researchers will look for improvements in PTSD symptoms, quality of life, participation in society, and employment status. Another VA study examines the impact of dogs adopted from an animal shelter on PTSD symptoms.

Mental Health Cohorts
The Long Term Health Outcomes of Women's Service During the Vietnam Era study is examining factors associated with mental and physical health and is the largest study to date of women Vietnam Veterans. Early findings indicate that, compared with the general population of U.S. women, women who served in Vietnam, in areas near Vietnam, and in the United States during the Vietnam War era, have lower all-cause mortality. They also have lower mortality from specific causes such as diabetes, heart disease, chronic obstructive pulmonary disease, and nervous system disease. However, women who served in Vietnam appear to have higher rates of death from pancreatic and brain-related cancers, a linkage that VA researchers are now studying further. Ongoing analyses of risk and resilience factors associated with long-term mental and physical health conditions will provide additional understanding of the long-term impact of the Vietnam war on this population, and help VA provide better services for women Veterans.

Other studies focusing on Veteran cohorts include the National Vietnam Veterans Longitudinal Study, the Vietnam Era Twins Registry, and a study of the neuropsychological and mental outcomes of Veterans of the Iraq war. VA will soon have large datasets available to characterize the health status over time for Vietnam, Iraq, and Afghanistan Veterans, providing a rich resource for future research.

Other Mental Health Conditions
Major depressive disorder (MDD) is among the most disabling and widespread of all mental disorders. MDD affects more than 300,000 VA patients per year. Thousands of Veterans with MDD do not respond adequately to initial treatments. Several second-line treatments are available, but it is unclear which treatment is best. A new study will evaluate the effectiveness of treatment options for Veterans with MDD who fail to improve in a satisfactory way with their initial antidepressant, and will help providers understand whether switching or augmenting antidepressant treatment is more effective.

Schizophrenia and bipolar disorder can cause lifelong disability, resulting in significant burdens on patients and their caregivers. VA scientists are investigating genetic risk factors for these disorders in a large multisite observational study, which will be particularly informative regarding functional disability.

TBI/Neurotrauma/Polytrauma
The annual cost of TBI to the nation is estimated at $76.5 billion. VA researchers are examining screening approaches to detect TBI (which can be difficult in mild cases), looking for biomarkers of mild TBI, and using imaging techniques to evaluate long-term structural and functional changes to the brain after TBI. Researchers are also studying treatments targeted to the specific and diverse needs of those with the injury, and at medications that may help those with TBIs recover lost function.
VA is collaborating with the Department of Education and the TBI Model Systems National Data and Statistical Center to develop the Veterans Traumatic Brain Injury Health Registry. The registry will provide military and civilian researchers with data on TBI in Iraq and Afghanistan Veterans. It will also provide the ability for longitudinal follow-up studies of Veterans with TBI-related diagnoses.

VA's electronic medical record system reminds clinicians to screen Veterans who have been deployed to Iraq or Afghanistan for mild TBI. Researchers found that VA's TBI screening process, which includes an initial TBI screen and a comprehensive examination for those who screen positive, is both inclusive and useful in referring patients for care. Some VA investigators are developing a screening tool for common TBI-related vision problems. Others are reviewing best practices for insomnia treatment in Veterans with TBI. Another effort is evaluating the practice of involving families in clinical decision-making, care plans, and educational efforts for their loved ones with TBI.

Investigators are hoping to increase reintegration of Veterans with TBI into the community by developing and testing the Community Participation through Self-Management Skills Development (COMPASS) program. This program tracks changes in functioning and community participation over time. Another recently funded project is focused on community reintegration in Veterans with moderate to severe TBI, examining both Veterans' experiences and the context in which they occur, in order to better understand factors that facilitate or impede reintegration.

Concussion Coach app—To better meet the needs of Veterans and others who have suffered mild to moderate concussion associated with TBI, VA developed a mobile app called "Concussion Coach." The app provides portable tools to recognize symptoms and to identify coping strategies. Features of the app include education about concussion symptoms and treatment options; tools for screening and tracking symptoms; relaxation exercises and other tools to manage concussion-related problems; links for community-based resources and support; and space for a personal contact list, resources, and support. In developing Concussion Coach, VA researchers applied the scientific and clinical recommendations that have emerged from efforts by many agencies, organizations, and institutions to better understand TBI.

Military Sexual Trauma

Military sexual trauma (MST) is associated with a wide range of physical and mental health conditions among both male and female Veterans. PTSD is the most common condition associated with MST.

VA and DoD researchers have examined official reporting of sexual assault in the military. Among other findings, the researchers found reporting concerns related to confidentiality, adverse treatment by peers, and beliefs that no action will be taken. Other research indicates that most female service members who experience sexual assault appear unlikely to seek post-assault medical and mental health care, at least in the short term. Concerns about confidentiality and career impacts, embarrassment, and not thinking that medical attention is needed were cited as reasons for not seeking care. Women who reported sexual assault were far more likely to receive care, suggesting the importance of increasing reporting of such assaults.

Another study examined the impact of various traumas across the life span among heterosexual and lesbian and bisexual women, and found a significant burden of interpersonal trauma for both sexual orientation groups; sexual assault during military

service appeared to increase PTSD risk for both groups. However, there were some differences by sexual orientation related to predictors of mental health status.

Prosthetics and Sensory Loss

> *"The VA research program is a jewel within VA that we support without hesitation or reservation"*—Carl Blake, National Legislative Director, Paralyzed Veterans of America, February 2015.

The number of Veterans accessing VA health care for prosthetics, sensory aids, and related services has increased by more than 70 percent since 2000. VA supports research to improve the lives of all Veterans who require these services.

VA's Center of Excellence for Limb Loss Prevention and Prosthetic Engineering investigates methods and devices to improve the quality of life and functional status of Veterans who are at risk for or who have undergone lower extremity amputation. The Center for Functional Electrical Stimulation investigates functional electrical stimulation, a technique that uses small electrical currents to activate paralyzed muscles. The Center of Excellence in Wheelchairs and Associated Rehabilitation Engineering improves the mobility and function of people with disabilities through advanced engineering, and contributes to the design of wheelchairs, seating systems, and other technology.

A noteworthy study in this area is the evaluation of an advanced prosthetic arm developed by DEKA Research and Development Corporation through funding from the Defense Advanced Research Projects Agency (DARPA). The DEKA arm was initially tested and refined in a multiyear, multisite, VA-funded study. More than three dozen study volunteers at four VA medical centers and one Army facility tested the prototype prosthesis. The study used virtual reality to allow users to practice controlling the arm in a simulated environment before being fitted with it. The Food and Drug Administration approved the DEKA arm in May 2014, paving the way for commercialization, marketing, and, ultimately, delivery to Veterans.

VA researchers are seeking to evaluate whether Veterans with chronic spinal cord injury achieve clinically meaningful improvements in their quality of life from home and community use of an exoskeletal-assisted walking device. The device will provide wheelchair-bound Veterans in the study an external framework for support with motorized hip and knee joints to help them walk. In addition to significant improvements to mobility, researchers hypothesize that improvements will be observed in bowel and bladder functions, which are among the daily life challenges that greatly impact this population.

> **SCI researchers honored—**In 2014 Drs. William Bauman and Ann Spungen were awarded the prestigious Samuel J. Heyman Science and Environment Medal. Samuel J. Heyman awards, also known as "Sammies," are presented by the nonprofit, nonpartisan Partnership for Public Service to federal employees who have made a significant contribution to the nation. Bauman, Spungen, and the research center they direct at the Bronx VAMC have made great progress in understanding the effects of spinal cord injury on the body. Their

work helped show that people with spinal cord injury are at a markedly increased risk for heart disease. The two researchers were the first to describe, and then treat, an asthma-like lung condition common in those with higher levels of paralysis. They have developed approaches to make it easier for paralyzed patients to undergo successful colonoscopies. The two have collaborated in VA for more than 25 years.

Other VA research is underway to learn if brain-computer systems may one day enable users of robotic arms to control the devices using only their thoughts. The Department is helping to test the “BrainGate2” system, which is developing better communication interfaces and improved accuracy and consistency of control over robotic and prosthetic limbs for those with limb loss or paralysis.

VA researchers are also looking at how to best match prosthetic components with the needs of amputees, including those with very active lifestyles. They are investigating different wound-care strategies for residual limbs after surgery, and evaluating CT scans of diabetic feet to identify foot types at highest risk for ulcers. One team is developing a program to teach caregivers complementary and alternative medicine techniques that lessen the anxiety and pain associated with traumatic limb loss.

Hearing

Hearing loss affects some 28 million Americans and, combined with tinnitus, is the number-one service-connected disability for Veterans. VA researchers, engineers, and clinicians are studying ways to prevent, diagnose, and treat hearing loss. They are also addressing a wide range of technological, medical, rehabilitative, and social issues associated with hearing loss. Much of this work takes place at VA’s National Center for Rehabilitative Auditory Research (NCRAR).

NCRAR researchers have published a management protocol for tinnitus, defined as a ringing, buzzing, or other type of noise that originates in the head. The protocol guides clinicians in helping those with tinnitus self-manage their condition, and in recommending clinical services as appropriate, especially if the tinnitus is causing other health problems such as depression and anxiety. Research in tinnitus management has expanded to evaluate telehealth delivery for Veterans with tinnitus and TBI, and is incorporating other psychological approaches.

Vision

VA estimates that nearly 1 million Veterans may be coping with severe visual impairments. In older Veterans, major causes of vision loss include age-related macular degeneration, glaucoma, cataracts, stroke, and diabetes. Among Iraq and Afghanistan Veterans, blast-related brain injuries can be followed by problems such as blurred vision, double vision, sensitivity to light, and difficulty reading. In addition to developing vision-restoring treatments, VA investigators are designing and improving assistive devices for those with visual impairments and developing better methods of vision testing. Much of this work takes place at VA’s Center for the Prevention and Treatment of Visual Loss.

Research at the center focuses on the early detection of potential blinding disorders of the Veteran and general population, including retinal disease, glaucoma, and traumatic brain injury. The center tests new ways of determining the earlier signs of progression and response to treatment, and develops new treatment innovations. Areas of exploration include the use of telemedicine and computer aided diagnosis for the detection of eye disease, and neuroprotection and neurotrophic growth factors for prevention and healing.

Employment/Vocational Rehabilitation

One of VA's most important responsibilities is to help disabled Veterans prepare for, find, and keep suitable jobs. Some Veterans with spinal cord injuries (SCI) have taken part in a VA program that provides integrated treatment along with job search help, a focus on competitive employment, and ongoing employment support. Findings from an ongoing study have shown that Veterans with SCI receiving this level of support are more than twice as likely to obtain employment. This trial is also examining the cost-effectiveness of such services, and how their level and intensity affects employment outcomes.

Pilot studies have found that Veterans with TBI or PTSD also benefit from supported employment, and researchers are now gathering more data. A large-scale study, begun in 2013 at several sites, has enrolled 540 Veterans with PTSD to compare VA's vocational rehabilitation strategies. Enrollment has been completed, and the study is now following participants over time to understand the duration of any benefit participants receive. Researchers are also examining supported employment for Veterans with mental health or substance dependence diagnoses who have felony convictions.

VA Research has also recently approved a study to better understand the experiences of Veterans with moderate to severe TBI as they transition to living in communities. This four-year study will provide a roadmap for designing and testing interventions to maximize community reintegration in employment, independent living, and social relationships. Additional research funded in 2015 will focus on employment, education, interpersonal relationships, homelessness, and other areas of community reintegration.

Homelessness

VA's homelessness research initiative continues to develop strategies for identifying and engaging homeless Veterans and ensuring they receive proper housing, a full range of physical and mental health care, and other relevant services. Research focuses on using existing data to identify and engage Veterans who are currently homeless, and to develop strategies to identify and intervene with Veterans who are at risk for becoming homeless.

Within the overall population of homeless Veterans, the number of those above the age of 55 is growing. VA researchers have found that while it takes about the same amount of time to place these Veterans in supported housing as younger Veterans, older Veterans have more medical problems, and are especially vulnerable to health problems relating to their homelessness.

Health impacts of housing—A team led by a VA researcher recently conducted a twelve-month study of 250 older homeless adults who were recruited at shelters in Boston. By the end of the time period, 41 percent of those Veterans had obtained housing. The team found that older homeless people who obtained housing during the study period had fewer symptoms of depression and fewer emergency department visits and hospitalizations compared to those who were still homeless. They found no difference between the two groups in difficulty completing basic daily activities such as bathing or dressing, or in symptoms of urinary incontinence.

Women Veterans are up to four times more likely than civilian women to experience homelessness. VA researchers have found that unemployment is the biggest single risk factor for homelessness among women Veterans. Military sexual trauma is another risk factor for homelessness, and sexual trauma rates differ between women Veterans and non-Veterans. VA is also looking at the special challenges faced by homeless women with children. Research has shown that they often place the safety and well-being of their children first, even if it means they may end up homeless and unable to live with their children.

Family/Caregiver Issues

Caring for an injured, disabled, or ill family member causes emotional, physical, and financial strain on caregivers. Several VA studies are looking at the impact of caregiver education and stress-reduction programs on the health of both Veterans and caregivers. Other studies are focusing on the short- and long-term needs of caregivers specifically, because many will be providing care for years.

VA Research has partnered with the VHA Caregiver Support Program and Social Work Services to establish a Caregiving Support Evaluation Center. The center will measure various aspects of VA's caregiving services, including outcomes of both Veteran and caregiver groups. It will provide information needed to revise current caregiver programs and plan new ones.

Acute Pain Management

Safe and effective treatment of pain has become a critical issue in VA, driven by the high prevalence of musculoskeletal pain reported by Iraq and Afghanistan Veterans, the variable management of pain in older Veterans with chronic diseases, and concerns about excessive use of opiates and overdose deaths in Veterans with chronic pain. VA has developed a National Pain Management Strategy to provide a system-wide standard of care to reduce suffering from preventable pain. VA researchers played an integral role in shaping this strategy, which in turn helps set the course for VA research and innovation in pain care. For example, VA is collaborating with DoD to develop clinical practice guidelines for low back pain, opioid use, and post-operative pain. VA has also published a toolkit for providers in support of this effort.

As part of this strategy, VA researchers helped establish the VA Stepped Care Model of Pain Management. In a study published in 2015, the stepped-care intervention resulted in reductions in pain severity and a 30-percent improvement in related disability when

delivered in primary care settings. A multisite study will evaluate the effects of pain screening and assessment approaches in such settings.

Researchers are also identifying and helping to address any disparities in Veterans' access to opioid therapy, looking at non-medication pain treatments such as cognitive behavioral and physical therapies, and studying cost-effective complementary and alternative approaches to treat or manage pain. These alternative approaches are also being studied and incorporated into new state-of-the-art pain-care quality metrics. Current initiatives focus on empowering Veterans to help manage their own pain, enabling Veterans to be a part of the clinical team. Veterans are learning how pain-management decisions are made and how to make informed decisions themselves.

VA researchers are developing innovative methods to treat acute pain following orthopedic procedures. Investigators have demonstrated that after rotator cuff surgery, ibuprofen delivered not orally but directly to the wound site using biodegradable materials decreases inflammation and pain, and also accelerates wound healing. Other researchers are testing transcranial direct current stimulation for pain following total knee replacement. The procedure is minimally invasive and can be delivered with very little discomfort. It can be used with ongoing drug therapy without the problems associated with drug interactions.

Researchers are creating a longitudinal database of Veterans with musculoskeletal diagnoses. So far, they have identified more than 4 million Veterans who received VHA care for such diagnoses between 2000 and 2012.

Substance Use Disorders

Substance use disorders, such as problem drinking or illicit drug use, are common in returning Veterans and are frequently complicated by co-existing disorders such as PTSD, chronic pain, or other mental health problems. Researchers are looking at treatment-seeking patterns: why and when Veterans ask for help, and why many Veterans don't. Treatment strategies, including cognitive behavioral strategies and Web-based approaches, are being studied. Other researchers are looking at the most effective therapies for Veterans with co-occurring disorders, such as depression and PTSD.

The dramatic increase in opiate use among Veterans has attracted increased attention from policymakers and researchers. From 2004 to 2012, the prevalence of opiate prescriptions among users of VA healthcare increased by 77 percent, according to a recent study. Research has documented a higher risk of overdose death among individuals receiving high opioid dosages and multiple opioid prescriptions. VA researchers have developed an Opioid Dashboard to track and help reduce the number of patients receiving high-dose prescriptions or multiple opioid prescriptions. An initial study of the VA Opioid Safety Initiative shows dramatic decreases in prescriptions for opioids, although the impact on pain control and patient safety and satisfaction are still unclear. VA Research is soliciting additional studies to examine the implementation of new informed-consent processes for patients being prescribed long-term opiate medications for pain.

II. Continued Care for the Veteran

> *"VA's clinical and biomedical research program has elevated the standards of care in western medicine, and has invented cutting-edge devices and treatment techniques that have improved the lives of millions of Veterans and non-Veterans."*—Ronald F. Hope, National Commander, Disabled American Veterans, February 2015.

The mission of VA research is to advance health care for Veterans of all ages across their entire lifespan. Beyond immediate post-deployment concerns, VA research invests in studies of chronic diseases, reproductive health, and preventive care to ensure continued high-quality care for Veterans throughout their lives.

Cancer

The VA cancer research portfolio has one of the largest investments in resources, with close to 250 active projects and $59.5 million allocated in 2017, and is targeted towards understanding and preventing cancers prevalent in the Veteran population. Topics being investigated in the portfolio range from the basic biology and genetic underpinning in laboratory based research to large definitive clinical trials of treatments and approaches to advance care. Discoveries improve Veterans' lives as well as the general population.

VA researchers are conducting a broad array of research on cancers common in the Veteran population. These include prostate, lung, colorectal, bladder, kidney, pancreatic, skin, esophageal, and female-specific cancers (such as breast and cervical cancer), as well as lymphomas and melanomas.

VA researchers conduct laboratory experiments aimed at discovering the molecular and genetic mechanisms involved in cancer; studies looking at the causes of disease; clinical trials to evaluate new or existing treatments; and studies focused on improving end-of-life care. One VA team is looking at a way to directly target chemotherapy treatments to reduce the side effects of chemotherapy, which include fatigue, hair loss, nausea, infertility, and organ damage. Using tiny gold capsules that carry drugs, the team has developed a nontoxic way to deliver chemotherapies directly to tumors. The capsules are small enough that they can fit through cell membranes. Once they are inside the membrane, they can be hit with lasers that will cause them to release the drug they carry. A peptide found in a species of toads fools the cells into accepting the capsule as a normal hormone. The team has already demonstrated that the capsules can penetrate tumor cells.

Other ongoing research is examining ways to increase the implementation of effective palliative care among patients with advanced cancer and other terminal conditions. One study is testing whether initiating palliative care even while patients are getting active treatment will improve outcomes. Another is examining oncologists' attitudes toward treating patients with advanced cancer, and their use of palliative care.

A study now underway will enroll 50,000 Veterans to compare colorectal cancer screening strategies. Colorectal cancer is among the most preventable of cancers. While colonoscopy is seen as the gold standard for screening, some recent findings raise

questions about its effectiveness in preventing colorectal cancer deaths. The trial is comparing the value of screening colonoscopy to annual non-invasive fecal immunochemical testing in preventing colorectal cancer deaths over 10 years.

Cardiovascular Disease

Cardiovascular disease (CVD), which includes heart disease, stroke, and other vascular disease, is the leading cause of death for men and women, Veterans and non-Veterans alike. VA research is focused on optimizing CVD prevention and treatment. Military experiences can contribute to stress and subsequent hypertension. Consequently, VA researchers are exploring the relationship between PTSD and CVD and looking at treatments that reduce stress in those with PTSD. On another front, researchers are studying how to use the electronic medical record to improve the assessment of cardiovascular risk in Veterans and guide their treatment decisions.

Gender differences in cardiac health—In a recent VA study, women Veterans who underwent cardiac catheterization in VA tended to be younger and more obese, and were more likely to have PTSD or depression, compared with their male counterparts. The women were also significantly less likely to have obstructive coronary disease, and consequently less likely to be prescribed heart medications. Despite these differences, their long-term outcomes were about the same as those of the men. Through this study and others, researchers have learned more about the complicated relationship between mental health and cardiovascular disease. For example, depression and PTSD can result in chest pain that is unrelated to heart disease, but at the same time they can contribute to the progression of heart disease. The study underscores the need for coordination between cardiologists and mental health providers.

Diabetes

Diabetes affects approximately 26 million people in the United States. Type 2 (adult onset) diabetes affects nearly 1 in 4 VA patients. Moreover, diabetes is the leading cause of kidney failure, non-traumatic lower-limb amputations, and new cases of blindness among adults. Up to 80 percent of patients with diabetes will develop macrovascular disease, such as heart attack and stroke. VA researchers are studying innovative strategies and technologies to enhance access to diabetes care and to improve outcomes for patients. They are also working to develop better ways to prevent or treat diabetes, and exploring its relationship to other conditions, such as kidney and heart disease, and mental illness.

VA researchers are conducting genetic “linkage studies” to identify genes associated with various diseases, including diabetes. Technological advances now permit investigators to search for common genetic patterns in affected families, or in large groups of individuals who do not have a family history of the disease. Using these approaches, researchers have identified several regions in the human genome that harbor indicators of increased diabetes risk and that may potentially serve as the basis for precision medicine treatments tailored to individual patients.

VA researchers participated in an international study that demonstrated an innovative way to transplant healthy beta cells—the pancreatic cells that store and release insulin— into

the human body without the usual risk of rejection. This has important implications for treating type 1 diabetes, the form of the disease caused by autoimmune destruction of beta cells. Using synthetic compounds that mimic growth hormone-releasing hormone (GHRH), the researchers found they could increase both the viability of transplanted beta cells and their ability to make insulin. The work may could potentially also help those with type 2 diabetes—namely those with more severe forms of the disease, who rely on daily insulin shots.

VA researchers are also involved in a major NIH-funded comparative effectiveness study of different diabetes drugs, all commonly used in combination with metformin. The trial is comparing the long-term risks and benefits of four widely used medications: sulfonylurea, which directly increases insulin levels; DPP-4 inhibitor, which boosts insulin levels indirectly by stimulating the release of an intestinal hormone; GLP-1 agonist, which increases the amount of insulin released in response to nutrients; and long-acting insulin.

Statin-diabetes link—In a VA-led database study of nearly 26,000 beneficiaries of Tricare, the military health system, those taking statin drugs to control their cholesterol were 87 percent more likely to develop diabetes. The study confirmed past findings on the link between the widely prescribed drugs and diabetes risk, but it was among the first to show the connection in a relatively healthy group of people. The study included only people who at baseline were free of heart disease, diabetes, and other severe chronic disease. The researchers stressed that the study doesn't definitively show that statins *cause* diabetes, nor does it mean people should stop using the drugs, which are widely prescribed to help people lower their cardiac risk factors. Rather, they said the study should alert researchers, clinical guideline writers, and policymakers that short-term clinical trials might not fully describe the risks and benefits of long-term statin use. They suggest the findings will also help inform conversations between patients and providers about the risks and benefits of the drugs.

Women's Health

Recognizing the dramatic increase in the number of women Veterans, VA research established the Women's Health Research Network to accelerate research that addresses needs of women Veterans. This innovative network is building capacity to develop research that will benefit women Veterans of all ages, including studies on women's health during and after deployment, reproductive health, primary care, and prevention. The network also fosters large multisite studies through a group of 37 VA medical centers that work together to facilitate research-clinical partnerships. The overall goal is to develop, test, implement, and disseminate effective innovations in care.

In 2015, VA researchers published studies on a wide array of issues related to women Veterans' health. An April 2015 supplement to the journal *Medical Care* reported research related to planning, financing, provision, evaluation, and improvement of health services and outcomes for women Veterans and women in the military. The supplement included important new findings related to access to care and rural health, primary care and prevention, mental health, reproductive health, military service and deployment, complex chronic diseases, and comprehensive care. Additional recent research found that mothers

with active PTSD were significantly more likely to experience spontaneous pre-term delivery. Other research revealed that pregnant women Veterans who use VA prenatal benefits are more likely to have symptoms of depression or PTSD.

Researchers have examined women Veterans' needs, priorities, and preferences for behavioral services, addressing issues such as depression, pain management, sleep problems, weight management, and PTSD. This and other research is focused on understanding women Veterans' experiences with care and preferences for different models of care, both for behavioral and physical health. Several research studies have addressed gender disparities in cardiovascular disease care, such as in receipt of guideline-recommended statin drugs to help control cholesterol.

New research has also been published on lifetime major depression among women Veterans, and intimate partner violence. Yet other newly published studies describe access to VA care among women Veterans in rural areas, and the implications of changes in DoD policy on women Veterans' exposure to combat, and their disclosure of sexual minority status. VA research is also examining satisfaction with VA care and potential gender disparities; care coordination among different women's health providers, including contract and non-VA care; and gender differences in post-deployment health and reintegration.

To improve the ability to study women's health issues, the Cooperative Studies Program Network of Dedicated Enrollment Sites (NODES) and Women's Health Practice-Based Research Network have begun a collaborative effort to share best practices in conducting studies involving women Veterans and providing tools for engaging and meeting needs of women interested in participating in VA clinical research.

Gulf War

Many 1990-1991 Gulf War Veterans are affected by a debilitating cluster of medically unexplained chronic symptoms that may include fatigue, headaches, joint pain, indigestion, insomnia, dizziness, respiratory disorders, and memory problems. VA researchers are dedicated to learning more about these problems and identifying the best ways to diagnose and treat them.

A number of different case definitions for this condition have been in use for many years, making it difficult to compare the results from different research studies. To address this problem, VA contracted with the National Academy of Sciences' Institute of Medicine (IOM) to develop a consensus case definition for chronic multi-symptom illness in 1990-1991 Gulf War Veterans. On the basis of the IOM report, VA is encouraging researchers to use the case definitions developed by the CDC in 1998 and by the Kansas Persian Gulf War Veterans Health Initiative in 2000. Additionally, VA will use the term "Gulf War illness presenting as chronic multi-symptom illness" to describe the multi-symptom condition that affects so many of these Veterans. This change will bring more consistency to Gulf War research.

VA researchers are continuing to study Gulf War illness and related health problems, and these efforts are guided by a strategic plan developed in 2013 with input from scientists, physicians, and Veterans. The plan was updated in 2015 to reflect the current state of knowledge about these subjects.

Two new drug treatments for Gulf War illness are being tested. In the first, a neurosteroid called pregnenolone will be given to a group of Veterans to treat their pain, cognitive symptoms, and fatigue. A control group of study volunteers will receive a placebo. In the second, duloxetine and pregabalin will be used to treat chronic pain. These drugs are currently used to treat fibromyalgia, a condition with many of the same symptoms displayed by Gulf War Veterans. The drugs will also be evaluated for their efficacy in treating fatigue, sleep problems, and mood disorders. Another non-medication trial is testing the use of light-emitting diodes to improve memory problems.

VA's Gulf War Registry program, which began in August 1992, offers a health examination at any VA health care facility to any Veteran with Gulf War service. As of February 2015, more than 150,000 Gulf War Veterans had undergone a registry exam, allowing their health concerns to be evaluated by VA physicians, and enabling them to be referred for additional care when needed. Since 2001, VA's War-Related Illness and Injury Study Center has used information from the registry and other data to support specialized care for Gulf War Veterans, and to conduct cutting-edge research and treatment programs specifically tailored to their needs.

VA is also developing research infrastructure to support epidemiologic and clinical studies. One example is the Gulf War Era Cohort and Biorepository. Through this project, epidemiological, survey, clinical, and environmental exposure data, along with blood specimens, are being collected to enable studies of conditions common among Gulf War Veterans. The project is currently evaluating best approaches for engaging Veterans and building the structure for a large-scale research effort. A complementary initiative, the Gulf War Veterans' Illnesses Biorepository, will collect and store brain and spinal cord tissue for the future study of neurological diseases. This project has completed its pilot phase and is recruiting participants now. Both these efforts will work collaboratively with the MVP, which is designed to identify relationships between reported illnesses and genetic variations. Based on the MVP dataset, a proposal investigating the genetic risk factors for Gulf War Veterans' illnesses is undergoing peer review.

A recently funded study is aimed at improving the care Gulf War era Veterans receive; the objectives of this study are to establish a comprehensive understanding of Gulf War I era Veterans' documented diagnoses, healthcare utilization patterns and costs, and patient-reported determinants of traditional and non-traditional healthcare utilization, associated healthcare costs, goals of care, and satisfaction. The study will examine the relationship between degree of concordance in illness perceptions between Gulf War Veterans with Chronic Multi-symptom Illness and their healthcare providers and Veteran health outcomes.

Amyotrophic Lateral Sclerosis (ALS)

ALS, also known as Lou Gehrig's disease, is a progressive neurodegenerative disorder that impacts the brain and spinal cord. VA researchers are studying environmental, toxic, traumatic medical, genetic, and occupational influences as possible contributors to the development of this disease. ALS is almost twice as prevalent among Veterans who were deployed to the Persian Gulf region in 1990 and 1991, compared with non-deployed Gulf War-era troops. VA has received several innovative proposals designed to investigate potential causes and treatments for this devastating disease.

Several current research projects focus on improving quality of life for Veterans with ALS. The results of a study of an EEG brain-computer interface for ALS patients are awaiting publication. Other studies and resources are aimed at determining the causes of ALS so that treatments can be developed. VA's Biorepository Brain Bank collects, processes, stores, and distributes specimens for future research studies. The Brain Bank accepts after-death neurologic tissue donations from Veterans with ALS and collected specimens are made available to qualified investigators.

Integrative Medicine

A growing number of VAMCs (VA Medical Center) are offering complementary and alternative (CAM) therapies to their patients, including yoga, acupuncture, and meditation training. VA researchers are committed to filling in scientific gaps relating to these treatments to determine which CAM therapies are truly effective, and for which conditions and populations they work best. Studies cover a range of common and promising therapies across a range of mental and physical health problems.

In 2014, the Department, in collaboration with the National Institutes of Health, funded several new studies on nondrug approaches to pain and symptom management in Veterans with co-morbid physical and mental conditions. The effort will provide a better understanding of how complementary approaches can be a cost-effective way to reduce pain and can be effectively integrated with regular care. It will also further the quality of care by developing better pain-care quality metrics that are Veteran-centric. One study funded under the initiative will look at the extent and cost-effectiveness of complementary and alternative medicine use among Veterans being treated at one VA facility for musculoskeletal disorder-related pain and related conditions.

Other studies have looked at acupuncture for managing symptoms in Hepatitis C. Preliminary findings suggest that acupuncture offered in group settings would be a feasible and acceptable alternative for the majority of Veterans. One study is examining the feasibility of conducting a trauma-sensitive yoga intervention in female Veterans with military sexual trauma and PTSD. Early findings showed that yoga may be acceptable to and preferred by many participants as an alternative to trauma-focused psychotherapy. Two other randomized controlled trials are underway to test mindfulness-based therapies: One targets suicidal thoughts; the other looks at reducing the risk of cardiovascular disease in women by stress reduction. Another pilot is examining the feasibility of implementing an Internet-based mantra repetition program for RNs caring for hospitalized Veterans.

Preventive Care and Health Promotion

Smoking Cessation

Veterans smoke cigarettes at higher rates than do their civilian counterparts. VA researchers are working to find a specific nicotine receptor in the brain that plays a key role in certain cravings—and then develop a medicine that delivers a targeted strike against those cravings. VA has also used the online virtual world Second Life, combined with traditional treatments and psychotherapy, to improve quit rates and get Veterans to smoke less. Transcranial magnetic stimulation, a treatment involving the application of an electromagnetic field to specific areas of the brain, is also being investigated, as is an intervention called abstinence reinforcement therapy, which combines evidenced-based treatment for smoking cessation with a smartphone-based support program. The study targets rural Veteran smokers.

In a recent review of previously completed studies, researchers with VA, the National Cancer Institute, and other institutions found that smokers had a nearly twofold risk of depression, compared with both former smokers and those who had never smoked. The results do not suggest that smoking causes depression; rather, they document only that many smokers are also depressed, and many depressed people are also smokers. The findings could help providers better understand their patients' needs.

Peer Support

Following up on a promising pilot study, researchers at VA's Center for Health Equity Research and Promotion (CHERP) are conducting a trial of peer mentors to help Veterans control their diabetes. The study will compare the impact of peer mentoring versus "usual care" on blood sugar levels, blood pressure, cholesterol levels, quality of life, and depression. Other innovative peer-support research includes a recent initiative combining peer support with Web-based cognitive behavioral therapy programs to improve mental health outcomes among Veterans; and a study on the use of peers to improve treatment engagement, housing retention, and community functioning among homeless Veterans.

Peer support in serious mental illness—A VA study published in 2015 looked at the value of peer support in treating serious mental illnesses. Based on the principle that Veterans understand each other, VA employs about 1,000 peer specialists across the country to help patients navigate their mental health illnesses, manage logistics like finding a home to rent or a job, and encourage positive behavior. The study compared outcomes between seriously mentally ill Veterans who had been assigned peer specialists and those who had not, and found that those who worked with specialists had the same level of recovery from their illness; quality of life; symptoms of illness; and ability to conduct interpersonal relations. However, Veterans with peer specialists had a small but significant improvement in one category: patient activation, which involves developing the skills and confidence that equip patients to become actively engaged in their own health care. While the improvement was small, other research has demonstrated that even small improvements in activation ratings can boost the rate at which recovery takes place.

Obesity

More than 7 in 10 Veterans who receive VA care are either overweight or obese. VA research on obesity looks at the biological processes of weight gain and weight loss, compares the safety and effectiveness of obesity treatments, and identifies ways to help Veterans stay at their optimal weight.

VA researchers explored the effects of treatments for weight loss and sleep apnea, which is linked to obesity. The team found that a 24-week weight-loss program significantly reduced inflammation and insulin resistance.

A recent study aims to address weight issues in Veterans from Afghanistan and Iraq (OEF/OIF) who are at high risk for becoming overweight and obese. This study is aimed to address younger Veterans who are more comfortable with technology-mediated interventions than older Veterans and who may not yet have developed obesity related chronic diseases. Additionally, OEF/OIF Veterans include a relatively high percentage of women compared to previous Veteran cohorts. These differences will address lifestyle interventions customized to OEF/OIF Veterans.

A group of VA investigators is examining mechanisms involved in regulating appetite. They are using dietary proteins to regulate satiety. This research has shown that a peptide called pituitary adenylate cyclase activating polypeptide (PACAP) plays an important role not only in regulating appetite but also in metabolism. Administration of PACAP in an animal model results in reduction of appetite and weight loss. PACAP is naturally occurring, but some individuals may be deficient in it. Using the principles of precision medicine, clinicians may eventually be able to identify these deficient individuals and offer them personalized treatment.

Risks and benefits of bariatric surgery—Bariatric surgeries, which include a number of different procedures performed on the stomach or intestines to induce weight loss, do more than help obese people shed pounds they cannot otherwise lose. They also help severely overweight patients live longer, according to a recent VA study. The retrospective cohort study found that the 2,500 Veterans who had had the surgery had a 53 percent lower risk of dying from any cause at 5 to 14 years after the procedure, compared with the 7,500 matched control patients who had not. The researchers also found that bariatric surgery has become safer, and that the risk of dying during or soon after bariatric surgery was lower in 2006-2011 than in 2001-2005.

Chronic Pain

VA's Center for Restoration of Nervous System Function focuses on neuropathic pain due to disease (multiple sclerosis and diabetes) and trauma (peripheral nerve and spinal cord injuries, traumatic limb amputation, and burns). Studies at the site are shedding light on variations in how Veterans with nerve injuries experience severe neuropathic pain (pain caused by damage or disease affecting the nervous system), and how they respond to pain treatments. The center was the first to demonstrate a cause-and-effect relationship

between mutations in the sodium channel and the development of chronic pain. This is important because drugs that modulate sodium channel function do not have the addictive properties of opioids. Recent studies have focused on precision medicine, using molecular biology and genetics to create individualized cell models that can be used to screen sodium channel blockers. The center is now collaborating with pharmaceutical companies to test novel sodium channel blockers in clinical trials.

Researchers at VA's Center of Innovation on Pain Research, Informatics, Multi-morbidities, and Education (PRIME) study the interactions between pain and behavioral health factors. PRIME's projects are exploring a variety of technologies, including interactive voice response, the Internet, smartphone applications, and video conferencing, as potential tools for pain management. The aim is to develop and enact approaches that are individualized and patient-centered.

Osteoarthritis is one of the most common causes of pain and disability among Veterans. A recently completed study compared the effectiveness of group-based physical therapy (PT) for knee osteoarthritis with usual individual PT care. The study found meaningful improvement overall (confirming the effectiveness of PT), with no substantial differences between groups (indicating that the group PT approach could provide equivalent treatment more efficiently, to larger numbers of patients).

III. Care for the "Golden Veteran"

VA researchers are pursuing new treatments, care models, and preventive strategies to improve aging Veterans' quality of life, and to support their caregivers.

Aging

VA is gathering a Veteran cohort from the NIH-funded longitudinal Health and Retirement Study (HRS), in collaboration with the National Institute on Aging (NIA). VA health data is being merged with information that has been provided to the HRS over the years to answer key questions about the health and well-being of Veterans, including those who do not use VA care. The data will include information about income, work, assets, pension plans, health insurance, disability, physical health and functioning, cognitive functioning, and health care expenditures. This data will be available to qualified researchers in 2016.

Neurodegenerative Disease

Alzheimer's Disease

Alzheimer's disease is the most common cause of dementia, and its complications over time generally result in death. There are currently no effective treatments to cure or slow down the progression of Alzheimer's disease and related dementia disorders. VA projects that roughly 218,000 Veterans will be diagnosed with dementia in 2017, an increase of more than 40,000 such diagnoses from 2008.

In Alzheimer’s disease, a protein called beta amyloid aggregates and forms hard plaques within neuronal networks in the brain. Until recently, amyloid plaques could be detected only after a patient died and an autopsy was performed. VA researchers associated with the Alzheimer’s Disease Neurological Initiative (ADNI) have been developing new methods to assess beta amyloid levels in the body, and several such tests are already being implemented in clinical trials. The goal is to establish methods of early detection, which will become more important as new treatments become available. ADNI is led by a VA researcher and funded mainly by the National Institute on Aging.

Because of the cognitive decline that occurs in Alzheimer’s disease, patients eventually need ongoing care either part-time or around the clock. Research is essential to provide caregivers of dementia patients with the resources, tools, and emotional support they need so they can better manage their caregiving experience, and continue to provide care for Veterans.

VA offers a program called Resources for Enhancing Alzheimer’s Caregiver Health in VA. It provides caregivers for Veterans with Alzheimer’s with 12 individual in-home and telephone counseling sessions, and five telephone support group sessions. Caregivers are also given a quick guide covering 48 behavioral and stress topics, plus education on safety and patient behavior management, and training for their individual health and well-being. VA research has documented the effectiveness of the program, which has been expanded to address other conditions, such as spinal cord injury and TBI. VA researchers have also created an online education and support program for caregivers of Veterans with Alzheimer’s disease. It includes a website, streaming videos, online education, and a discussion forum. Previous studies have suggested that such education and support may not only benefit caregivers but also lessen negative behaviors on the part of those with Alzheimer’s.

Although there is no treatment that can halt or reverse the progression of Alzheimer’s disease, a non-invasive, inexpensive, and reliable test for diagnosing the disease could spare people with dementia and their families the anxiety associated with uncertainty, direct them to support services earlier, and improve their likelihood of benefiting from current and future advances in treatment.

Parkinson’s Disease
In 2001, VA created six specialized centers known as the Parkinson’s Disease (PD) Research, Education, and Clinical Centers (PADRECCs). These centers of excellence serve the estimated 60,000 VA patients affected by PD through research, clinical care, education, outreach, and advocacy.

In 2012, VA researchers published the results of a 36-month study of 159 patients that found that patients with Parkinson’s disease who undergo deep brain stimulation (DBS)—a treatment in which a pacemaker-like device sends pulses to electrodes in the brain—can expect stable improvement in their muscle symptoms for at least three years. The trial, based at the PADRECCs and conducted in collaboration with the National Institute of

Neurological Disorders and Stroke, generated some of the strongest evidence to date on the pros and cons of DBS. A longer-term follow-up study is near completion.

Research has shown that people with PD can benefit greatly from exercise. Not only do exercise programs improve motor function and reduce the risk of falls, but they also improve overall quality of life and may slow the course of the disease. However, exercise programs that involve supervision in the home are expensive, and programs that require travel to a central site often result in non-compliance over time. A VA research team is evaluating a safe, home-based exercise program for people with PD. The program focuses on remote, real-time instruction using smartphone technology.

Best practices for end-of-life care—VA researchers created the Best Practices for End-of-Life Care for Our Nation's Veterans (BEACON) trial to test an intervention that could improve the quality of end-of-life care at VA medical centers. The four-month intervention, tested at six VA sites, trained hospital staff to identify actively dying patients and to implement a set of best practices traditionally used in home-based hospice care for these patients. The research team encouraged providers to allow patients access to their favorite food and drinks, tried to minimize invasive procedures, and increase the duration of family visits. Over the course of six years, the team found that the intervention improved the last days of Veterans with respect to a number of care variables, including increasing the use of medication for pain or confusion, advance directives, and nasogastric tubes. The rates were the same across the study groups for do-not-resuscitate orders, intravenous tubes, and restraints.

Diseases Prevalent in the Elderly

Stroke

Stroke is a common and costly problem in the Veteran population. Some 6,500 Veterans are hospitalized in VA with an acute ischemic stroke every year. VA is now developing a comprehensive system to provide optimal acute stroke care to all eligible Veterans.

VA researchers are looking at how the body can rehabilitate or repair itself after a stroke. VA also maintains a website, called RESCUE (Resources and Education for Stroke Caregivers Understanding and Empowerment), that provides stroke caregivers with information and resources to help them take better care of their loved ones, and to help them take care of themselves. It is currently being evaluated for its impact in reducing depression among caregivers.

Heart Failure

Among Veterans, heart failure is the most frequent cause for hospital admission and one of the most frequent causes of unplanned hospital readmission. More than 90 percent of Veterans with congestive heart failure are discharged on guideline-recommended medications, yet many do not receive optimal doses. The optimal dose of these medications (especially beta blockers) has been shown to improve cardiovascular outcomes. A new project that leverages natural language processing will provide key clinical data to Patient Aligned Care Team (PACT) members during outpatient visits to

support timely, guideline-based use of beta-blockers at the point of care. The goal is to reduce patient readmissions and boost outcomes. Additionally, a recently launched study will investigate whether implantable cardioverter defibrillators can prevent heart failure in the elderly.

Coronary artery disease (CAD) is a disease in which plaque builds up inside the heart muscle. Non-obstructive CAD occurs when those deposits do not obstruct the blood flow to the heart. Historically, doctors have considered these partial obstructions insignificant, but VA researchers have found that non-obstructive CAD should not be ignored, especially among those showing symptoms of heart disease. Patients should not consider a diagnosis of non-obstructive CAD to be good news, and if angiograms show blockages of 30 percent or more in one artery, the patient should be on preventive therapy.

IV. Ensuring Access and High-Quality Care/Special Initiatives

Ensuring access to timely and high-quality care is one of VA's highest priorities. VA Research works to identify and evaluate innovative strategies that can improve access and quality, especially for those Veterans who may face barriers to care, such as rural Veterans or racial or ethnic minorities.

Access to Care/Rural Health

Many Veterans who rely on VA for health care live in remote areas. VA researchers have been instrumental in understanding these Veterans' health care needs and developing and evaluating new initiatives to fill gaps in care. These efforts include understanding Veteran preferences and perceptions of access and barriers to care, developing new models for access to specialty care, and advancing telehealth innovations.

In four recently funded studies on mental health care for rural Veterans, researchers are developing a patient-centered survey to measure Veterans' perceived access to mental health services; testing interventions to increase engagement in mental health care at VA Community-Based Outpatient Clinics (CBOCs); testing clinical and technological interventions to improve the quality and outcomes of mental health care at CBOCs; and testing Web-based interventions and evidence-based training to enhance access to PTSD care for women Veterans and Veterans using CBOCs. New clinical and technology innovations are also being tested to improve specialty care through VA's Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO). The program is designed to help manage chronic and complex diseases in rural and medically underserved areas.

A study at 22 VA CBOCs found that implementing telemedicine-based collaborative care in small rural clinics that lack on-site psychiatrists and psychologists increases the percentage of Veterans who take the medications they are prescribed, and improves treatment response rates. In another study, videoconferencing was as effective as face-to-face treatment in providing cognitive processing therapy to Veterans with PTSD in rural settings. Veterans also reported high levels of satisfaction with the treatment. Other research indicates VA psychotherapy use has been increasing among both urban- and

rural-dwelling Veterans with a new diagnosis of depression, anxiety, or PTSD, although the proportion of rural Veterans receiving psychotherapy is less than for urban Veterans.

In another analysis, researchers found that Veterans with prostate cancer who live in rural settings had less access to comprehensive cancer resources than Veterans living in urban settings. Also, on average, those in rural areas had to travel five times further for care. However, despite these differences in access, rural patients received similar or better quality of care on four of five measures, and the time between diagnosis and the initiation of treatment was similar for rural and urban Veterans. Other recent research has raised questions about communication between VA and non-VA primary care providers in co-managing rural Veterans' care.

Veteran Engagement in Research

VA research established a Veteran Engagement Workgroup in 2015, empowering a diverse, representative group of VA investigators and Veterans to identify best practices for engaging Veterans in helping to set VA's research agenda and contribute to the design and the conduct of individual studies. Three subgroups are identifying and documenting current best practices in Veteran engagement in research projects, health services research and development center activities, and in the community. They will also make suggestions drawn from other agencies, such as the Patient-Centered Outcomes Research Institute. One funded project is creating a library of patient narratives from Veterans with TBI to document the most important issues affecting Veteran reintegration after a TBI. The repository will help inform future TBI studies and outcome measures.

Connected Health

The prevalence of high-speed Internet access and mobile technologies give Veterans multiple options for connecting with their VA health care team and managing their own health conditions. VA researchers have led the way in exploring how care can be enhanced by use of the telephone, Internet, videoconferencing, email, smartphone, text messaging, and wearable technologies. Researchers have conducted a number of studies comparing the use of these technologies to standard care and integrating patient-generated data in research. Among the key findings on connected health reported in 2015:

- VA clinicians' proactive use of secure messaging through MyHealth*e*Vet may enhance primary care visits by offering opportunities for patients to plan ahead and maximize in-person time with members of their clinical team.
- MyHealth*e*Vet helps improve patients' abilities to self-manage diabetes and promotes better outcomes in glycemic control, lipid control, and blood pressure.
- VA OpenNotes, which provides online access to clinical notes, helps Veterans take medications as prescribed, understand health conditions better, and adhere to care plans.
- VA is learning to successfully cope with a nationwide shortage of intensive-care physicians through the use of tele-intensive care services.
- Innovations including team-based telehealth collaborative care for patients with HIV; collaboration with local health systems, including campus health services; and home-based cardiac rehabilitation can all bring a broad range of health services closer to Veterans' homes.

- Smartphone applications can deliver or augment provider-delivered, evidence-based psychotherapies, as can other connected-health methods.

In 2015, VA continued to fund innovative research in connected health. Examples include testing two new health technology tools, one for measuring Veterans' sleep, and the other for managing sleep; and testing a Secure Messaging for Medication Reconciliation Tool trial among Veterans who are recently discharged from the hospital.

Physical Infrastructure

The physical condition of VA's research facilities is an important factor in recruiting and retaining world-class researchers. Since more than 60 percent of VA researchers are also clinicians taking care of patients, recruiting and retaining high-caliber researchers is essential to patient care.

In 2006, Congress directed VA to undertake a comprehensive review of its research facilities, and to report deficiencies and provide recommendations for correcting them. In response, VA conducted a detailed review of the physical structures housing research laboratories, vivaria, and support spaces, as well as plumbing, mechanical, electrical, and fire-protection systems supporting research spaces. The 2012 report, based on an assessment of 74 sites, indicated a widespread need for repairs and improvements, estimated to cost $774 million. The identified deficiencies, including cost estimates, were incorporated into the VA Capital Asset Inventory in 2013, and will inform facility condition assessments that VA conducts system-wide every three years.

Since release of the 2012 report, VA has corrected many of the deficiencies and increased funding. New research space is being constructed at several sites. Phase 2 of the modernization project, to be completed in 2016, will reassess research space at 25 stations to determine the effect of recent improvements or the extent of continued degradation. In addition, up to 20 additional stations will receive administrative follow-up visits. The infrastructure program will thus continue to support state-of-the art research laboratories to advance Veterans' health by recruiting and retaining top-tier clinician scientists.

QUERI

The VA Quality Enhancement Research Initiative (QUERI) improves Veteran health by supporting rapid implementation of effective treatments into practice. QUERI has provided an essential combination of scientific rigor and partnership with VA operations since 1998. QUERI was an integral component in VA's major transformation from a hospital to a primary care-based system, and has become the engine for VA's ongoing transformation into a successful learning health care system. QUERI is helping with VA transformational efforts through three major goals:

- rapidly translating evidence-based treatments into clinical practice;
- increasing the impact of VA research findings through bi-directional partnership, rigorous evaluation, and communication; and
- making VA a model learning health care organization through innovative implementation science, primarily through national collaborations involving VA and non-VA implementation and quality-improvement scientists.

In 2015, QUERI updated its strategic plan to better align with VA national priority goals. Recent VA initiatives supported by QUERI efforts include designing and deploying an effective strategy for implementing evidence-based mental health treatment in primary care practices; establishing Veterans Stakeholder Councils as models for eliciting consumer input, establishing appropriate clinical action measures to prevent over-treatment and potential harm among Veterans with chronic illnesses, and implementing secure messaging in VA primary care, regardless of location.

QUERI also funded seven projects to evaluate the implementation of the Veterans Choice Act, in collaboration with the Office of Analytics and Business Intelligence. The projects address the impact of the act on care for special populations; outcomes associated with care across different treatment settings; and Veteran satisfaction and access to care.

QUERI also supports the implementation of Partnered Evaluation Centers in collaboration with VA leadership and clinical operations. Ten partnered centers are in ongoing collaborations with the offices of Specialty Care, Nursing Services, Social Work, and Patient-Centered Care and Cultural Transformation.

Health Informatics and Big Data

The health information technology landscape is changing rapidly as a result of increased computing power, health information exchange initiatives, new mobile and wearable technologies, and new expectations on the part of patients, providers, and other stakeholders. To capitalize on this evolving digital environment, VA Research invests significant resources in supporting health care informatics and "Big Data" research.

A critical foundation of this research is the Veterans Informatics and Computing Infrastructure (VINCI). Funded by VA Research and the Office of Information and Technology, VINCI provides a high-performance computing environment and access to comprehensive VHA data. This infrastructure supports researchers' access to national data on the entire VA patient population, provides computing capability to researchers, and facilitates the creation of sophisticated analytic tools to address a broad array of issues. Research has developed natural language processing techniques to extract data from unstructured "free text" in clinical notes, and developed data modeling tools that convert VA medical data into standardized formats for research data-sharing. These tools allow VHA data to be used efficiently and effectively for research or clinical care.

In 2015, VA funded a wide range of health-informatics studies, including a study on regional electronic health information exchanges to improve care coordination for Veterans treated in non-VA hospitals, and another that uses a natural language processing system to translate medical jargon into consumer-friendly language. In addition, VA has funded projects that use mobile technologies to address Veterans' mental health issues and promote medication reconciliation. These informatics projects will leverage data within the electronic health record, administrative records, and patient-generated data to improve diagnosis and treatment and facilitate more patient-centered health care.

A recently funded group of five projects will use population informatics tools to make VA medication management data accessible to clinicians. The projects use the electronic health record and administrative records to help improve diagnosis and prescribing.

Technology Transfer Program

VA researchers have invented many notable drugs and technologies. These inventions have little value unless they are made available to those who can be helped by them. VA's Technology Transfer Program (TTP) protects intellectual property developed in VA. The program finds private industry partners to invest in the new technology and conduct further development and commercialization. One example of successful development is a new device for measuring oxygen in the blood. TTP patented the device and found a company to work with VA to test the device under a Cooperative Research and Development Agreement. After the device is validated, the technology will be commercialized. A second example is a new tissue-preservation solution formulated by VA scientists to stabilize veins and arteries for coronary bypass surgery. VA has licensed the technology and the company is conducting clinical trials for FDA approval.

Public Access to Research Data

A White House directive in February 2013 required VA to make the published results of research freely available to the public within one year of publication. VA implemented a policy to ensure that peer-reviewed full-text articles resulting from ORD-funded research are available through PubMed Central, a National Library of Medicine (NLM) database. To date, more than 1,000 publications have been uploaded by VA researchers. Additionally, pilot work has begun to establish procedures and policies to enable broader access to study data. VA Research has always promoted free exchange of scientific and medical information. Investigators are expected to report results at professional meetings and in scientific and medical journals. Those results are now more accessible to the public. Dissemination is also advanced by making clinical trials and their results available online through NLM's ClinicalTrials.gov web site. By requiring all clinical trials to be registered and their results subsequently posted online, VA has helped pioneer best practices that are still only under consideration in other research settings.

Designated Research Areas

Designated Research Areas (DRA) represent areas of particular importance to our Veteran patient population. The amounts shown for these research areas are not mutually exclusive. Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total to more than the VA research appropriation. This method of reporting is consistent with other Federal agencies.

In 2017, VA research is reprioritizing its portfolio towards precision medicine, including the substantial $50 million investment in genomic sequencing on Veterans enrolled in MVP. This genomic sequencing initiative is not a project, per se, and as a result it is not reflected in the following DRA tables. Thus, most DRAs show a minor decrease from 2016 levels, as some additional program resources are directed towards precision medicine. Projected spending and number of projects for every DRA are above 2015 levels.

Appropriations by Designated Research Areas
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Request	2016-2017 Inc/Dec
Acute & Traumatic Injury	$20,298	$21,313	$21,313	$21,313	$0
Aging	$146,856	$154,199	$154,199	$150,344	($3,855)
Autoimmune, Allergic & Hematopoietic Disorders	$27,699	$29,084	$29,084	$28,357	($727)
Cancer	$52,120	$57,783	$57,783	$59,500	$1,717
CNS Injury & Associated Disorders	$89,041	$93,493	$93,493	$91,156	($2,337)
Degenerative Diseases of Bones & Joints	$30,242	$31,754	$31,754	$30,960	($794)
Dementia & Neuronal Degeneration	$24,838	$26,080	$26,080	$25,428	($652)
Diabetes & Major Complications	$35,009	$36,759	$36,759	$35,840	($919)
Digestive Diseases	$20,680	$21,714	$21,714	$21,171	($543)
Emerging Pathogens/Bio-Terrorism	$959	$1,007	$1,007	$982	($25)
Gulf War Veterans Illness	$10,500	$15,000	$12,500	$12,188	($313)
Health Systems	$62,467	$72,667	$72,667	$70,850	($1,817)
Heart Disease/Cardiovascular Health	$62,322	$65,438	$65,438	$63,802	($1,636)
Infectious Diseases	$33,042	$34,694	$34,694	$33,827	($867)
Kidney Disorders	$20,914	$21,960	$21,960	$21,411	($549)
Lung Disorders	$26,990	$28,340	$28,340	$27,632	($709)
Mental Illness	$110,310	$115,826	$115,826	$115,826	$0
Military Occupations & Environ. Exposures	$14,045	$16,633	$16,633	$16,217	($416)
Other Chronic Diseases	$4,883	$5,127	$5,127	$4,999	($128)
Prosthetics	$15,075	$15,829	$15,829	$15,433	($396)
Sensory Loss	$17,085	$17,939	$17,939	$17,491	($448)
Special Populations	$19,588	$20,567	$20,567	$20,053	($514)
Substance Abuse	$29,405	$30,875	$30,875	$30,103	($772)

Because many research activities involve more than one particular subject (e.g., a study about diabetes may also involve aging), many individual research projects involve more than one DRA. Therefore, the sum of the projects shown in the "Projects by Designated Research Areas" table below exceeds the number of distinct projects actually supported. Projects supported under the President's Precision Medicine Initiative, particularly the proposed Clinical Precision Medicine Initiative, will span many of these DRAs.

Projects by Designated Research Areas

		2016			
	2015	Budget	Current	2017	2016-2017
Description	Actual	Estimate	Estimate	Request	Inc/Dec
Acute & Traumatic Injury	97	102	102	102	0
Aging	737	774	774	755	(19)
Autoimmune, Allergic & Hemaptopoietic Disorders	143	150	150	146	(4)
Cancer	258	271	271	275	4
Central Nervous System Injury & Associated Disorders	385	404	404	394	(10)
Degenerative Diseases of Bones & Joints	153	161	161	157	(4)
Dementia & Neuronal Degeneration	115	121	121	118	(3)
Diabetes & Major Complications	187	196	196	191	(5)
Digestive Diseases	107	112	112	109	(3)
Emerging Pathogens/Bio-Terrorism	5	5	5	5	(0)
Gulf War Research Illness	42	52	52	51	(1)
Health Systems	247	301	301	293	(8)
Heart Disease	315	331	331	323	(8)
Infectious Diseases	173	182	182	177	(5)
Kidney Disorders	107	112	112	109	(3)
Lung Disorders	141	148	148	144	(4)
Mental Illness	427	438	438	438	0
Military Occupations & Environ. Exposures	54	57	57	56	(1)
Other Chronic Diseases	19	20	20	20	(1)
Prosthetics	48	50	50	49	(1)
Sensory Loss	82	86	86	84	(2)
Special Populations	95	100	100	98	(3)
Substance Abuse	154	162	170	166	(4)

Employment Summary, FTE by Grade				
	2015	2016	2017	2016-2017
GS Grade or Title 38	Actual	Estimate	Estimate	Inc/Dec
SES..	0	0	0	0
Title 38......................................	110	110	110	0
15 or higher................................	149	149	149	0
14...	187	189	187	(2)
13...	662	667	662	(5)
12...	390	395	390	(5)
11...	553	561	553	(8)
10...	23	24	23	(1)
9...	541	549	541	(8)
8...	71	71	71	0
7...	380	381	380	(1)
6...	151	151	151	0
5...	181	181	181	0
4...	44	44	44	0
3...	16	16	16	0
2...	12	12	12	0
1...	5	5	5	0
Wage Board................................	46	46	46	0
Total Number of FTE................	3,521	3,551	3,521	(30)

Analysis of FTE Distribution Headquarters/Field		
	2015	2015
GS Grade or Title 38	HQ-EST	Field-EST
SES..	0	0
Title 38......................................	4	106
15 or higher................................	9	140
14...	4	183
13...	0	662
12...	4	386
11...	0	553
10...	0	23
9...	3	538
8...	0	71
7...	0	380
6...	0	151
5...	1	180
4...	0	44
3...	0	16
2...	0	12
1...	0	5
Wage Board............................	0	46
Total Number of FTE................	25	3,496

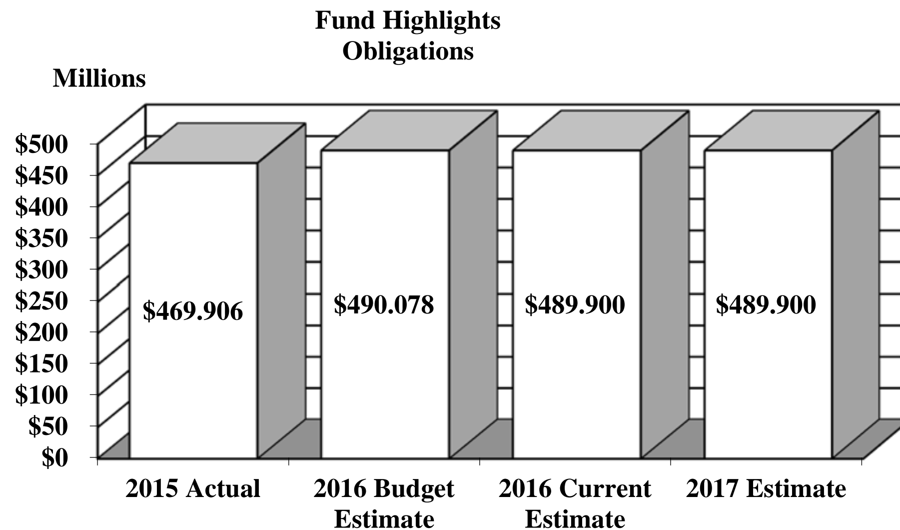
Obligations by Object Classification
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Request	2016-2017 Inc/Dec
10 Personal Services	$336,034	$336,813	$350,570	$348,483	($2,087)
21 Travel & Transportation of Persons:					
Employee Travel	$5,289	$3,971	$5,910	$5,300	($610)
All Other	$132	$29	$200	$100	($100)
Subtotal	$5,421	$4,000	$6,110	$5,400	($710)
22 Transportation of Things	$110	$50	$200	$100	($100)
23 Communication, Utilities & Misc	$1,166	$2,911	$1,229	$1,229	$0
24 Printing & Reproduction	$666	$1,000	$700	$600	($100)
25 Other Services:					
Medical Care Contracts & Agree. w/Insts.	$82,673	$82,000	$89,025	$139,025	$50,000
Fee Basis - Medical & Nursing Services, O	$400	$415	$500	$500	$0
Consultants & Attendance	$15,975	$14,100	$15,000	$15,000	$0
Scarce Medical Specialist	$222	$504	$350	$350	$0
Repair of Furniture & Equipment	$2,670	$1,665	$3,200	$3,200	$0
Maintenance & Repair Services	$575	$712	$1,013	$1,013	$0
Administrative Contractual Services	$157,585	$139,478	$127,000	$121,776	($5,224)
Training Contractual Services	$1,145	$1,126	$1,150	$1,150	$0
Subtotal	$261,245	$240,000	$237,238	$282,014	$44,776
26 Supplies & Materials	$36,504	$36,000	$42,173	$40,000	($2,173)
31 Equipment	$20,375	$41,000	$35,114	$25,500	($9,614)
32 Lands & Structures	$69	$39	$40	$40	$0
Total Obligations	$661,590	$661,813	$673,374	$703,366	$29,992

Medical and Prosthetic Research Summary
(dollars in thousands)

Appropriation	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Request	2016-2017 Inc/Dec
Medical research and support..............................	$588,513	$621,813	$630,735	$663,366	$32,631
Budget Authority...	$588,513	$621,813	$630,735	$663,366	$32,631
Reimbursements...	$32,751	$40,000	$40,000	$40,000	$0
Budget Authority (Gross)....................................	$621,264	$661,813	$670,735	$703,366	$32,631
Adjustments to obligations:					
Unobligated balance (SOY):					
No-year...	$1,125	$0	$2,557	$2,500	($57)
2-year..	$76,882	$50,000	$72,782	$50,000	($22,782)
Supplemental	$0	$0	$0	$0	$0
Prior Year Recoveries................................	$37,666	$0	$0	$0	
Emergency Designation..............................	$0	$0	$0	$0	$0
Subtotal unobligated balance (SOY)....................	$115,673	$50,000	$75,339	$52,500	($22,839)
Unobligated balance (EOY):					
No-year...	($2,557)	$0	($2,500)	($2,500)	$0
2-year..	($72,782)	($50,000)	($50,000)	($50,000)	$0
Supplemental	$0	$0	$0	$0	$0
Subtotal unobligated balance (EOY)	($75,339)	($50,000)	($52,500)	($52,500)	$0
Change in Unobligated balance (non-add)..........	$40,334	$0	$22,839	$0	($22,839)
Balance Transferred Out			($20,200)		
Unobligated balance expiring (lapse)............	($8)	$0	$0	$0	$0
Obligations..	$661,590	$661,813	$673,374	$703,366	$29,992
Obligations..	$661,590	$661,813	$673,374	$703,366	$29,992
Obligated Balance (SOY)....................................	$240,526	$278,521	$220,521	$243,871	$23,350
Obligated Balance (EOY)....................................	($214,940)	($296,646)	($243,871)	($263,494)	($19,623)
Adjustments in Expired Accounts.......................	($42,151)	$0	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Unexp.).....	($22)	$0	$0	$0	$0
Chg. Uncol. Cust. Pay Fed. Sources (Exp.)..........	$295	$0	$0	$0	$0
Outlays, Gross...	$645,298	$643,688	$650,024	$683,743	$33,719
Offsetting Collections..	($33,193)	($40,000)	($40,000)	($40,000)	$0
Outlays, Net...	$612,105	$603,688	$610,024	$643,743	$33,719
Full-Time Equivalents (FTE):					
Direct FTE...	3,380	3,410	3,410	3,380	(30)
Reimbursable FTE...	141	141	141	141	0

Veterans Canteen Service Revolving Fund



Program Description
The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish, at reasonable prices, meals, merchandise, and services necessary for the comfort and well-being of Veterans in hospitals and domiciliaries operated by the Department of Veterans Affairs (Title 38 U.S.C. 7801-10). It has since expanded to provide reasonably priced merchandise and services to America's Veterans enrolled in VA's Healthcare System, their families, caregivers, VA employees, volunteers, and visitors.

Congress originally appropriated a total of $4,965,000 for the operation of the VCS and no additional appropriations have been required. Funds in excess of the needs of the Service totaling $12,068,000 have been returned to the U.S. Treasury. However, provisions of the Veterans' Benefits Act of 1988 (Public Law 100-322) eliminated the requirement that excess funds be returned to the Treasury and authorized such funds to be invested in interest-bearing accounts, specifically Treasury Bills and Notes. Gains realized from these accounts are used to fund business operations. Currently, VCS has no interest-bearing investments.

Creating an environment where patrons can truly enjoy their shopping or dining experience has become a necessity for modern businesses. Providing VA customers the same high quality service found outside the work environment has been, and will continue to be, necessary for VCS. This philosophy will take VCS into the budgeted fiscal year 2017 and beyond.

Fund Highlights*
(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Estimate	2016 to 2017 Increase/ Decrease
Total revenue...............	$481,715	$500,000	$496,000	$496,000	$0
Obligations..................	$469,906	$490,078	$489,900	$489,900	$0
Outlays (net).................	($11,495)	$3,000	$3,000	$9,000	$6,000
FTE..............................	3,351	3,475	3,351	3,351	0

* The numbers in the chart above reflect an estimate of the activity during the Federal Government Fiscal Year (October – September), as the Veterans Canteen Service uses a retail industry fiscal year (February – January) used by similar private sector retailers to enhance their ability to compare their operations to their private sector peers.

In fiscal year 2009, VCS management changed reporting to a retail calendar fiscal year which resulted in an 11-month reporting period. This reporting cycle has been adopted in order to better align VCS operations with the financial reporting structure of the retail industry. The calendar uses a (4-5-4) weekly cycle for the monthly reporting schedule. The 4-5-4 retail accounting calendar divides the year, beginning with the month of February, into quarters with the first and last month of each quarter consisting of four weeks each and the middle month of each quarter consisting of five weeks. Although the retail accounting calendar is used for management purposes, VCS will continue to report to VA on a federal fiscal year basis.

Summary of Budget Request

No appropriation by Congress will be required for VCS to operate during 2017. The VCS is a self-sustaining, revolving fund activity that obtains its revenues from non-federal sources; therefore, no Congressional action is required. Within VA, VCS functions independently and has primary control over its major activities, including sales, procurement, supply, finance, and personnel management.

Changes From 2016 Budget Request (dollars in thousands)			
	2016		
Description	Budget Estimate	Current Estimate	Increase/ Decrease
Total revenue......................	$500,000	$496,000	($4,000)
Obligations..........................	$490,078	$489,900	($178)
Outlays (net).......................	$3,000	$3,000	$0
FTE.......................................	3,475	3,351	(124)

Summary of Employment

For personnel management, VCS uses techniques generally applied in commercial retail chain store, food and vending operations. Primary consideration is given to salary expenses in relation to sales. Salary expense data are provided to management personnel for each department in each Canteen, as well as VCS in total. These data are compared to the corresponding period from the previous year and to productivity goals and standards prior to making decisions regarding employment increases or decreases. Productivity is the standard by which VCS measures personnel cost management.

The following chart reflects the full-time equivalent employment (FTE) for 2015 through 2017:

Summary of Employment					
		2016			**2016 to 2017**
	2015 Actual	**Budget Estimate**	**Current Estimate**	**2017 Estimate**	**Increase/ Decrease**
FTE..	3,351	3,475	3,351	3,351	0

Revenues and Expenses (dollars in thousands)					
		2016			2016 to 2017
	2015 Actual	Budget Estimate	Current Estimate	2017 Estimate	Increase/ Decrease
Sales Program:					
Revenue	$481,715	$500,000	$496,000	$496,000	$0
Less operating expenses	($481,801)	($495,280)	($495,900)	($495,900)	$0
Net operating income-sales	($86)	$4,720	$100	$100	$0
Nonoperating income or loss (-):					
Proceeds from sale of equipment	$0	$50	$0	$0	$0
Net book value of assets sold	$0	($125)	$0	$0	$0
Net Gain or (Loss)	$0	($75)	$0	$0	$0
Interest income	$0	$0	$0	$0	$0
Miscellaneous income/(loss)	$0	($4,350)	$0	$0	$0
Net non-operating income	$0	($4,425)	$0	$0	$0
Net income for the year	($86)	$295	$100	$100	$0

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2016. Changes from year to year are the result of anticipated changes in revenues, obligations, and outlays previously portrayed.

Financial Condition (dollars in thousands)					
		2016			2016 to 2017
	2015 Actual	Budget Estimate	Current Estimate	2017 Estimate	Increase/ Decrease
Assets:					
Cash with Treasury, in banks, in transit	$74,883	$22,000	$45,613	$45,713	$100
Accounts receivable (net)	$44,027	$44,404	$42,000	$42,000	$0
Inventories	$35,995	$43,000	$43,000	$43,000	$0
Real property and equipment (net)	$29,050	$47,376	$68,088	$68,088	$0
Other assets	$0	$372	$371	$371	$0
Total assets	$183,955	$157,152	$199,072	$199,172	$100
Liabilities:					
Accounts payable including funded accrued liabilities	$51,187	$65,000	$65,371	$65,371	$0
Unfunded annual leave and coupons books	$26,167	$8,000	$27,000	$27,000	$0
Total liabilities	$77,354	$73,000	$92,371	$92,371	$0
Government equity:					
Unexpended balance:					
Unobligated balance	$87,324	$35,000	$58,515	$58,615	$100
Undelivered orders	$109	$4,789	$3,554	$3,554	$0
Invested capital	$19,168	$44,363	$44,632	$44,632	$0
Total Government equity (end-of-year)	$106,601	$84,152	$106,701	$106,801	$100

Government Equity (dollars in thousands)					
		2016			2016 to 2017
	2015 Actual	Budget Estimate	Current Estimate	2017 Estimate	Increase/ Decrease
Retained Income:					
Opening Balance..	$87,324	$83,857	$106,601	$106,701	$100
Transactions:					
Net Operating Income...................................	($86)	$4,720	$100	$100	$0
Net Operating Gain.......................................	$19,363	($4,425)	$0	$0	$0
Closing Balance..	$106,601	$84,152	$106,701	$106,801	$100
Total Government Equity (end-of-year)............	$106,601	$84,152	$106,701	$106,801	$100

* 2016 Budget Estimate Opening Balance has been updated from what was submitted in the 2016 President's Budget

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Medical Center Research Organizations

Program Description

The Veterans' Benefits and Services Act of 1988 (Public Law 100-322) authorizes "Medical Center Research Organizations" to be created at Department of Veterans Affairs Medical Centers (VAMC). These nonprofit corporations (NPCs) provide flexible funding mechanisms for the conduct of VA-approved research and educational activities. They administer funds from non-VA Federal and private sources to operate various research and educational activities in VA. These corporations are private, state-chartered entities. They are self-sustaining and funds are not received into a government account. No appropriation is required to support these activities.

Prior to June 1, 2004, 93 VAMCs had received approval for the formation of nonprofit research corporations. Presently, 83 are active. Most of the corporations have indefinite, ongoing operations. However, recent changes in the law permit NPC mergers. This may result in a decrease in the number of NPCs overall.

All 83 NPCs have received their authority from the Internal Revenue Service Code of 1986, under Article 501(c)(3) or similar Code Sections. The fiscal years for these organizations vary, with most having year-ends at September 30th or December 31st. The table below reflects estimated revenues and expenses from 2015 to 2017.

Contribution Highlights
(dollars in thousands)

		2016			
	2015 Actual	Budget Estimate	Current Estimate	2017 Estimate	Increase/ Decrease
Contributions.......	$267,999	$239,014	$247,654	$250,130	$2,476
Expenses...............	$268,079	$236,288	$245,189	$246,517	$1,328

The following table is a list of research corporations that have received approval for formation along with their estimated 2015 contributions from the non-VA Federal and private sources. In addition, NPCs with no contributions have been approved for operation. Some have received contributions in the past, others have not, to date, received any contributions:

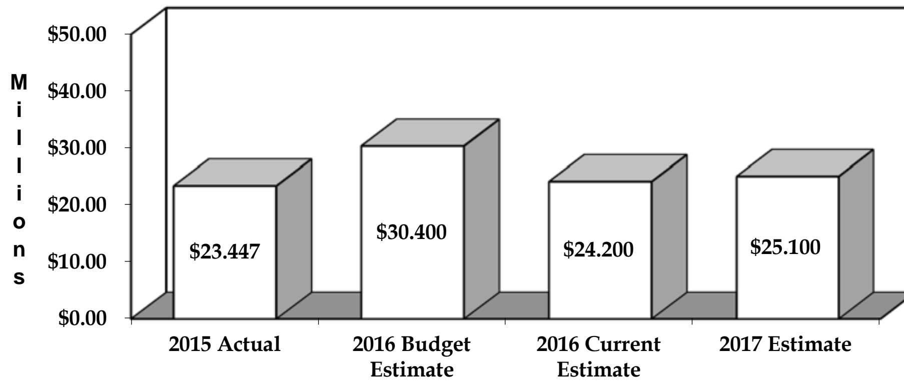
	City	State	Estimated Revenues (Contributions) 2015
1. Albany Research Institute, Inc	Albany	NY	$657,000
2. Asheville Medical Research and Education Corporation	Asheville	NC	$97,000
3. Atlanta Research and Education Foundation, Inc	Atlanta	GA	$8,121,000
4. Augusta Biomedical Research Corporation	Augusta	GA	$308,000
5. Baltimore Research and Education Foundation	Baltimore	MD	$3,046,000
6. Bedford VA Research Corporation, Inc	Bedford	MA	$924,000
7. Biomedical Research and Education Foundation of Southern Arizona	Tucson	AZ	$751,000
8. Biomedical Research Foundation	Little Rock	AR	$1,332,000
9. Biomedical Research Institute of New Mexico	Albuquerque	NM	$11,952,000
10. Boston VA Research Institute, Inc	Boston	MA	$15,500,000
11. Brentwood Biomedical Research Institute	Los Angeles	CA	$9,885,000
12. Bronx Veterans Medical Research Foundation	Bronx	NY	$3,740,000
13. Buffalo Institute for Medical Research, Inc	Buffalo	NY	$531,000
14. Carl T. Hayden Medical Research Foundation	Phoenix	AZ	$3,369,000
15. Central New York Research Corporation	Syracuse	NY	$1,341,000
16. Central Texas Veterans Research Foundation	Temple	TX	$724,000
17. Charleston Research Institute, Inc	Charleston	SC	$931,000
18. Chicago Association for Research and Education in Science	Hines	IL	$4,335,000
19. Cincinnati Education & Research for Veterans Foundation	Cincinnati	OH	$2,093,000
20. Clinical Research Foundation, Inc	Louisville	KY	$485,000
21. Dallas VA Research Corporation	Dallas	TX	$2,522,000
22. Dayton VA Research and Education Foundation	Dayton	OH	$132,000
23. Denver Research Institute	Denver	CO	$7,189,000
24. Dorn Research Institute	Columbia	SC	$450,000
25. East Bay Institute for Research and Education	Sacramento	CA	$141,000
26. Foundation for Advancing Veterans' Health Research	San Antonio	TX	$1,789,000
27. Great Plains Medical Research Foundation	Sioux Falls	SD	$51,000
28. Houston VA Research and Education Foundation	Houston	TX	$2,214,000

	City	State	Estimated Revenues (Contributions) 2015
29. Huntington Institute for Research and Education	Huntington	WV	$2,000
30. Indiana Institute for Medical Research, Inc	Indianapolis	IN	$258,000
31. Institute for Clinical Research, Inc	Washington	DC	$12,149,000
32. Institute for Medical Research, Inc	Durham	NC	$2,560,000
33. Idaho Veterans Research and Education Foundation	Boise	ID	$264,000
34. Iowa City VA Medical Research Foundation	Iowa City	IA	$419,000
35. Lexington Biomedical Research Institute, Inc	Lexington	KY	$559,000
36. Loma Linda Veterans Association for Research and Education, Inc	Loma Linda	CA	$3,955,000
37. Louisiana Veterans Research and Education Corporation	New Orleans	LA	$0
38. McGuire Research Institute, Inc	Richmond	VA	$2,535,000
39. Metropolitan Detroit Research and Education Foundation	Detroit	MI	$141,000
40. Middle Tennessee Research Institute, Inc	Nashville	TN	$323,000
41. Midwest Biomedical Research Foundation	Kansas City	MO	$2,796,000
42. Minnesota Veterans Research Institute	Minneapolis	MN	$4,286,000
43. Missiouri Foundation for Medical Research	Columbia	MO	$328,000
44. Mountain Home Research and Education Corporation	Mountain Home	TN	$77,000
45. Mountaineer Education and Research Corporation	Clarksburg	WV	$0
46. Narrows Institute for Biomedical Research, Inc	Brooklyn	NY	$1,684,000
47. Nebraska Educational Biomedical Research Association	Omaha	NE	$1,030,000
48. North Florida Foundation for Research and Education, Inc	Gainesville	FL	$1,991,000
49. Northern California Institute for Research and Education, Inc	San Francisco	CA	$44,310,000
50. Ocean State Research Institute, Inc	Providence	RI	$2,648,000
51. Overton Brooks Research Corporation	Shreveport	LA	$87,000
52. Pacific Health Research and Education Institute	Honolulu	HI	$3,021,000
53. Palo Alto Institute for Research and Education, Inc	Palo Alto	CA	$24,249,000
54. Philadelphia Research and Education Foundation	Philadelphia	PA	$1,328,000
55. Portland VA Research Foundation, Inc	Portland	OR	$7,255,000
56. Research Mississippi, Inc	Jackson	MS	$125,000

	City	State	Estimated Revenues (Contributions) 2015
57. Research, Incorporated	Memphis	TN	$3,609,000
58. Salem Research Institute, Inc	Salem	VA	$539,000
59. Salisbury Foundation for Research and Education	Salisbury	NC	$14,000
60. Seattle Institute for Biomedical and Clinical Research	Seattle	WA	$11,939,000
61. Sepulveda Research Corporation	Sepulveda	CA	$3,557,000
62. Sierra Veterans Research and Education Foundation	Reno	NV	$464,000
63. Sociedad de Investigacion Cientificas, Inc	San Juan	PR	$290,000
64. South Florida Veterans Affairs Foundation for Research and Education	Miami	FL	$2,623,000
65. Southern California Institute for Research and Education	Long Beach	CA	$4,951,000
66. Tampa VA Research and Education Foundation	Tampa	FL	$1,115,000
67. The Bay Pines Foundation, Inc	Bay Pines	FL	$683,000
68. The Cleveland VA Medical Research and Education Foundation	Cleveland	OH	$1,307,000
69. The Research Corporation of Long Island, Inc	Northport	NY	$267,000
70. Tuscaloosa Research and Education Advancement Corporation	Tuscaloosa	AL	$178,000
71. VA Black Hills Research and Education Foundation	Fort Meade	SD	$6,000
72. VA Connecticut Research and Education Foundation	West Haven	CT	$766,000
73. Veterans Bio-Medical Research Institute, Inc	East Orange	NJ	$2,274,000
74. Veterans Education and Research Association of Michigan	Ann Arbor	MI	$2,497,000
75. Veterans Education and Research Ass'n. of Northern New England, Inc	White River Junction	CT	$812,000
76. Veterans Medical Research Foundation of San Diego	San Diego	CA	$21,472,000
77. Veterans Research and Education Foundation	Oklahoma City	OK	$540,000
78. Veterans Research and Education Foundation of St. Louis	St Louis	MO	$437,000
79. Veterans Research Foundation of Pittsburgh	Pittsburgh	PA	$1,751,000
80. VISTAR, Inc	Birmingham	AL	$246,000
81. Western Institute for Biomedical Research	Salt Lake City	UT	$1,841,000
82. Westside Institute for Science and Education	Chicago	IL	$413,000
83. Wisconsin Corporation for Biomedical Research	Milwaukee	WI	$418,000
Total			$267,999,000

General Post Fund

Budgetary Resources*



***Fund consists of gifts, bequests and proceeds from the sale of property.**

Program Description

This trust fund consists of gifts, bequests, and proceeds from the sale of property left in the care of Department of Veterans Affairs facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of Veterans at hospitals and other facilities for which no general appropriation is available. Also, donations from pharmaceutical companies, non-profit corporations, and individuals to support VA medical research can be deposited into this fund (title 38 U.S.C., Chapters 83, Acceptance of Gifts and Bequests, and 85, Disposition of Deceased Veterans' Personal Property). The resources from this trust fund are for the direct benefit of the patients.

Expenditures from this fund are for recreational and religious projects; specific equipment purchases; national recreational events; the vehicle transportation network; television projects; and other items as outlined in Veteran Health Administration Directive 4721, General Post Fund. In addition, Public Law 102-54 authorizes the receipts from the sale of a property acquired for transitional housing to be deposited in the General Post Fund and used for the acquisition, management and maintenance of other transitional housing properties.

Summary of Budget Request

Operations of this trust fund are financed from fund receipts. Congress has provided permanent, indefinite budget authority for this fund and no appropriation is required.

Fund Highlights

(dollars in thousands)

Description	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Estimate	2016 to 2017 Increase/ Decrease
Budget Authority (permanent, indefinite)..................	$23,447	$30,400	$24,200	$25,100	$900
Obligations:					
Trust Fund and Donation.......................................	$20,410	$25,000	$21,100	$21,900	$800
Therapeutic Residences..	$1,021	$1,000	$1,100	$1,100	$0
Total Obligations..	$21,431	$26,000	$22,200	$23,000	$800
Outlays..	$21,222	$20,800	$21,900	$22,700	$800

Changes From Original 2016 Budget Estimate

(dollars in thousands)

Description	2016 Budget Estimate	2016 Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite)...............	$30,400	$24,200	($6,200)
Obligations:			
Trust Fund and Donation....................................	$25,000	$21,100	($3,900)
Therapeutic Residences......................................	$1,000	$1,100	$100
Total Obligations..	$26,000	$22,200	($3,800)
Outlays...	$20,800	$21,900	$1,100

Program Activity

Trust Fund and Donations
Estimates of trust fund obligations revised for 2016 and 2017 are $22,200,000 and $23,000,000 respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended (Comptroller General's Decision B-125715, November 10, 1955) and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects, or equipment (e.g., televisions, medical equipment and physical therapy equipment) purchases.

Cash receipts from donations and estates for both fiscal years 2016 and 2017 are estimated to reach $21,100,000 and $21,900,000 respectively. The invested reserve for 2016 and 2017 is estimated to be approximately $116,148,000 and $124,671,000 respectively. This level of investment exceeds the requirement to retain at least five times the total amount paid to heirs during the preceding five year period.

Compensated Work Therapy - Therapeutic Residences (CWT-TR)
Per title 38, U.S.C. Section 1772(h), funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500,000 from the fund above the amount credited to the fund in a fiscal year from proceeds of this program.

Financial Actions and Conditions

(dollars in thousands)

	2015 Actual	2016 Budget Estimate	2016 Current Estimate	2017 Estimate	2016 to 2017 Increase/ Decrease
Balance beginning of year:					
Cash	$41,823	$26,845	$2,669	$11,625	$8,956
Investments	$66,726	$89,811	$108,225	$116,148	$7,923
Property, Plant, Equipment & Other Assets	$48,703	$72,480	$54,995	$63,072	$8,077
Total	$157,252	$189,136	$165,889	$190,845	$24,956
Increase during period:					
Cash	$40,222	$80,300	$80,300	$81,100	$800
Investments	$58,257	$52,900	$58,800	$59,400	$600
Property, Plant, Equipment & Other Assets	$11,962	$26,700	$12,100	$12,200	$100
Total	$110,441	$159,900	$151,200	$152,700	$1,500
Decrease during period:					
Cash	$79,376	$71,344	$71,344	$71,344	$0
Investments	$16,758	$50,877	$50,877	$50,877	$0
Property, Plant, Equipment & Other Assets	$5,670	$4,023	$4,023	$4,023	$0
Total	$101,804	$126,244	$126,244	$126,244	$0
Balance at end of year:					
Cash	$2,669	$35,801	$11,625	$21,381	$9,756
Investments	$108,225	$91,834	$116,148	$124,671	$8,523
Property, Plant, Equipment & Other Assets	$54,995	$95,157	$63,072	$71,249	$8,177
Total	$165,889	$222,792	$190,845	$217,301	$26,456

* 2015 Actual Opening Balance has been updated from what was submitted in the FY16 President's Budget

Information and Technology

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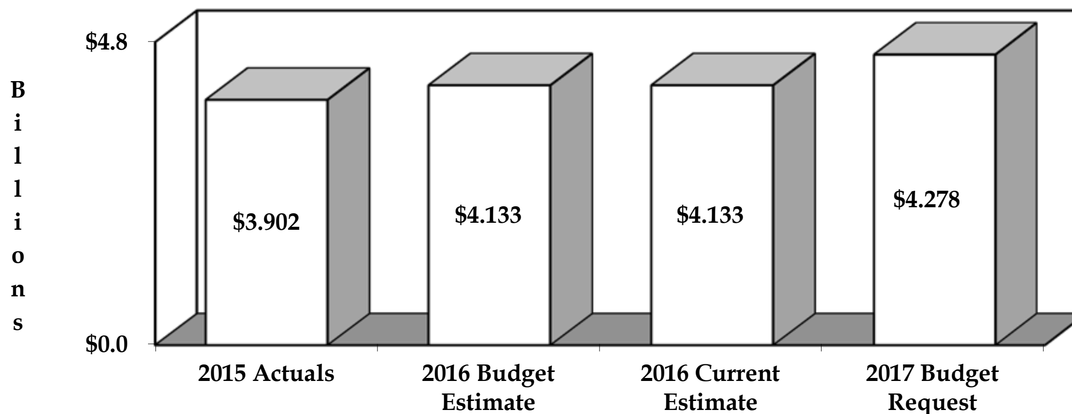

Appropriations Language

For necessary expenses for information technology systems and telecommunications support, including developmental information systems and operational information systems; for pay and associated costs; and for the capital asset acquisition of information technology systems, including management and related contractual costs of said acquisitions, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, [$4,133,363,000] *$4,278,259,000*, plus reimbursements: *Provided*, That [$1,115,757,000] *$1,272,548,000* shall be for pay and associated costs, of which not to exceed [$34,800,000] *$37,100,000* shall remain available until September 30, [2017] *2018*: *Provided further*, That [$2,512,863,000] *$2,534,442,000* shall be for operations and maintenance, of which not to exceed [$175,000,000] *$180,200,000* shall remain available until September 30, [2017] *2018*: Provided further, That
[$504,743,000] *$471,269,000* shall be for information technology systems development, modernization, and enhancement, and shall remain available until
September 30, [2017] *2018*: *Provided further*, That amounts made available for information technology systems development, modernization, and enhancement may not be obligated or expended until the Secretary of Veterans Affairs or the Chief Information Officer of the Department of Veterans Affairs submits to the Committees on Appropriations of both Houses of Congress a certification of the amounts, in parts or in full, to be obligated and expended for each development project: *Provided further*, That amounts made available for salaries and expenses, operations and maintenance, and information technology systems development,

modernization, and enhancement may be transferred among the three subaccounts after the Secretary of Veterans Affairs [requests from] *submits notice thereof to* the Committees on Appropriations of both Houses of Congress [the authority to make the transfer and an approval is issued]: *Provided further*, That amounts made available for the "Information Technology Systems" account for development, modernization, and enhancement may be transferred among projects or to newly defined projects: *Provided further*, That no project may be increased or decreased by more than [$1,000,000] *$3,000,000* of cost prior to submitting [a request] *notice thereof* to the Committees on Appropriations of both Houses of Congress [to make the transfer and an approval is issued, or absent a response, a period of 30 days has elapsed: *Provided further*, That funds under this heading may be used by the Interagency Program Office through the Department of Veterans Affairs to define data standards, code sets, and value sets used to enable interoperability: *Provided further*, That, of the funds made available for information technology systems development, modernization, and enhancement for VistA Evolution, not more than 25 percent may be obligated or expended until the Secretary of Veterans Affairs submits to the Committees on Appropriations of both Houses of Congress, and such Committees approve, a report that describes: (1) the status of and changes to the VistA Evolution program plan dated March 24, 2014 (hereinafter referred to as the "Plan"), the VistA 4 product roadmap dated February 26, 2015 ("Roadmap"), and the VistA 4 Incremental Life Cycle Cost Estimate, dated October 26, 2014; (2) any changes to the scope or functionality of projects within the VistA Evolution program as established in the Plan; (3) actual program costs incurred to date; (4) progress in meeting the schedule milestones that have been established in the Plan; (5) a Project Management Accountability System (PMAS) Dashboard Progress report that identifies each VistA Evolution project being tracked through PMAS, what functionality it is intended to provide, and what evaluation scores it has received throughout development; (6) the definition being used for interoperability between the electronic health record systems of the Department of Defense and the Department of Veterans Affairs, the metrics to measure the extent of interoperability, the milestones and timeline associated with achieving interoperability, and the baseline measurements associated with interoperability; (7) progress toward developing and implementing all components and levels of interoperability, including semantic interoperability; (8) the change management tools in place to facilitate the implementation of VistA Evolution and interoperability; and (9) any changes to the governance structure for the VistA Evolution program and its chain of decision-making authority: *Provided further*, That the funds made available under this heading for information technology systems development, modernization, and enhancement, shall be for the projects, and in the amounts, specified under this heading in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act)]. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2016.)*

IT Resource Statements

In accordance with the requirements set forth in the Federal Information Technology Acquisition Reform Act (PL 113-291, Title VIII, Subtitle D), the following statements are provided:

- The VA Chief Information Officer (CIO) affirms that she has reviewed the major IT investments in this budget request and approves of them;

- The VA CIO and Chief Financial Officer (CFO) affirm that the CIO had a significant role in reviewing the IT support planned for major program objectives and significant increases and decreases in IT resources; and
- The VA CIO and CFO assert that the IT Portfolio, as defined by OMB Circular A-11, Section 55.6, includes appropriate estimates of all IT resources included in the budget request.

Explanation of Language Change

VA is proposing that the threshold at which a request is required be made from both Houses of Congress prior to the transfer of funds between projects be raised to $3,000,000. In the above language, "project" refers to the VA's congressional development, modernization enhancement (DME) projects report located in the budget appendix.

VA is proposing that the 25 percent restriction on VistA Evolution funding, pending submission of the VistA Evolution report as described in prior year appropriation language, be removed as it impacts the implementation of project activities. VA has been responsive to Congress, providing quarterly updates on the VistA Evolution project and has addressed their questions on the project.

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Information and Technology

Appropriation Highlights

Appropriation Highlights
(Dollars in Thousands)

	2015	2015/2016	2016		2017	2016-2017
	Actuals	Carryover	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Subaccounts:						
Development	548,335	92,293	504,743	504,743	471,269	-33,474
Sustainment	2,316,009	41,000	2,512,863	2,512,863	2,534,442	21,579
Pay & Administration	1,039,000	19,424	1,115,757	1,115,757	1,272,548	156,791
Rescission	-1,066					
Emergency Supplemental						
Appropriation 1/	**$3,902,278**	**$152,717**	**$4,133,363**	**$4,133,363**	**$4,278,259**	**144,896**
Funding Sources:						
Appropriation	**3,902,278**		**4,133,363**	**4,133,363**	**4,278,259**	**144,896**
Veterans Choice Act 801	376,600					
Unobligated Choice Act 801 2/	-308,933			308,933		-308,933
H1N1 Supplemental (P.L. 111.32)	2					0
OEF/OIF Supplemental (P.L. 110-128)	2,055					0
Recoveries	13,360					0
North Chicago Facility Transfers	-6,968		-7,158	-7,158	-7,301	-143
Veterans Choice Act 801 Transfer	-14,100					0
Denver Hospital Transfers	-240			-75,731		75,731
Reimbursements (+)	39,136		56,837	63,851	73,740	9,889
Available Balance SOY (+)	166,335		173,400	154,300		-154,300
Available Balance EOY (-)	-154,300					
Unobligated Balance (Expiring) Lapse	-2,077					
Total Obligations	**$4,013,147**		**$4,356,442**	**$4,577,559**	**$4,344,698**	**-232,861**
Total Full Time Equivalents (FTE)	**7,309**		**7,615**	**7,631**	**8,334**	**703**
Direct	7,214		7,325	7,325	7,365	40
Direct (PL 113-146 The Choice Act)	17		192	192	192	0
Reimbursement 3/	78		98	114	178	64
Enterprise Operations 4/					599	599

Numbers may not add due to rounding
1/ Numbers include prior year carryover but exclude reimbursements and transfers.
2/In FY2016 Budget Estimate, this line represents anticipated carryover for Veterans Access Choice and Accountability Act (Choice Act).
3/ In FY2017 this line includes an additional 79 Enterprise Operations Franchise Fund Reimbursement FTE
4/In FY2017 this line includes 599 FTE transferred from the Enterprise Operations Franchise Fund

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Information and Technology

Executive Overview

Strategic Priorities

The Office of Information and Technology (OIT) of the Department of Veterans Affairs (VA) provides information technology support across VA to ensure that the mission, vision, and strategic objectives of VA's Agency Priority Goals (APGs) are met. The current four VA APGs are to:

- Improve Access to Care;
- Improve Access to VA Benefits;
- Improve Veterans Experience with VA; and
- Improve the Employee Experience.

In alignment with these goals, OIT's mission is to provide available, adaptable, secure, and cost effective information technology products and services to VA customers, enabling VA staff to provide mission-critical support to the Nation's Veterans. The technology and the resources required to support the APGs underpin every aspect of the care, benefits, and services that are delivered to Veterans. Information Technology (IT) is a vehicle that enables VA to support critical areas such as healthcare, improved benefits processing, provision of enhanced customer care and services to Veterans, maintenance of the Department's information security posture, and maintenance of the IT Infrastructure.

The 2017 Budget request focuses on the following critical areas in addition to the VA APGs:

- Expanding Information Security;
- Maintaining the IT Infrastructure;
- Other Development Programs; and
- VistA Evolution (Veterans Health Information Systems and Technology Architecture), Interoperability and VLER (Virtual Lifetime Electronic Record) Health.

Access to Care

VA is committed to providing Veterans and other eligible beneficiaries timely and high-quality accessible health services. The Veterans Health Administration (VHA) leads the effort in health care services including: (1) inpatient and outpatient services; (2) pharmacy; (3) prosthetics; and (4) long-term care, as well as other programs. OIT provides crucial technical connectivity nationwide to hospitals, Community-Based Outpatient Clinics (CBOC), domiciliary facilities, Vet Centers, and other VHA facilities. These joint VHA-OIT

efforts improve technology necessary for new medical treatments, the security of patient data, and business operations at medical facilities. OIT also prioritizes state-of-the-art technology and ensures its availability to Veterans in rural America.

Technology is a crucial part of VA's effort to deliver the very best health care this nation has to offer to its Veterans. Future IT investments in this area will focus on providing Veterans with high-quality, interoperable health care programs. IT efforts will also support resources to help modernize the enrollment program and provide customer service and support to Veterans, caregivers, other government agencies, and the general public regarding VA health benefits, eligibility, and billing questions through the Health Research Center (HRC). IT efforts are also planned to enable VA to discover knowledge, develop researchers and health care leaders, and create innovations that advance health care for our Veterans and the nation.

Access to VA Benefits

Reducing the length of time it takes to process disability claims is integral to VA's mission of providing benefits to eligible Veterans in a timely, accurate, and compassionate manner. Technology is a vital component in VA's mission to provide a variety of benefits and services to Veterans and their families. The IT investments in this area will focus on providing Veterans with a modernized technology solution that supports the delivery of benefits to our nations Veterans, including Veterans Benefits Management System (VBMS), which greatly improves the speed and accuracy with which VA resolves Veterans disability compensation claims and VETSNET, a custom-built, mature suite of inter-related applications designed and implemented to deliver critical business systems for compensation and pension claims.

IT efforts will also support resources to provide educational assistance to Servicemembers, Veterans, and their dependents; and process claims appeals through a modernized appeals process. By September 2017, VBA is expecting to meet or exceed timeliness and quality standards for processing benefits claims: 125 days for Disability Rating Claims and 45 days for Vocational Rehabilitation and Employment (VRE) entitlement claims.

Improve Veterans Experience with VA

Technological advancements and modernization will allow VA to deliver excellent access to care and benefits that prioritizes the needs of our customers, Veterans, and their families. IT investments in this area focus on integrated service delivery and streamlined identification processes. We will deliver and execute an enterprise-wide scalable, commoditized, Veteran-centric, services-based technology environment with best-in-class and industry-standard customer service with clear satisfaction and delivery measures. Technological infrastructure improvements will also be required to comply with the Veterans Identification Card Act 2015 that requires VA to issue general purpose VA Identification Cards to all Veterans.

Improve the Employee Experience

Technology investments and improvements will enable VA to improve the employee experience, transform into a 21st Century organization, and make VA an employer of choice to attract the best and the brightest employees to provide world-class service to our Veterans and those who serve them. IT investments in this area will focus on the modernization of resources management, legal, training, and information management systems.

Information Security

VA is committed to meeting the highest standards in protecting sensitive Veteran and employee information. OIT's Office of Information Security (OIS) is responsible for ensuring that the security and privacy of Veteran data remain one of VA's highest priorities. OIS is led by the Deputy Assistant Secretary for Information Security and works with organizations across the VA to ensure that Veteran and beneficiary data security and privacy needs are accounted for in all aspects of VA's business. This includes the administration of benefits, healthcare, cemetery operations, and all other VA services. OIS integrates a continuous cycle of performance measurement, risk assessment, threat mitigation and oversight and compliance to ensure that information security complements VA business operations and is integrated throughout the lifecycle of VA operating systems and software.

Information Technology will continue to enable OIS to make information security advancements in areas such as: (1) Cybersecurity Strategy Implementation; (2); Continuous Readiness Information Security Program (CRISP) Support; (3) Cyber Security Programs; (4) Network Operations; (5) Security Operations ; (6) Privacy and Records Management; (7) and Business Continuity Services. VA's budget request includes an increase in funding to support the Federal cybersecurity strategy efforts. In FY 2017 OIS will execute the VA Enterprise Cybersecurity Strategy and Implementation Plan (VA-ECSIP), which defines the comprehensive set of actions, processes, and emerging security technologies that will further enhance the cybersecurity of VA's information and assets and improve the resilience of VA networks.

Maintain and Enhance the IT Infrastructure

The IT Infrastructure provides the backbone necessary to meet the day-to-day operational needs of VA Medical Centers, Veteran facing systems, benefits delivery systems, memorial services, and all other IT systems supporting the Departments' mission. The IT Infrastructure includes providing for VA's data storage, transmission, and communications requirements. A robust, healthy IT infrastructure is necessary to ensure delivery of reliable, available, and responsive IT services to all VA staff offices and administration customers as well as Veteran clients. A viable and reliable infrastructure supports VA's 21st century transformation as well as underlying missions and strategic plans, and service level requirements for all customers.

OIT works closely with its stakeholders (Veterans and their families, VHA, VBA, the National Cemetery Administration (NCA), Veterans Service Organizations (VSO), and non-VA medical providers) to meet their technology needs. In order to keep pace with these

needs, OIT has developed new systems, platforms, and applications. Now that these technology assets have deployed to the enterprise, OIT must allocate funds to maintain these new technologies in addition to existing technology. The delivery of medical care and benefits, and protection of the security and privacy of sensitive Veteran information depend on: (1) a reliable and accessible IT infrastructure; (2) a high-performing IT workforce; and (3) modernized information systems that are flexible enough to meet both existing and emerging service delivery requirements.

For years, VA had operated a number of Enterprise Operations data centers as Franchise Fund providers. The Enterprise Operations data centers operated on a fee-for-service arrangement, as authorized under the Government Management Reform Act of 1994. While these data centers were pre-authorized to do business with any Federal agency, it turned out over time that VA OIT's was their exclusive customer. Prior to FY 2017, this fee-for-service arrangement manifested itself in VA's OIT's budget essentially as a "bill." This bill covered costs for operating the data centers and was a "non-pay" item in the IT budget. The operating costs included necessary FTE to support the data center's operations, and were part of that bill; however, as this payment was viewed as a bill, the associated FTE were not disaggregated in the IT budget prior to this year. For management and fiscal efficiency, as well as budget transparency, the Franchise Fund Board, acting on this, decided in early FY 2016 to divest the Enterprise Operations data centers back to the operational control of OIT. Therefore, the FY 2017 budget request now shows funding for the FTE that are in those data centers. There is a concomitant decrease in the Enterprise Operations line; the overall effect of this action is neutral on VA's IT budget.

2017 Budget Request

In FY 2017, OIT is requesting $4.278 billion, an increase of $145 million (3.5 percent) above the 2016 level. The request is separated into three subaccounts, as follows:

1. **Development Modernization Enhancement (DME)** – The request of $471 million is $33 million (7 percent) below the 2016 request; it represents the highest priority development projects for VA. The funds will support development of programs such as VistA Evolution (VE), Veterans Customer Experience (VCE), Board of Veterans Appeals Modernization, Memorials Development support, Education Assistance to Veterans and their dependents (Chapter 33) and other clinical and benefits systems support.

2. **Operations and Maintenance (OM)** – The request of $2.534 billion is $21.2 million (1 percent) above the 2016 level. The funds will provide for the operations and maintenance of existing infrastructure systems and marginal sustainment for development efforts, which supports newly deployed projects that have not fully matured into mandatory sustainment. It also includes funding for activating medical facilities, protecting Veterans' personal information, and implementing an enhanced security strategy.

3. **Staffing and Support Services** – The request of $1.272 billion is $156.8 million (14.1 percent) above the 2016 level. The majority of this funding is to support the hospital and regional office IT support staff that are responsible for the operations of IT systems.

These funds are also for support services and contractor support expenses to include sustainment of IT staff hired under the Veterans Choice Act in 2015 and 2016 (Veterans Choice Act funding may not be received in 2017). In addition to the appropriated level, OIT anticipates a transfer of 599 Enterprise Operations (EO) FTE from VA's Franchise Fund. The Enterprise Operations (EO) organization is managed within the OIT Service Delivery and Engineering program office, but it has been funded through VA's Franchise Fund. EO provides services to several VA functions and one external government agency, but the bulk of its funding, over 92 percent, is provided by OIT. This transfer was directed by VA Executive Leadership to improve efficiency and responsiveness of this critical infrastructure component. This does not change OIT's overall 2017 budget request.

4. **Reimbursements** – In addition to the appropriated level, OIT anticipates $73.7 million in reimbursements, of which $46.4 million is in non-pay and $27.3 million is in pay reimbursements from other Federal agencies, credit reform programs and non-appropriated insurance benefits programs. The increase in non-pay reimbursements is $5.5 million above the 2016 level. Anticipated pay reimbursements is $4.4 million above the 2016 level. OIT reimbursements also include FTE that will be transferred from the Franchise Fund for Enterprise Operations as well.

Budget Category Perspective

The 2017 request is broken down into the following categories: staffing and support services; mandatory sustainment; information security; activations (equipment and licensing requirements for new facilities); critical infrastructure, regular infrastructure upgrades, marginal sustainment; and continuing development. The largest category of the IT budget is mandatory sustainment, which accounts for $ 2.534 billion (59 percent) of the total 2017 request. The second largest category of spending in 2017 is staffing and support services, which will support 8,156 FTE (excluding reimbursements) in headquarters, regional and field offices, and VA hospitals (24x7 coverage) nationwide.

The 2017 budget categories are prioritized to determine funding allocations among IT projects. Mandatory sustainment includes "must pay" one-time and/or recurring costs, such as software licensing, telecommunications, IT support contracts, and hardware maintenance; regular infrastructure upgrades are necessary non-critical sustainment efforts to continue or enhance OIT operations; critical infrastructure upgrades are needed for systems that are already beyond their useful life; marginal sustainment supports newly deployed projects that have not fully matured into mandatory sustainment; and development covers development, modernization and enhancement (DME) of projects.

The table below provides a budget category view of the 2017 IT budget request.

Budget By Category (Dollars in Thousands)						
	2015	2015/2016	2016		2017	2016-2017
	Actuals	Carryover	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Development	$ 473,042	$ 92,294	$ 504,743	$ 504,743	$ 471,269	$ (33,474)
Marginal Sustainment	$ 124,990	$ -	$ 107,931	$ 107,931	$ 89,276	$ (18,655)
Regular Infrastructure Upgrades	$ 240,000	$ -	$ 180,000	$ 180,000	$ 102,822	$ (77,178)
Critical Infrastructure Upgrades	$ -	$ -	$ -	$ -	$ 102,178	$ 102,178
Activations*	$ 84,000	$ -	$ 90,000	$ 90,000	$ 47,700	$ (42,300)
Information Security*	$ 156,000	$ -	$ 179,501	$ 179,501	$ 370,067	$ 190,566
Mandatory Sustainment	$ 1,711,019	$ -	$ 1,955,431	$ 1,955,431	$ 1,822,399	$ (133,032)
Staffing and Support Service**	$ 1,037,934	$ -	$ 1,115,757	$ 1,115,757	$ 1,272,548	$ 156,791
Total	$ 3,826,985	$ 92,294	$ 4,133,363	$ 4,133,363	$ 4,278,259	$ 144,896

*Information Security and Activations are categorized as Mandatory Sustainment

** FY2017 Staffing and Support Services includes a 1.3% payraise and the FTE transferred from Enterprise Operations/Franchise Fund.

Information and Technology

Access to Healthcare

Access to Healthcare (Dollars in Thousands)	2015 Actuals		2015/2016 Carryover	2016 Budget Estimate		2016 Current Estimate		2017 Budget Request		2016-2017 Increase / Decrease	
	DME	OM	DME	DME	OM	DME	OM	DME	OM	DME	OM
Health Provider Systems	$ 39,408	$ 11,896	$ 35,672	$ 75,360	$ 63,090	$ 75,360	$ 63,090	$ 69,472	$ 80,733	$ (5,888)	$ 17,643
Health Administrative Systems	$ 34,617	$ -	$ 20,519	$ 54,800	$ 1,200	$ 54,800	$ 1,200	$ 9,860	$ 13,740	$ (44,940)	$ 12,540
Health Registries Program (HREG)	$ 2,386	$ -	$ 1,937	$ 12,720	$ 3,500	$ 12,720	$ 3,500	$ 9,858	$ 3,007	$ (2,862)	$ (493)
Access to Care (VHA)	$ -	$ -	$ -	$ 17,970	$ 13,780	$ 17,970	$ 13,780	$ -	$ -	$ (17,970)	$ (13,780)
Repository	$ -	$ -	$ -	$ 7,920	$ 1,020	$ 7,920	$ 1,020	$ -	$ -	$ (7,920)	$ (1,020)
Standards and Terminology Services (STS)	$ -	$ -	$ -	$ 2,000	$ 5,320	$ 2,000	$ 5,320	$ -	$ -	$ (2,000)	$ (5,320)
Data Access Services (DAS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Healthcare Reform / Affordable Care Act	$ -	$ -	$ 2,200	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotals	**$ 76,411**	**$ 11,896**	**$ 60,329**	**$ 170,770**	**$ 87,910**	**$ 170,770**	**$ 87,910**	**$ 89,190**	**$ 97,480**	**$ (81,580)**	**$ 9,570**
TOTAL DME and OM	**$ 88,307**		**$ 60,329**	**$ 258,680**		**$ 258,680**		**$ 186,670**		**$ (72,010)**	

Total Improve Veteran Access to Healthcare - $186.7 million

The 2017 request of $186.7 million will fund the programs that support the Agency's Priority Goal of Improving Access to Care. These programs will support the development and proliferation of an organizational approach that is personalized, proactive, and patient-driven. VA is committed to providing Veterans and other eligible beneficiaries timely and high-quality accessible health services. In 2017 the following programs will support improving veteran access to healthcare.

Health Provider Systems (HPS) - $150.2 million

Computerized Patient Record System

Health Provider Systems consists of critical major enhancements for the Computerized Patient Record System (CPRS) and important maintenance for a variety of related systems. CPRS is the system interface used by providers, nurses and other clinical staff to view patient centric information and is the electronic medical record that is used throughout VA in all health care settings (Inpatient, Outpatient, Long-term care), covering all aspects of patient care and treatment. The primary goal of CPRS is to provide a fast and easy-to-use application that provides a framework that supports clinical workflow.

The application integrates many clinical packages (laboratory, pharmacy, radiology, etc.) and provides an environment that coordinated care is reviewed, documented and preserved. The accessibility to this online clinical information is a significant factor in the delivery of timely, safe and quality care to the veteran population. CPRS v32 development projects will address requested features and functions as well as outstanding patient safety issues, and end-user reported issues/ enhancements as prioritized by CPRS Business Owners and Subject Matter

Experts.

This program also provides life-cycle support for several programs including: 1) deployed VistA health applications that ensure users have a reliable system for executing the business operations of VA/VHA; 2) full Tier 3 VistA application support, RAI/MDS system software product, and a Health Level Seven (HL7) interface between the product and the Veterans Health Information Systems and Technology Architecture (VistA) to support the collection of MDS data to determine workload, Veterans equitable Resources Allocation (VERA) reimbursements, and quality indicators as well as capture resident preferences for care; and 3) addresses defect repair for Enterprise Applications which ensures they are responsive to Veteran's Health Administration's (VHA) needs for executing its mission to care for Veterans.

FY2017 Request

In FY2017, the funding in development and sustainment will address numerous business needs.

Interoperability will be provided between VA and the DoD by delivering standard, interoperable immunization data for exchange with the DoD as well as the private sector. It will bring VistA into compliance with required standards for EHR certification and Meaningful Use demonstration that relate to immunizations. A long identified need to provide the ability to process a prescription request without an immediate accompanying requirement to dispense the prescription or set a prescription fill date will be fulfilled.

This version of CPRS fills numerous gaps in current allergy checking to improve patient safety and reduce the risk of prescribing a medication a Veteran is allergic to or not prescribing an indicated medication because of a prior issue that wasn't a true allergy.

In addition to the above other capabilities, this version will include changes to the nurse order verification's effect on the order status, an update to the surrogate management functionality, an expansion of the clinical reminder code space to allow for more characters, adding in the lab address to reports in the Health Summary, the addition of an alert that indicates to providers the number of refills and last fill date of an active prescription, improvements to alert processing , a capability to confirm providers when there are providers with similar names, the addition of a button which would link a "No Assessment" warning to Allergy Assessment Screens, the addition of a notification in real-time of potentially missed order checks, and improvements to the display of progress notes.

FY2017 Outcomes

- The ability to access a patient's clinical information throughout the VHA system is a key driver for the continued delivery of quality clinical care.
- CPRS will reduce excess costs by reducing unnecessary vaccinations, reduce inventory waste, and improve accuracy of patient health records.
- In addition Veterans will no longer receive unnecessary medications with the ability to hold a prescription from being dispensed when not needed. It will become clear to providers that

a medication they are prescribing is new to the patient so that the appropriate level of instruction and risk benefit conversation takes place.

FY2016 Deliverables

The accessibility to patients' online clinical information is a significant factor in the delivery of timely, safe, and quality care to the Veteran population. The CPRS development project addresses requested enhancements including Park-A-Prescription, Nurse Order Verifications Effect on Order Status Request, Update Surrogate Management Functionality, CPRS Notification Alert Processing Improvement Request, and Adverse Reaction Reporting File Modification Request. In FY2016 CPRS will complete Initial Operational Capability and begin National Deployment of CPRS v32.

VHA IT Development Research

The Office of Research and Development (ORD) develops VA researchers and health care leaders, and creates innovations that advance health care for our Veterans and the nation. ORD oversees biological and laboratory science research, clinical trials research, health services research, rehabilitation research and technology transfer research at 110 VA medical centers including a number of world renowned research centers nationwide with a special focus on the healthcare needs of veterans. Clinical research programs and participation bring benefits to patients and to society as a whole providing knowledge for advanced interventions to improve healthcare outcomes. In order to continue to meet the VA Research mission for advancing the healthcare of Veterans as identified in the VHA Blueprint for Excellence, IT funding is required for existing projects that play a strategic role in VA Research's mission.

FY2017 Request

Funding for the VHA Research Program will allow VA to further develop existing projects:

Genomic Informatics System for Integrative Science (GenISIS) – The Million Veteran Program (MVP) was launched in 2011, with the goal of enabling genomic discoveries that can translate to improvements in the healthcare of Veterans and the nation at large. GenISIS is the IT infrastructure that is the underpinning of MVP. With over 400,000 Veterans already enrolled, the program aims at building one of the world's largest databases of genomic, clinical, lifestyle, and military exposure information, ultimately enrolling at least one million participants. This program will serve as a national resource for an unprecedented scope of discovery, including in precision medicine. The vision is that participation in MVP will be available to all Veterans and active duty military personnel and that the de-identified data will be available to a broad community of researchers from federal as well as academic institutions.

The GenISIS computational environment needs to be versatile and agile, with a high compute capacity that supports over a thousand simultaneous users, provides a wide array of tools for analysis, and is user-friendly. Protecting data privacy and security is of the highest priority, with data being accessed in a secure enclave, and an adequate disaster recovery system built into the environment. GenISIS/MVP can also play a key role as a prototype for the President's Precision Medicine Initiative (PMI). Through linkage to the DoD and potentially with other Federal partners, there is a strong incentive for GenISIS to be the platform on which PMI is iterated and refined. Current GenISIS platform was sized to handle ~300,000 veteran participants. Continued development is required to continue the pace of enrollment (target 100,000 – 200,000 newly enrolled veterans annually).

VA Informatics and Computing Infrastructure (VINCI) - The VA Informatics and Computing Infrastructure (VINCI) Program is intended to fulfill the need of the VA Health Services research community and business intelligence for a secure and powerful analytical environment that provides access to data from VistA and other key electronic sources. The VINCI Program provides data, data analysis tools, software, software development tools and support for VA Researchers and is expanding VA capability for informatics research and business intelligence. This includes a wide variety of health services research including outcomes research, translational research, health behavior research, health economics research, quality and performance enhancement research, predictive analytics, and effectiveness studies. VINCI also develops advanced Natural Language Processing (NLP) toolsets and makes those tools available to a wide community of researchers and operational programs. All of these types of research lead directly to improved patient care outcomes.

VINCI will provide service to other organizations such as the DoD, Health and Human Services, State Departments of Health and academic institutions and is a key element in the VA's Affordable Care Act (ACA)/Patient Centered Outcomes and Research Initiative (PCORI) strategy. The services to be provided by VINCI include hosting of projects, materialization of data sets, and connection to software and development tools in a secure and powerful computing environment. VINCI also supports the phenotyping efforts necessary for GenISIS/MVP to successfully analyze genome relations to veteran's health. Continued development is required to keep pace with the billions of new rows of records that are generated monthly from the world's largest and best integrated health record system and serve as a research repository for comparable electronic health record data from DoD.

Research Administration Management System (RAMS) – ORD is responsible for the management and administration of the national Department of Veterans Affairs intramural research program. ORD aims to improve the efficiency and performance of the national VA research program by implementing an enterprise-wide Research Administrative Management System (RAMS) accessible to active field research offices and ORD Central Office. RAMS will support the major business functions of the local research office, management of the Research and Development Committee and its subcommittees Institutional Review Board (IRB), Institutional Animal Care and Use Committee (IACUC), Subcommittee on Research Safety (SRS), etc.), local research office reporting to ORD, permit the tracking of projects, finances and personnel, and provide a common database for tracking and reporting of administrative research program data throughout the VA. Centralized systems will allow economies of scale, streamlined database organization (enter once, reuse multiple times), and eventually replace dozens of obsolete legacy systems that are poorly matched for the modern research enterprise.

FY2017 Outcomes

The outcomes for the projects within Research and Development will provide significant benefit to the Veteran:

- GenISIS will, through its dual purpose of supporting research and clinical care, establish an IT platform for providing results of genomic discoveries and analysis back to health care providers, along with clinical decision support, reducing testing and introducing precision therapy. Critical research and patient benefits in the areas of pharmacogenomics, population health screening, carrier testing, rare disease diagnosis, genomic based cancer treatment, chronic disease management and wellness strategies may all be realizable thru MVP/GenISIS.
- GenISIS IT Development funds will increase the number of enrolling sites from the current ~50 to ~75-100, launch web-based recruitment, enrollment, consenting, initiate recruitment of the 200,000 person DoD Millennium Cohort into MVP, open enrollment to all veterans and active duty staff, make more than one million specimens available to a wide group of VA and non-VA investigators (~1000 simultaneous genomics users). GenISIS IT Sustainment funds will continue to support the ongoing costs of hardware maintenance, software license and support, and IT support contracts required for a large, complex high performance computing platform.
- VINCI will provide research services including hosting of projects, materialization of data sets, and connection to software and development tools in a secure and powerful computing environment. The type of health services research supported by VINCI includes outcomes research, health behavior research, effectiveness studies, implementation research, health economics studies, quality and performance measurement and research into quality factors. All these types of health services research contribute directly to improved health care processes and outcomes (better care at lower cost). Additionally VINCI will deliver the capacity to support 900-1000 concurrent research users. VINCI now contains trillions of rows of VA electronic health data and receives billions of rows of new data annually and must expand to collect DOD electronic health data for seamless longitudinal research abilities.
- VINCI IT Development funds will be used to expand enterprise natural language processing of text documents, enable inclusion of DoD electronic health records into the research

database, and expand the ability of VINCI to support phenotyping function in support of MVP/GenISIS. VINCI IT Sustainment funds will continue to support ongoing cost of hardware maintenance, software license and support, IT support contracts as well as allow natural capacity expansion as the longitudinal VA-DOD research data expands.

- RAMS will provide a robust centralized research management system resulting in economies of scale, streamlined database organization and will ultimately replace dozens of obsolete legacy management systems that are poorly matched for the modern research enterprise. RAMS will facilitate the complex research oversight, compliance and regulatory aspects of human subjects research and integrate field research offices into a national research portfolio allowing stakeholders (patient advocate groups, Congress, etc.) to view the depth and breadth of VA research concentrations and contributions.
- RAMS IT Development funds will be used to expand automation from a central IRB, to include animal committee, biosafety committee, and radiation committee regulatory activities. RAMS IT Sustainment funds will be used for ongoing support of installed IT infrastructure.

FY2016 Deliverables

- GenISIS – rehosting of the GenISIS 1.0 platform from VA medical center computer rooms to VA Enterprise Operations data centers, creation of initial web-based on-line recruitment tools, conversion from manual data upload of genomic data from sequencing vendors to automated data transmission over the wide area network.
- VINCI – conversion of ~45 researcher-developed natural language tools to optimized software code for enterprise production readiness, mapping existing data tables to open source data models enabling health services researchers to fetch data in a self-service mode.
- RAMS – delivery of the central IRB function into full production including committee workflow and routing capabilities and migration of ~ 30 legacies IRB databased from the field to the central system.

Enrollment Program

The Enterprise Health Benefits Determination Program (EHBDP) is a continuing effort to enhance and centralize on-line processing of applications for Veterans' enrollment in VA's health care system, through the Enrollment System (ES) application and its various components. Implementation of this initiative will ensure that Veterans are enrolled through the authoritative ES, eliminating data inconsistencies and significantly reducing enrollment errors. Improvements to the Enrollment System include allowing updates to the enterprise Enrollment System to be shared with the field sites; and allowing the Health Eligibility Center (HEC) staff to determine and communicate verified medical benefits eligibility and enrollment information for all Veterans and beneficiaries with both the VHA and the Veterans Benefits Administration.
The Health Eligibility Center is part of the Chief Business Office (CBO), and supports the delivery of VHA health care benefits as the national service center and authoritative source for registration, eligibility and enrollment. HEC processes applications by telephone, mail, and on-line. HEC partners with VA medical facilities to process applications for enrollment in VA's health care system. Another major function of the program is verification of Veterans' self-reported income information in concert with the IRS/SSA to establish eligibility for health care

services, co-payment status, and enrollment priority assignment. Additionally, HEC validates Social Security number to support collection of Federal tax information.

The Health Eligibility Center goal is to improve customer service and time frames to deliver accurate enrollment decisions. The overarching initiative is to centralize on-line application processing at the HEC through phased implementation by Veterans Integrated Service Networks (VISN).

The Enrollment System (ES) allows staff at the HEC to work effectively and efficiently, to determine patient eligibility in a timely manner. Messaging with VA medical facilities allows updates to the enterprise Enrollment System to be shared with the field. The two main functions of the ES are the expert system and the work flow (case management) system. The expert system is based on information obtained from sites, VBA, and military information, to enable HEC staff to determine and communicate verified medical benefits eligibility and enrollment information for all Veterans and beneficiaries. The work flow system, also known as Case Management, is utilized where the expert system process cannot make a determination and "cases" are created for human intervention.

The Enrollment System will benefit Veterans following ways:

- Improve enrollment services for our clients.
- Will be an authoritative source for Veteran's eligibility and enrollment.
- Will provide a Veterans Health Benefits Handbook that allows VA to consistently communicate health care benefits to which they are eligible.
- Improve accessibility to health care benefits for Veterans by centralizing enrollment process.
- Enable veterans to submit an application for enrollment electronically from anywhere an Internet connection is available.

Benefits to VA include:

- Ease of data collection from veterans by means of on-line transactions.
- Eligibility and enrollment services are more efficient to deliver within its boundaries.
- Centralized processing for the authoritative source of enrollment and eligibility information.

FY2017 Outcomes

Beginning FY2017, HEC will process all Veterans Online Applications for health benefits. Implementing this initiative will support our stated goal, which establishes a five – business day requirement for processing applications for health benefits. Currently, facilities are not mandated to use the Enrollment System, which can result in data inconsistencies and a delay in the enrollment process. Implementation of this initiative will ensure that Veterans are enrolled directly into the authoritative Enrollment System (ES), eliminating data inconsistencies and reducing catastrophic edits. HEC's core business function is processing applications and we have the tools and resources to accurately disposition applications.

FY2017 Request

In FY2017, development funds will:

- Modernize the enrollment system and enhance usability studies.
- Provide the ability to print communications (letters) from the ES.
- Deploy the Universal Learning Integrated Network Connection (uLink), a comprehensive solution to provide content knowledge and learning management capabilities to internal and external staff.
- Improve reporting capabilities.
- Reduce Pending Verification files in the ES.

Sustainment funds will allow the program to continue to support the Enterprise Health Benefits Determination (EHBD) Enrollment System sustainment capabilities in the production environment.

FY2016 Deliverables

- Provide one Health Benefits System (HBS) that distributes health benefits decision-making and management across the VA enterprise.
- Provide greater transparency into the Core Registration, Eligibility and Enrollment and Health Benefits information.
- Improvement in: the enrollment pre-determination process; handling of Core Registration, Eligibility and Enrollment and Health Benefits data inconsistencies; Core Registration, Eligibility and Enrollment and Health Benefits data quality; Address Management; and business processes across the agency and the mechanism for one HBS.
- Improve Core Registration, Eligibility and Enrollment and Health Benefits Auditing and Access Control.
- Provide one source for Core Registration, Eligibility and Enrollment and Health Benefits auditable reporting that support varied levels throughout the Government.
- Provide the ability to integrate ES with eFolder.

TeleHealth/Connected Health

The prevalence of high-speed Internet access and mobile technologies give Veterans multiple options for connecting with their VA health care team. 92 percent of Veterans served by VHA are younger than 40 years old and those 65 and older have a higher illness burden. Therefore, the importance of increasing efforts to identify disease early is imperative for which treatment is available and the need to enable frequent and easily achievable communications with the health care team for initiation of treatments and ongoing follow up. New Models of Care supports these efforts through Connected Health Office (CHO) including MyHealtheVet and Mobile development and Telehealth. VHA Connected Health focuses on health care improvement by engaging Veterans, their families and Caregivers outside of traditional health care visits by proactively providing opportunities for patient engagement earlier in their course of care. It also focuses on aligning health information technologies within VHA; improving data sharing to increase the value of health information; enhancing direct communication between Veterans,

Caregivers and VA care teams; and improving health care provider efficiency and satisfaction, particularly as they interact with Veterans by means of technology.

My HealtheVet is a web-based application that creates a new, online environment where Veterans, family, and clinicians may come together to optimize Veterans' health care. It provides Veterans opportunities and tools to make informed decisions and manage their health care. Web technology will combine essential health record information enhanced by online health resources to enable and encourage patient/clinician collaboration. The implications of My HealtheVet are far-reaching. Clinicians will be able to communicate and collaborate with Veterans much more easily. The new online environment will map closely to existing clinical business practices, while extending the way care is delivered and managed. As Veterans build up their lifelong personal health records, they will be able to choose to share all or part of the information in their account with all their health care providers, inside and outside the VA. This has the potential to dramatically improve the quality of care available to our nation's Veterans.

Thirty-six percent of Veterans served by VHA reside in rural communities. Providers, both in primary care and specialty care, are often not present in these communities, nor are the degree of even further specialized expertise necessarily available. Telehealth and Connected Health bring a portion of that expertise to the Veteran. The OIT infrastructure required to maintain and expand these services is significant. If it is not maintained and expanded to support the use of current and newer technologies as they become available, VA puts our vulnerable population considerably at risk. It is not the issue of VA care or community care, it is often VA care or no care.

Since 2002, Telehealth in VA has provided healthcare to more than 1.7 million Veterans. In FY 2014 alone, more than 700,000 Veterans received care from one or more of VA's Telehealth programs, totaling more than 2 million Telehealth visits. These visits occurred at more than 1,180 VA sites of care that have been equipped with the necessary resources to do so and also directly into the homes of more than 160,000 Veterans. Telehealth uses health informatics, disease management and innovative medical care technologies to improve access to care, improving the health of Veterans while often decreasing financial cost of care (fewer ER visits and hospitalizations) and maintaining Veteran independence prolonging the time until living support may be necessary (Non-institutional Care patients). Telehealth changes the location where health care services are routinely provided and is part of a spectrum of non-face-to-face care (i.e., Virtual Care) services that VA provides to Veteran patients.

VA has three (3) Telehealth modalities, that are defined by the technology framework employed, the clinical pathways used and/or location of care, which are: Clinical Video Telehealth (CVT), Home Telehealth (HT), and Store and Forward Telehealth (SFT). Every type of Telehealth that VA provides is a clinical encounter that involves a synchronous or asynchronous interaction between a Veteran and a clinician that includes an assessment, education, instruction, diagnosis, and/or a clinical recommendation. Bringing care as close to the Veteran as possible, whenever and whatever is needed, involves robust interaction and joining of resources from Telehealth, Biomedical Engineering/Healthcare Technology Management and OIT.

FY2017 Request

Twenty-two million households are expected to use virtual care solutions in 2018, up from one million in 2013. The program will create innovative new programs, focus on increasing access to underserved rural populations, and monitor the quality of clinical care to ensure its continued excellence. For example, as of July 2015, a total of 3,587 Veterans received VA care using video connections directly in their homes by means of CVT into the Home. In 2017, the funding request will enable Telehealth Services to provide support for 1.1 million Veterans, by sustaining and expanding the services that were developed in 2015.

Sustainment funding will support the expected Telehealth program growth from 15-20 percent each year. Program growth is based on estimates listed in the Telehealth FY15-16 Strategic Plan and was developed with a conservative estimate of 16 percent of growth each year for all Telehealth programs forecasted out to Fiscal Year 2021.

Fiscal Yr.	# of Patients	# of Encounters
FY2015	916,500	2,588,417
FY2016	1,063,140	3,002,564
FY2017	1,233,242	3,482,974
FY2018	1,430,561	4,040,250
FY2019	1,659,451	4,686,690
FY2020	1,924,963	5,436,560
FY2021	2,232,957	6,306,410

VHA needs more providers. With the advent of technologies, many providers can provide care through teleworking, decreasing the need for additional brick and mortar facilities. Other providers who may reside in brick and mortar facilities may increase their efficiency as a result of the current and burgeoning technologies. To not maintain OIT resources would be to halt successes in access that have been achieved. To not expand due to lack of funding for OIT infrastructure and support is to diminish provider and personnel efficiency which in turn results in higher costs or also a decrease from current achievement.

The Veterans that VHA serves have a higher illness burden than do recipients of comparable age in a Medicare population. Access to care, especially for our rural Veterans, is significantly impacted by transportation, geography, and lack of medical resources in many of these rural areas. Telehealth and Connected Health are significant players in removing barriers to access by using technology advances to bring care as close to the Veteran as possible. Expansions of specific programs that benefit our Veterans are necessary if VHA expects to achieve better outcomes or at least parity with the private sector. Examples include:

- Expansion of Tele-Intensive Care Unit (Tele-ICU) which provides state of the art ICU care, even in areas in which ICU specialty providers, called intensivists, are very difficult to recruit.

- Expansion of critical specialties to be available across the nation to direct state of the art care as in stroke care.

- Expansion of care into the home through technology and teleworking of providers. Reduces the need for increasing brick and mortar facilities to house the additional providers; but requires a much more robust program for connectivity between the provider and the location of the Veteran

FY2017 Outcomes

Part of the overall outcome for Connected Health includes: developing Application Programming Interfaces (APIs) for Secure Messaging and Prescription refill to enable use of common services within an enterprise architecture (e.g., for re-use by mobile applications), enhancing data refresh processes for importing data from the VA Electronic Health Record into My HealtheVet to improve the user experience, selecting and purchasing a Content Management System to enable improved management of site content and enable future synergy with Web and Mobile Solutions, new HealtheLiving Assessment was added to the portal to enable Veterans to create reports that show health age and current health status, and provide suggestions to improve health and lower the risk of disease.

FY2016 Deliverables

Areas of clinical care that new Telehealth program development in 2016 will focus on to address priority areas of Veteran care include: TeleMental Health, including National Specialist Networks; Clinical Video Telehealth expansion to Veterans in their homes; TeleAudiology; TelePathology; TeleCardiology; TeleNeurology; TeleICU Services; TeleWound Care; Home Telehealth model for Veterans with low-complexity healthcare needs; Women's Telehealth for gynecology, reproductive health and mental health; TelePulmonology, including TeleSpirometry; TeleRetinal Imaging for macular degeneration; TeleSurgery for pre- and post-operative care and including transplant care. Telehealth expansion with non-VA sites to improve Veterans' access to care to include, but not limited to, the Department of Defense and Indian Health Service.
The Connected Health program will redesign/enrich "My HealtheVet"(MHV) user experience to promote patient-centered care, deliver Blue Button Medical Imaging system to allow patients to view, download, and share images in Vista Imaging system with external providers, initiate integration of virtual care video visits hosted and promoted through MHV portal, and enhance universal access for patient-facing applications.

Healthcare Efficiency (HCE)

Healthcare Efficiency (HCE) focuses on the identification, reduction, or elimination of organizational variation in business and clinical areas. The elimination of unwanted variation throughout the organization will reduce health care operational costs and create a more

streamlined deployment of targeted programs. This standardization will enhance program efficiency throughout the VHA.

HCE includes other programs such as the Veterans Transportation Program (VTP) which is comprised of three business lines; Veterans Transportation Service (VTS), Beneficiary Travel (BT) and Highly Rural Transportation Grants (HRTG). Under the VTS, the VA seeks to improve Veteran's access to health care by introducing a more systematic approach to providing Veterans with rides to and from VA health care facilities. VTS requires a ride scheduling software solution to manage the business of a 21st Century transportation service.

VA seeks to provide an integrated transportation approach with vehicle tracking devices, passenger tracking, dynamic routing, detailed scheduling and reporting and VTS provides a potential "first' step in the creation of a transportation service through which an optimal and cost effective ride is brokered and managed. Under BT, VA provides eligible Veterans and other beneficiaries mileage reimbursement; common carrier reimbursement (plane, train, bus, taxi, light rail, etc.); or, when medically indicated, "special mode" transport (ambulance, wheelchair van) for travel to and from VA, or VA authorized non-VA health care facilities for which the Veteran is eligible. HRTG provides grants (annually $3.0M) to eligible recipients to assist veterans in highly rural areas improve their access to VA medical care, through innovative services. Non-VA Care- Claims Processing, Voluntary Service System, and Real Time Location System (RTLS) will be sustained in FY2017.

FY2017 Outcomes

All aspects of the program are designed to create organizational value by reducing costs while maintaining quality. Enhanced care to the Veteran is provided through the standardization of clinical and business practices, evaluation of specially funded programs, analysis of expenses associated with various organizational oversight programs, and the acceleration of cost-savings initiatives.

FY2017 Request

In FY2017, funding will support the below activities.

- Medical Center participation in the Veteran Transportation Service with a Mobility Manager to conduct one million trips
- Initiation of five Mobility Management sessions, to include training of 40 Mobility Managers.
- Implementation of the one-click-one call *United We Ride* concept, whereby VTS has the capability to use ride scheduling software which will broker rides with external community partners.

FY2016 Deliverables

VTS will continue current operational status and plans to add twenty additional Medical Centers to the program which will support the operation of eight thousand trips. In the 2016 the program

also plans to conduct five Mobility Management sessions, to train forty Mobility Managers. In 2016 VTS also plans to deploy VTS to the ten SCI Centers that do not currently have a VTS Program in operation, and increase the resources of the VTS Programs currently operating at fifteen Medical/SCI Centers.

Health Administrative Systems – $23.6 million

The Health Administrative Systems (HAS) program supports several critical VHA business functions that ultimately expand Veterans' access to care and reduce the cost of that care. It partners with key VHA and VBA stakeholders to develop health information technology solutions for transformational healthcare delivery with strategies including efforts to decrease Veterans call wait times for appointments; increasing Veteran client satisfaction with services; upgrading systems that improve the accuracy of eligibility determinations and claims payments; improve the network of transportation services and resources to increase access to VA and non-VA healthcare services; provide customer service and support to Veterans, caregivers, other government agencies and the general public regarding VA health benefits, eligibility, and billing questions; and enhance the ability to effectively manage and provide high quality prosthetic and sensory aid devices to Veterans.

Customer Relationship Management (CRM) – Fix the Phones (FtP) is desktop software designed to optimize the Veteran experience through the unification and integration of multiple CRM applications into "one view" for a VHA Patient Aligned Care Team (PACT) Call Center agent, in order to simplify the Veteran's interaction with their clinical and administrative support team.

FY2017 Outcomes

The outcomes for the several projects within Health Administrative Systems will provide significant benefit to the Veteran.

The CRM "Fix the Phones" project will result in decreased Veterans' overall call wait times and the VA's ability to respond more promptly to their concerns while dramatically improving the call agent and care team's ability to respond to increased demand for clinical appointments and interactions. These outcomes will result in increased levels of Veteran satisfaction through increased access to clinical care-appointments, increased First Call Resolution, decreased call handle times and increased speed-to-answer rates.

FY2017 Request

In FY2017, the request of $9.9 million in development funds, and $13.7 million marginal sustainment will support the above outcomes.

FY2016 Deliverables

The CRM FtP activities include expanded capability and "hi-usage" system integration

activities in addition to continued roll out of capabilities across remaining VISN 21 call centers.

Health Registries Program (HREG) - $12.9 million

The Health Registry Program is comprised of more than a dozen individual registries that are used to coordinate care, track health outcomes, and develop best clinical practices.
The HREG Program benefits include improved healthcare outcomes for those veterans with conditions monitored by the registries, such as Oncology Tumor Registry, Traumatic Brain Injury Registry and Breast Cancer Registry. It also ensures that registries are used as an organized system for the collection, storage, retrieval, analysis, and dissemination of information on Veterans who have either a particular disease, a condition (e.g., risk factor) that predisposes to the occurrences of a health-related event, or prior exposure to substances (circumstances) known or suspected to cause adverse health effects.

Future enhancement of this program will give health professionals the ability to exchange Veteran information based upon their related diseases, conditions, injury, etc., from each registry's reports. For example, if a Veteran suffered Traumatic Brain Injury (TBI Registry) while in conflict, then they might also have an amputation, transplant, or eye injury. With the new Converged Registry System (CRS), sharing of reports from multiple registries the Veteran may be entered will give the health professional greater and more accurate information to base decisions upon, thus giving more options for treatment(s).

The Homelessness Registries Program consists of two systems, Health Management Information System (HMIS) and Veteran Re-entry Identification System (VRIS), that support the Eliminate Veteran Homelessness (EVH) program's efforts by automating processes to gather data needed to provide services to Veterans that are in need of homelessness services.

Homelessness Registries will provide a tremendous benefit to Veterans by:

- Identifying incarcerated Veterans (Incarceration is the most powerful predictor of homelessness)
- Ensuring faster implementation of services to incarcerated Veterans by local Healthcare for Re-entry Veterans (HCRV) and Veterans Justice Outreach (VJO) Specialists. Results generated by VRIS are used by VJO staff daily to conduct outreach to Veterans in prison, jail and court facilities
- Allowing local communities to identify Veterans currently accessing non-VA community homeless programs
- Helping local providers connect homeless Veterans to VA services.

FY2017 Request

The 2017 funding request will provide support for the following:

- Continuous improvement of Converged Registry Solution (CRS) and identification of new registries that need to be integrated with the CRS framework/platform;

- Enhancement of CRS by improving data security, developing more analytic and reporting tools, and improving data standardization; and
- Enhancement capability and functionality of existing registries.
- Provide sustainment of VRIS to provide an automated method to identify incarcerated Veterans in custody in U.S. correctional facilities.
- Provide sustainment of HMIS which is the integral to meeting reporting requirements by Supportive Services for Veteran Families (SSVF) grantees.

FY2017 Outcomes

- Identification of Veterans in different classifications, such as infectious and non- infectious disease, and providing information used in:
    - estimating magnitude of the problem,
    - determining the incidence of disease,
    - examining the trends of disease over time,
    - assessing service delivery,
    - identifying groups at high risk, and documenting the types of patients served by a health provider;
- Monitoring and tracking diagnostic testing and treatments and facilitating coordination of care to improve management and timeliness of treatment for all veterans and their beneficiaries; and
- Improvement of management structure for all registries and CRS framework to eliminate the stovepipe/fragmented approach that created a non-standardized, duplicative, and inefficient situation and create a single project approach to provide the opportunity for improved coordination and streamlining of the effort and also create a forum for business customers to collaborate and identify common capabilities, as well as the registry specific capabilities.

FY2016 Deliverables

The deliverables planned for 2016 provide support for the following:
- Integration of individual registries and utilization of common capabilities and data as much as possible;
- Minimization of the duplication of effort among the various registries;
- Improvement of VA's ability to support the rapid development of new "quick reaction" registries;
- Development of a common registries framework;
- Future integration planning with the Vista Enhancement's Enterprise Health Management Platform (eHMP).

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Information and Technology

Improve Access to Benefits

Improve Access to Benefits											
(Dollars in Thousands)											
	2015 Actuals		2015/2016 Carryover	2016 Budget Estimate		2016 Current Estimate		2017 Budget Request		2016-2017 Increase / Decrease	
	DME	OM	DME	DME	OM	DME	OM	DME	OM	DME	OM
Veterans Benefits Management Systems (VBMS)	$ 66,979	$ 78,892	$ 1,120	$ 76,000	$ 177,000	$ 76,000	$ 177,000	$ 75,000	$ 68,000	$ (1,000)	$ (109,000)
Memorial Legacy Development	$ 7,976	$ 118	$ 502	$ 10,000	$ 1,496	$ 10,000	$ 1,496	$ 17,857	$ 2,686	$ 7,857	$ 1,190
Appeals Modernization	$ -	$ -	$ -	$ 19,100	$ -	$ 19,100	$ -	$ 19,100	$ -	$ -	$ -
Chapter 33	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,826	$ 6,103	$ 11,826	$ 6,103
Veterans Service Network (VETSNET)/Finance and Accounting Syste	$ 11,532	$ -	$ 869	$ 10,000	$ 13,000	$ 10,000	$ 13,000	$ 10,288	$ 4,314	$ 288	$ (8,686)
Common Shared Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,397	$ -	$ 11,397
Compensation and Pension Records Interface (CAPRI)/Disability Exam and Assessment Program (DEAP)	$ 1,028	$ -	$ 72	$ 8,300	$ 750	$ 8,300	$ 750	$ 4,522	$ 250	$ (3,778)	$ (500)
Compensation	$ 744	$ -	$ 6	$ 640	$ -	$ 640	$ -	$ 1,665	$ 260	$ 1,025	$ 260
Vocational Rehabilitation and Employment (VRE)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,790	$ -	$ 1,790
Corporate Waco-Indianapolis-Newark-Roanoke-Seattle (CWINRS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,215	$ -	$ 1,215
Mobile Development	$ -	$ -	$ -	$ 11,000	$ 1,725	$ 11,000	$ 1,725	$ -	$ -	$ (11,000)	$ (1,725)
Virtual Lifetime Electronic Record (VLER) Core	$ 10,121	$ -	$ 1	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
VACAA Section 701/702	$ 975	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotals	**$ 99,355**	**$ 79,010**	**$ 2,570**	**$ 135,040**	**$ 193,971**	**$ 135,040**	**$ 193,971**	**$ 140,258**	**$ 96,015**	**$ 5,218**	**$ (97,956)**
TOTAL DME and OM	**$**	**178,365**	**$ 2,570**		**$ 329,011**	**$**	**329,011**	**$**	**236,273**	**$**	**(92,738)**

Total Improve Access to Benefits - $236.3 million

The 2017 request of $236.3 million supports VA's initiative to improve veteran access to benefits. The IT investments in this area will focus on providing Veterans with a modernized technology solution that supports the delivery of benefits to our nations Veterans such as the Veterans Benefits Management System (VBMS), and VETSNET, a custom-built, mature suite of inter-related applications designed and implemented to deliver critical business systems for compensation and pension claims.

Veterans Benefits Management System (VBMS) - $143.0 million

VBMS serves as the technological cornerstone of the Department's benefits claims processing capability. Since the initial phases of its development, VBMS has become the foundation and platform for automating future claims processing across all Veterans Benefits Administration (VBA) business lines. Each month, VBA processes approximately $3 billion in service-connected disability compensation benefits for over three million beneficiaries. With each release VBMS improves efficiency and functionality to support the disability compensation benefits process.

VBMS is an internally facing VA system used by VBA claims processors at all 56 VA regional offices (ROs). Additional stakeholder groups, including the Veterans Health Administration, Board of Veteran Appeals, and Veterans Service Organizations access VBMS to support the claims process and execute their respective missions. To date, VBMS has helped significantly reduce the claims backlog, supporting quicker and more accurate delivery of benefits to millions

of Veterans and beneficiaries. In addition, the system has improved the overall speed, accuracy, and consistency of decisions for Veterans by providing the tools the workforce needs to meet growing demand and claim complexity.

As the Department’s technology environment evolves, additional work is needed in VBMS to improve Veterans’ experience with the benefits claim process. The current Veteran experience includes several challenges such as the Department’s lack of a single, common, and integrated authoritative data source for Veteran information. Currently, the lack of a single data source places administrative burdens on the Veteran to update their information multiple times through various channels and systems. It also results in delays to claim processing and delivery of services and compensation due to data errors and related rework. Systems and applications that are not fully integrated result in confusion and hinder Veterans’ access to services and benefits. In the current environment, Veterans and stakeholders must access multiple applications to interact with the Department. The myriad of systems and channels for communicating with the Department preclude a seamless Veteran experience and exacerbate an inability to provide Veterans with on demand access to the latest information on the status of their benefits and claims through a single portal.

In FY2017, VBMS will begin closing out major development of the initial VBMS investment and transitioning to the next generation of development, which will be driven by the desired Veteran experience and associated interoperability goals while continuing to deliver the necessary capabilities for the compensation disability and pension VBA business lines. VBMS will continue development and implementation using a phased approach consisting of incremental software releases to ensure delivery of mission-critical functionality. The vision for the desired Veteran’s experience and integrated technology environment is based on an end state that:

- Empowers Veterans by providing common access points, on-demand access to a full array of benefits information, and a seamless experience when interacting with the Department
- Engages partners through improved data exchange capabilities, automation, and information access
- Enhances VA operations through expansion of eFolder capabilities, refined and/or automated business processes, and a more integrated approach to overall benefits delivery

These desired outcomes and vision align with VA’s Strategic Objective to “increase customer satisfaction through improvements in benefits and service delivery…interfaces” and the Secretary’s MyVA priorities. Specific VBMS program goals for FY2017 reflect the program’s focus on outcomes tied to enhancing VA operations, improving the Veteran experience, and enhancing strategic partnerships.

In FY2017, VBMS will lay the foundation for transitioning to a modular approach to business architecture and design while continuing to deliver functionality enhancements that support claims processing improvements. The emphasis of requirements gathering and design activities in FY2017 will reflect the program’s shift in focus to delivering broader enterprise business capabilities.

Empowering Veterans through common access points and enhanced business capabilities

VBA is identifying people, process, and technology enhancements that will serve as the enabling infrastructure for achieving the Secretary's vision of a VA-wide customer service, Veteran-centric organization. A key component of this infrastructure is an integrated electronic operating environment that will serve as the backbone for a unified digital experience for the Veteran. VBMS will ultimately support this unified Veteran experience by providing Veterans with access to their eFolders, enabling on-demand access to their information anytime, anywhere.

Enhancing trusted partnerships through better stakeholder access and information exchange

Planned VBMS capabilities will facilitate more robust relationships and information exchange with external stakeholders such as the Department of Defense (DoD), Social Security Administration (SSA), and Internal Revenue Service (IRS).

The integrated electronic operating environment will enable our internal and external partners to support common processes for delivering benefits and services to Veterans.

FY2017 Request

In FY2017 VBMS budget request is broken into $75 million in development and $68 million in sustainment funds. Development funds will be used to deliver planned functionality listed in the table below. FY2017 will be a pivotal year in VBA's ongoing transformation and the Department's drive to improve the Veteran experience. VBMS serves as the cornerstone of the benefits technology infrastructure and continued investment in VBMS development is critical to achieving the Department's broader goals relative to improving the Veteran experience and developing a unified digital operating environment.

VBMS sustainment funds will be used to ensure continued availability and performance of VBMS, which is VBA's mission-critical system, used at every VA Regional Office across the country and overseas to process compensation claims. Given its criticality to VBA operations and delivery of benefits to the nation's Veterans and beneficiaries, it is imperative that the system has the appropriate infrastructure to remain operational at all times. When the system is down there is a direct impact to the number of claims being processed. The criticality of system responsiveness and performance is reflected in the performance metrics against which the program and system are measured. The table below provides an overview of VBMS metrics and associated performance requirements.

Further reduce reliance and support sunset of relevant legacy applications.	Integrate remaining functionality for Rating, VETSNET Awards. Continue functionality implementation to support future sunset of MAP-D. Integrate remaining data feeds from VVA needed for Compensation and Pension claim processing.

Complete mission critical VBMS application development and automation improvements.	Deliver additional remaining claims processing functionality to support appeals and pension claims processing. Implement additional automation for pension claims processing. Develop functionality to support national workload strategy (NWQ Phase 2) related to appeals and non-rating work.
Perform foundational work required to deliver enterprise business capabilities.	Analyze business process, workflow, and business rule commonalities across business lines and define business capabilities to meet those needs (e.g., eligibility determination is required across VBA business lines). Define, standardize, and publish business interfaces to support enterprise business capability delivery. Identify architecture, software and hardware improvements needed to support enterprise business capabilities approach. Further enhance and upgrade the eFolder to support all VBA business lines and exposure to the Veteran.
Implement Customer Data Integration (CDI) functionality to support one authoritative source for Veteran contact information.	Complete remaining technical work to support implementation of Master Veteran Index (MVI) functionality. Implement business capabilities required to enable authoritative address and other CDI initiatives.

Given the required performance levels, mandatory sustainment costs are essential to ensuring continuous availability of the system. Sustainment supports maintenance and operations costs for OIT projects at the current capability and performance level. Sustainment costs do not support new functionality or enhancements, but rather the maintenance of existing information systems and applications. In addition to infrastructure, sustainment funding corrects critical software defects having an immediate and adverse impact on both OIT and our business partner's capability to support the VA's daily mission-critical requirements. This includes software maintenance and equipment replacement.

Benefit to the Veteran

While VBMS is not Veteran facing, VBMS provides a platform for automating future claims processing in all VBA business lines. This allows every claims processor to serve each Veteran more efficiently with higher quality.

VBMS will deliver further efficiency gains that enable transparency in the delivery of decisions to Veterans through support and integration with Veteran-facing applications, specifically eBenefits. These integrated improvements will benefit Veterans by:

- Improving the ability for Veterans to navigate the entire portfolio of VA services, as well as manage and update their information, from a single point of entry (e.g., providing Veteran access to the VBMS eFolder through eBenefits)

- Supporting a seamless, integrated, and responsive customer service experience for Veterans by providing the back end, single authoritative data source
- Eliminating burdens and errors associated with frequent, duplicative data entry

FY2017 Outcomes

As part of a larger organizational mission to transform to an integrated electronic environment, a new model to support future initiatives will begin in FY16.

- In FY17, VBMS development will assist VBA's goals to: Create common access points for the Veteran (by maintaining and improving integration with Veteran-facing applications)
- Enhance trusted Partnerships through better stakeholder access
- Expand the VBMS eFolder

Notional FY2017 performance indicators are provided below and align to each of the VBMS program goals.

FY2017 Functionality (Planned) and FY2017 Outcomes

Relevant Planned Functionality/Software Enhancement Examples	Benefits and Outcomes
Integrate remaining functionality for Rating, VETSNET Awards. Continue functionality implementation to support future sunset of MAP-D. Integrate remaining data feeds from VVA needed for Compensation and Pension claim processing.	Reduce time spent accessing multiple applications to process claims by providing complete information within the eFolder and access to data from a single application. Streamline benefits IT investment portfolio by reducing redundancy and sunset outdated applications. Reduce overall sustainment costs associated with maintaining legacy applications. Allow redeployment of staff resources to support value-added development efforts.
Deliver additional remaining claims processing functionality to support appeals and pension claims processing. Implement additional automation for pension claims processing. Develop functionality to support national workload strategy (NWQ Phase 2) related to appeals and non-rating work.	Increase automation through additional business rules for pension claims processing. Balance and normalize workloads to reduce claims processing time. Provide tools and functionality to support increasing volume of appeals work.
Analyze business process, workflow, and business rule commonalities across business lines and define business capabilities to meet those needs (e.g., eligibility determination is required across VBA lines of business). Define, standardize, and publish business interfaces to support enterprise business capability delivery.	Improve Veterans' access to data and documentation housed in the eFolder. Improve transparency and accuracy of Veteran data by enabling a single, comprehensive eFolder that provides on-demand, relevant benefits information. Improve the Veteran experience by reducing the need for duplicative applications and documentation submissions across VBA lines of business.

Relevant Planned Functionality/Software Enhancement Examples	Benefits and Outcomes
Identify architecture, software and hardware improvements needed to support enterprise business capabilities approach. Further enhance and upgrade the eFolder to support all VBA lines of business and exposure to the Veteran.	Improve communication with the Veteran by providing comprehensive eFolder and data to National Call Center (NCC) representatives and VBA staff across VBA business lines.
Complete remaining technical work to support implementation of Master Veteran Index (MVI) functionality. Implement business capabilities required to enable authoritative address and other CDI initiatives.	Improves the Veteran experience by eliminating administrative burdens associated with correcting contact information. Ensure Veterans and beneficiaries receive timely and accurate correspondence. Reduce staff time and rework to correct data entry errors. Prevent delays in claims processing by ensuring on-demand access to correct information. Empower Veterans by providing self-service capabilities to update information.

FY2016 Deliverables

Expected deliverables in FY2016 include functionality that integrates complex automation features within VBMS and across external systems. The goals for FY2016 reflect the program's focus on integration enhancements , reducing reliance on legacy systems, and forward-looking enterprise needs to support claims processing across VBA's lines of business. The table below provides planned functionality and system enhancements aligned with FY2016 program goals.

Table 1: FY2016 Functionality (Planned) and Goal Alignment

FY2016 Goals	Relevant Planned Functionality/Software Enhancement Examples
Continue to reduce reliance on legacy systems.	Integration of legacy system functionality for Modern Award Processing – Development (MAP-D), Virtual VA (VVA), and Personal Computer-Generated Letter (PCGL) applications. Awards generation upgrades and Generation 2 development. Enhancements to exam request management and additional Clinician User Interface (CUI) integration. Foundational Pension claims processing capabilities and automation. Centralized mail support including electronic identifiers added to correspondence.

FY2016 Goals	Relevant Planned Functionality/Software Enhancement Examples
Integrate and enhance VBMS capabilities with the Department of Defense (DoD).	Health Artifact and Image Management Solution (HAIMS) integration improvements and Service Treatment Records (STRs) / processing and reporting upgrades.
Implement improvements to electronic communication and access to the eFolder.	eFolder technical improvements such as integration upgrades for uploading and downloading files. Correspondence language updates and new letter generation capabilities. Appeals Integration. National Work Queue enhancements.
Implement functionality required to establish one authoritative source for Veterans' contact information.	Master Veteran Index (MVI) implementation. Creation of Veteran record in corporate and beneficiary identification records locator subsystem.

In addition to the examples cited above, the VBMS program will continue to deliver key functionality enhancements that directly support compensation and pension claims processing activities. FY2016 software releases build on efficiencies gained through existing processes and functionality and provide the foundation for subsequent integration at the enterprise level, particularly in the area of eFolder expansion.

VBMS will continue to follow an Agile software methodology to deliver functionality in three-month increments. This approach has proven successful in ensuring collaboration between business and IT partners, allowing for flexibility to meet emergent business needs, and supporting a continuous focus on the core mission of serving the Veteran.

Memorial Legacy Development - $20.5 million

The Memorials Legacy Development Program supports the transformation of the National Cemetery Administration (NCA) by working to improve the efficiency of Veterans' access to memorial benefits, improving end-user functionality and data quality, enhancing tracking of Veteran case status, enabling remains tracking capability, and increasing NCA customer satisfaction. In FY2017, the Memorials Legacy Development Program will continue to enhance and deliver new capabilities within the Memorial Benefits Management System (MBMS) suite of IT Products. MBMS leverages modern technology with web-based, on-line application systems designed for data flow interchange with VA's standardized modern platforms. When completely implemented, MBMS will provide interoperability with external systems, allowing Veterans, their next of kin, and other users to save time with faster eligibility and forms processing capabilities.

MBMS will also improve end-user functionality, end-to-end decedent chain of custody tracking, real time Veteran case status and will also enable state of the art remains tracking through digital real time Geographic Information System (GIS)/Global Positioning System (GPS) based mapping and geographic information, as well as mobile and web based user enabling tools.

These new capabilities will enable the achievement of VA strategic goals for more effective and Veteran centric delivery of services and improved support of Veterans and their families.

Specific FY2017 goals of the Memorials Development Program include the following:

- Improve Veterans' awareness of and access to burial and memorial benefits.
- Expand the use of innovative methods for outreach and self-service to Veterans, their families, and the public.
- Develop and implement an automated, pre-need eligibility certification system and VA system interfaces to eliminate multiple inquiries from VA over the lifecycle of benefits delivery.
- Leverage VA common data and services to reduce the burden of requesting a benefit.

FY2017 Request

In FY2017, the Memorial Legacy Development budget requests $17.9 million in development and $2.7 million in sustainment funding. Funding will be used to continuously improve the Burial Operations Support System (BOSS) Enterprise solution through the investment of resources that will automate manual business processes. In FY 2016, NCA plans to implement several new capabilities to guarantee that the legacy system will be a viable platform as the transition to enterprise services begins to take shape in 2017. Also in 2017, MBMS will continue to support the transformation of NCA by enhancing and improving the delivery of Memorial Benefits IT capabilities. MBMS will improve end-user functionality, data quality, and continue to move NCA from a stove piped system to an enterprise solution.

The modernization of the end-to-end NCA systems platform is a very complex undertaking, requiring the program team to address issues such as:

- Assessing and addressing compliance (Section 508, security, etc.) weaknesses with the existing systems.
- Engaging with and adopting new Enterprise Architecture (EA) Data standards for OneVA EA and enterprise shared services.
- Architecting and designing services based solution for Veteran management that integrates with new enterprise services and other Veteran authoritative systems across the VA.
- Designing, approving and deploying, new web based functionality directly accessible to Veterans, their representatives, and funeral homes, requiring access and identity management controls, and potential integration with One VA web platforms.
- Developing new technologies to consume enterprise Veteran Management services.
- Enhancing system support for business functionalities including but not limited to:
  - Automated scheduling
  - Automated Dig Slip
  - Remains tracking
  - Use of mobile technology
  - Adoption of digital mapping for cemetery management and burial operations
  - Enterprise reporting (e.g. data inconsistencies between systems)
- Stabilizing current platform.
  - A number of the applications supporting NCA have non-compliance issues (508, security…).
  - Data quality and inconsistency issues impacting reporting
- Modernizing the application architecture to align with the OneVA EA
  - Upgrade user interface for consistency and quality
  - Improve integration with other VA systems to improve Veterans' records
  - Evaluate the use of enterprise services
  - Migrate to event based architecture using rules based workflow capabilities
  - Enhance integration with web technologies to enable engagement with non-VA stakeholders

Memorials Legacy Development sustainment funding will address those capabilities that will be delivered or implemented in FY2016.

FY2016 Deliverables

Cemetery Management Phase 1

- Deliver a standardized and automated tool for cemetery staff to conduct the interment process and create other workflows to ensure best practices are always used and the process can be reviewed for accuracy. This will allow NCA to continuous improve and monitor the accuracy of tracking remains and ensuring confidence in the delivery of service for Veterans.
- The automation of the Interment Notice will eliminate manual checklist and signatures. Gravesite Information will be pre-populated with decedent information and adjacent gravesite information. The foreman and field crew will be able to use hand held devices to update the completion of burials in real time. By leveraging automation for NCA caretaker activities, NCA can reduce redundant data entry efforts, provide better reporting and tracking to assure the Veteran a robust and accurate interment process is implemented and continuously monitored for accuracy.

Memorial Pre-Need/Enterprise Veteran Self Service

- Provide changes to the PreNeed program design and processing to allow for an interface with the One VA WEB portal, which is expected to increase customer self-service allowing the freedom of choice for the Veteran in choosing how and when they make a benefit request.

Memorials Veteran Benefit - Enterprise Memorial Letters

- Implement a tool that allows NCA to specify standard templates for customer responses and edit or create templates as requirements dictate. This will allow for a single, consistent voice to the Veteran and expedite the process of their benefit request.

Memorials Veterans Eligibility – Pre-Need/Enterprise Legacy

- The NCA eligibility and benefits system will be modified to ingest content from the Enterprise Veteran Self Service Portal. This will allow for the automation of Pre-Need eligibility determination and eligibility for other Memorial Benefits. By automating these manual tasks the NCA will be able to expedite the determination process for the Veteran and free up resources for more complex cases that can only be resolved by one on one communication with the Veteran.

Board of Veterans Appeals (BVA) Appeals Modernization - $19.1 million

The Board of Veterans' Appeals is seeking continued funding to support the Appeals Modernization initiative in FY2017 in order to mitigate the risk inherent in the current manual, cumbersome processing of appeals. The current process uses disjointed uncoordinated systems, which creates a severe accountability gap in appeals management across the Department.

Presently appeals are managed throughout the Department using a legacy database created in the 1980s, the Veterans Appeals Control and Locator System (VACOLS) that is not integrated in any way with VBMS and other systems. (VACOLS is a paper appeals tracking system, which

was designed with the paper claims file serving as the manual trigger point). Appeals Modernization is truly an Enterprise-Wide initiative that will have a direct impact on Veterans by enabling the Department to provide timely and quality appeals decisions, as well as seamless accountability and visibility on appeals across the Department and improved information security capability with the technology being developed.

By way of background, modernization has occurred on the front end (i.e., claims) and the back end (i.e., federal courts) of the VA benefits process, yet VA appeals processing at VBA (and other appeals business lines) and the Board relies on manual data processing by utilizing antiquated, uncoordinated systems. Appeals across the Department (to include VBA, VHA, NCA, OGC and the Board) are currently processed in a hybrid environment - with reliance on paper, and multiple unsynchronized, outdated legacy systems. Manual data entry and lack of appeals-specific paperless functionality creates risk for the Department in workload management as well as a drag on processing, and there is minimal appeals-specific paperless functionality, which creates inefficiencies in end-to-end appeals processing.

VA has seen the benefits of people, process and technology transformation at the *claims* level with increased claims decisions being issued and more Veterans being served - 1.3M in FY14 and record-breaking projections for claims decided in future years - the same rigorous, multi-pronged efforts to modernize must be applied to the appeals process. The Board is leading this initiative, partnering with all stakeholders in the appeals process (VBA, VHA, NCA, OGC, OIT, VSOs) and advocating for full funding to support this initiative, which includes robust IT and FTE components, in order to mitigate risks inherent in the status quo and to provide timely service to Veterans and their families.

Continued funding is requested for Appeals Modernization, which will leverage people, process and technology enhancements to mitigate the risk inherent in disjointed manual appeals processing from multiple business lines, causing increased wait times for Veterans and their families and a lack of accountability of all appeals by the Department. Appeals Modernization will allow the Department to contain and ultimately reduce the VA appeals inventory (which stood at over 440,000 appeals in December 2015, and which has been increasing at a rate of over 35,000 per year on average since 2012), and efficiently process future appeals workload. On average, 11-12 percent of VA claims decisions are appealed - a rate that has held steady over the past 20 years. As more claims have been completed over the past 5 years, more appeals have emerged at a steady proportional rate.

Appeals Modernization will enable the Department to process appeals decisions more efficiently, which will reduce wait times for Veterans and their families. It will also allow the Department to contain and further prevent the creation of a new "appeals backlog" and will help VA restore public trust by getting ahead of a looming appeals workload crisis caused by antiquated, manual, paper-bound appeals processing in multiple disjointed systems throughout VA. Additionally, this initiative will ultimately reduce error from manual appeals processing and manual work-around currently in place to address technology voids.
Benefit to the Veteran

- Appeals Modernization will improve the experience of Veterans by enabling transparency of appeals processing and ultimately facilitating the delivery of more timely appeals decisions.

- Appeals Modernization furthers the MyVA and Customer Data Integration (CDI) vision of Enterprise-wide integration of data and systems. Foundational to Appeals Modernization is integration with VBMS and other systems to ensure seamless accountability of all appeals across the Department, in addition to leveraging already-existing data in the eFolder.
- Appeals Modernization also furthers MyVA's goal of optimizing employee engagement by employing user centered design principles and providing employees the necessary tools to fulfill their mission.

FY2017 Request

The FY2017 funding request for Appeals Modernization is $19.1 million. FY2017 funding will be focused on the continued development of the Appeals Modernization initiative, requiring software development to be completed by a combination of the Digital Service, internal government resources and contractors. Specifically, this development will focus on replacing additional portions of the VACOLS system in anticipation of its eventual deprecation. Development will also provide the required information security capability needed. Important additions, such as a performance dashboard will begin to be integrated, which will increase management oversight, optimize proactive intervention, and enable the ability to quickly troubleshoot and mitigate challenges.

Funding will be used for servers and the sustainment of acquired products, including the eReader/Annotation software that will enable Board staff to more efficiently review all documents in the claims folder, as well as for support of cloud and server maintenance. Development funds will be utilized to modernize the document generation and mailing process. New hardware will be acquired to support the most efficient uses of the new systems. FY2017 funds are also critical to support the piloting, rollout, and training of individual components to different users across the Board and other appeals lines of business.

FY2016 Deliverables

The Board obtained $19.1 million development funding in FY2016 to support Appeals Modernization activities. The foundational elements of Appeals Modernization will be delivered in FY2016, and three streams of improvements will be addressed in FY2016: integration, workability, and accountability.

- <u>Integration</u>: The integration work stream is designed to address significant risks in the current environment that are caused by hand-off gaps between different jurisdictions and systems. The Caseflow Tool (built by the Board's Presidential Innovation Fellow (PIF) in FY15) will be fully launched in FY2016, preventing cases from being lost when transitioned from VBA to the Board. The tool will also prevent significant extra work for cases which are certified by VBA to the Board before they are ready for Board adjudication due to missing documents, etc.
- <u>Workability</u>: The workability work stream will improve the ability of Board staff to efficiently review documents in the claims file and process appeals. Following an RFI to understand the eReader and evidence review market, FY2016 will be focused on selecting and/or designing the appropriate software. This will be performed by working directly with

users to pilot/design the selected software in an effort to reduce the significant extra time required to review paperless cases. This will contribute to the improvement of the throughput of cases reviewed at the Board.

- Accountability: The accountability work stream is centered on the first stages of the replacement of VACOLS, a system that was developed almost 30 years ago. This work stream will enforce user-level authentication rather than the existing VBA Regional Office (RO)-level authentication. The technology will be designed to facilitate the seamless paperless processing of appeals in a secure environment. Specifically, a workflow capability and integration of the case review process will allow the Board to more accurately and efficiently process appeals. It currently takes double the time for intake to be completed for paperless cases as compared with paper cases as a result of the various disjointed, legacy and standalone systems, which were not originally designed for their current use.

Chapter 33 - $17.9 million

Chapter 33 provides educational assistance to service members, Veterans, and their dependents. These education benefits can be applied to undergraduate and graduate-level degree programs, vocational training, on-the-job training, and various technical, professional, and certification programs. The Long-Term Solution (LTS) and related legacy systems process education benefits claims.

System improvements under this program will impact education beneficiaries in several ways, to include; improving the timeliness and delivery of education benefits and provide increased customer satisfaction to Veterans and their beneficiaries. Additional funding for the continued development of LTS will enable Education Service to keep up with the demand for processing education claims and reduce the need for human intervention.

FY2017 Request

The Chapter 33 budget request is broken into $11.8 million in development and $6.1 million in sustainment funds. Development funding will be used to develop and automate the Chapter 33 Certificate of Eligibility in the Long-Term Solution system. Automated Certificate of Eligibility will provide faster service (possibility one-day service) as opposed to the current 19 day processing time. Sustainment funding will support existing and newly implemented applications that will provide value to the Veteran and support ongoing benefits delivery.

FY2017 Outcomes

Currently, the Chapter 33 Education Service is providing Post-9/11 GI Bill education benefits to over 1.4 million Veterans and their beneficiaries. Funding to automate the Certificate of Eligibility (COE) will significantly improve service delivery to Veterans by as much as 11 days for original claims, a 39 percent improvement in timeliness and a cost savings of over $5.8 million dollars per year. Funding for the continued development of LTS and legacy systems will also enable Education Service to keep up with the demand for processing education claims through increased automation of supplemental claims, further reducing the need for human intervention. Education Service projects to generate and mail over 4.9 million letters to claimants. With additional funding to improve our systems, Veterans would be able to view

their electronic letters online versus receiving them through mail. This effort would minimize human intervention of printing, stuffing and mailing letters and would lead to a cost savings of over $3.5 million per year.

Veteran Service Network (VETSNET) Finance and Accounting System - $14.6 million

The Veteran Service Network (VETSNET) is the redesigned, windows-based application that replaces the legacy Compensation and Pension system called Benefits Delivery Network (BDN). The Finance and Accounting System (FAS) is one of four major applications that is supported by VETSNET and provides support for the generation and audit of benefit payments.

The 2017 initiative is primarily concerned with 4 areas:

- Paying $5 million Veterans and Beneficiaries nearly $60 billion dollars annually.
- Ensuring Veteran and Beneficiary payments by complying with external requirements for the FAS application by external agencies and departments, i.e. Treasury, Debt Management Center (DMC), and others.
- Mitigating the risk of BDN support loss by transferring functionality to more contemporary systems.

Providing enhancements to backend functionality and payment functionality required by transformational projects to succeed. Includes Share services, FAS enhancements and Batch processing needed for VBMS' National Work Queue (NWQ), VRM's Intent To File (ITF), Automation projects and other initiatives as they are developed.

FY2017 Request-

The VETSNET/FAS budget request of $14.6 million is broken into $10.3 million in development and $4.3 million in sustainment funds. Sustainment funding will be used to support functionality that was previously implemented in FY2016. The development project will:

- Ensure that FAS will continue to successfully interface with all internal and external stakeholders, and therefore continue to pay our 5 million Veterans and Beneficiaries nearly 60 billion dollars annually.
- Provide the following payment functionality through FAS and retire the same from BDN, along with record conversion from the legacy system to the VBA CORPORATE database:
    - Chapter 18 – Benefits for Children of Vietnam Veterans benefit payments
    - Chapter 33- Post-9/11 G.I. Bill benefit payments
    - Burials benefit payments
    - Restored Entitlement Program for Survivors (REPS) payments
    - Provide functionality to OMB initiative to identify current year funds separately from prior year funds.
- Deliver transitional project's dependencies on CORP data services, and on back-end Oracle and Batch functionality that has not yet been built into replacement systems:
    - National Work Queue (NWQ) dependencies on COVERS, SHARE and Batch Processing
    - Intent-To-File (ITF) dependencies on SHARE and Batch Processing

- o Other dependencies that provide significant risk to the schedule and success of transitional projects as they are identified – recent examples include automating the First Notice of Death (FNOD) process, automating the processing required when we discover that a Veteran is incarcerated, and automating Month of Death and Burial Plot payments. While this is not an exhaustive list, it provides a few examples of the required work that is done by VETSNET-funded resources.

Funding will support the system's ability to react to required changes by the Department of Treasury and other external stakeholders. Many of the program's systems depend heavily on VN backend services, Share, CSS and even VN-Awards – and will continue to do so until the new systems are built out with replacement functionality. Therefore, without adequate VETSNET funding, any new development on VBMS, EVSS, CRM and other transformational projects will not work.

Other program initiatives have to do with increased risk associated with payments. As BDN support knowledge is lessened through attrition, VA loses the ability to react to increased risk of older system maintenance needs, and any new requirements realized by external agencies, changes in law, interfaces to internal and external systems, etc. With an ever-decreasing support base for BDN systems, and an ongoing incentive for BDN retirement, the impact to the Veteran is experienced in the added risks of continued dependency on these systems, and vendor support for BDN is expected to stop completely in 2016, adding significant risk to its continued operation and criticality to the migration of this functionality to CORP.

FY2017 Outcomes

VETSNET's FY2017 budget request allows all the above functionality to be realized, including:

- Uninterrupted payments to Veterans and Beneficiaries: 5 million beneficiaries receiving 60 billion dollars over the year.
- Moving Ch. 18, Ch.33 and REPS production systems on BDN, which is scheduled to lose all vendor support, to CORP/FAS to avoid potential data and payment disasters.
- Delivering requirements for VBMS and VRM initiatives – these transformational projects are critical to VBA's strategic goals and will not be possible without VETSNET's Oracle backend functionality.

FY2016 Deliverables

FY2016 deliverables include FAS, Share and COVERS enhancements necessary for VBMS and VRM projects, initial phases of BDN migration as stated above, and automation projects including Automating FNOD and Automating Incarceration adjustments.

Common Shared Services - $11.4 million

The Common Shared Services program includes support for systems such as the Centralized Administrative Transaction System (CAATS) and the Systematic Technical Accuracy Review system (STAR). CAATS is a web-based automated system that allows electronic input and approval of accounting source documents / transactions, improves internal controls, provides an electronic audit trail, standardizes accounting entries, and ensures separation of duties. It is the

central interface to the Financial Management System (FMS) for both Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA). The initiative was championed because VBA / NCA will better serve Veterans through improved efficiency of resources, and this supports VA Strategic Goal 3 – Manage and Improve VA Operations to Deliver Seamless and Integrated Support. Under the manual way of doing business, technicians took 3 days to process transactions. CAATS has streamlined these same processes and made them more efficient. By using CAATS, those same users can process transactions in one day – allowing VBA/NCA to better utilize VA resources.

The program is intended to deliver a host of technical improvements to existing mission critical tools used in the daily activities surrounding the adjudication of Veterans disability compensation claims. It is also intended to establish centralized transaction accounting systems, and upgrade STAR, the quality control database and enhance the ability to provide up-to-date information to all field claims adjudicators. In addition funding will enable the system to improve regulatory systems that will provide the cumulative effect of increased productivity and improvement in the quality and efficiency of the delivery of Veteran benefits and services.

FY2017 Request

The FY2017 budget request of $11.4 million in sustainment funding. Funds will be used to continue adding new functionality to CAATS which includes enhancements to Hines' Re-certification Accounting and Tracking System, requisition module (RATS), an invoicing system for the Contract Exams module. Other enhancements include additional modules for Vocational Rehabilitation and Employment (VR&E), the Paralympics module, and a new Processing and Enhancement Module (to allow users to submit processing and/or enhancement requests electronically to the CAATS Administrators).
Sustainment funds will be used to continue the operation and maintenance of the CAATS application.

FY2016 Deliverables

The expected deliverables for FY2015 / 2016 / 2017 include:

- Recertification Accounting & Tracking System (RATS) – Integration of the VBA Finance Center Hines' RATS application into the CAATS platform. This integrated application will ensure a more prompt and efficient return of funds back to Veterans and VA appropriations, improve employee accountability, establish audit history for actions taken within the system, and develop standard and ad-hoc user reports.
- Invoicing System for the Contract Exam Module – Will allow CAATS to invoice all exam requests submitted through CAATS. The system will enforce the National Correct Coding Initiative to ensure users utilize correct coding methodologies – which will limit improper coding resulting in inappropriate payment for Contracted Examinations. In addition, the system will prevent the user from invoicing using proprietary CPT codes.
- VRE Purchase Card Module – Will allow VR&E employees to input all purchase card orders and reconcile their charges in CAATS instead of utilizing US Bank. CAATS will be able to provide more detailed reports for management to review, and ensure that VR&E cardholders are following the proper procedures and policies.

- VRE Requisition Module – Will allow users to request VR&E contracting requirements and send them electronically to the Electronic Contract Management System (eCMS). This module will enhance reporting capabilities for VR&E management and help them determine if there is a need to award certain types of contracts on a national level.
- Veterans Benefits Management System (VBMS) Integration – This will allow CAATS to receive files of medical examinations in order to track funding and send these files to the third party contractors for processing.
- Archiving Functionality – Will take CAATS historical records and store them in a different location in the database so users will not run into duplicate transactions and so CAATS will be in compliance with VA records management policies.
- Paralympics Phase II – Will allow the Paralympics Veterans and the US Olympic Committee coaches to access CAATS to update and verify training data for payment. This will speed up the payment processing
- Processing and Enhancement Module – Will allow users to submit processing and/or enhancement requests electronically to the CAATS Administrators.
- Help Functionality – Will allow users to find helpful information needed inside the system.
- New Payment Module for New Payment Module for Dignified Burial and Other Veterans' Benefits –NCA only – Will allow for the payment of casket and/or urn for burial of Dignified Burial and Other Veterans' Benefits –NCA only
- Education (Chapter 31) Payments – Will allow vendors to input invoices directly into CAATS external website for education payments.

Compensation and Pension Record Interchange (CAPRI)/Disability Exam Assessment Program (DEAP) - $4.8 million

The Compensation and Pension Record Interchange (CAPRI) project improves service to disabled veterans by promoting efficient communication between the Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA). The CAPRI interface is currently the only Compensation & Pension (C&P) exam management system available for use for VHA/VBA C&P staff to support and track VBA exam requests and exam fulfillment by VHA clinicians.

The next generation IT solution for improved disability exam is Disability Exam and Assessment Program (DEAP). When fully developed, it will replace C&P exam management functionality in CAPRI with centralized functionality that supports disability exam processing and improves accuracy and timeliness of exams. The program will deliver a clinical disability exam and assessment workflow system that universally assists healthcare professionals in conducting quality, timely and complete medical evaluations while simultaneously tracking performance and workload ,and generating and delivering the medical evidence needed to the disability claims adjudicator and DoD, as needed. DEAP will provide a secure, integrated, centralized location evaluators and VBA end users can access and complete Disability Benefits Questionnaire (DBQ); whereby, improving the user experience of clinicians and raters by aligning DBQs with individual rating and clinical workflows; and providing computable data to facilitate a paperless claim process.

FY2017 Request

The CAPRI application without the necessary modifications to implement the necessary exam management workflow processes with DEAP will hinder the Department's goal targeted at reducing the backlog and collaborating with the DoD. The centralized and standardized automation contributes to the VA's goal of processing claims within 125 days with 98 percent accuracy. When the application is fully developed and deployed for use it will expedite the claims adjudication process by providing information needed to rate a claim. DEAP will provide the ability for an enterprise-wide system to route exams according to geography, site capability, enrollment, employment, and Veteran/Servicemember preferences. The CAPRI application will also support easy communication between VBA and VHA (essential to support National Work Queue) and ability to easily associate related requests, records and addendums.

FY2016 Deliverables

In July 2014, Veterans Relationship Management's (VRM's) Disability Exam and Assessment Program (DEAP), Enhanced Exam Management Pilot delivered a new increment that provides enhancements to exam management capabilities that benefit both evaluators and patients. With the latest increment, DEAP provides a secure, integrated, and centralized location for Compensation, Pension, and Fiduciary (CPF) evaluators and VBA end users to access and complete DBQs to obtain information for responding to requests and payments for exams. This enhancement promotes information sharing, reduces the time required to perform CPF evaluations, eliminates inadequate evaluations, empowers Veterans to actively participate in their claims, and provides computable data to facilitate a paperless claim process.

The latest version/release of DEAP is anticipated to start the pilot in October/November and expected to last from 30 to 90 days with the users as early adopters of DEAP performing manual data entry.

Compensation - $1.9 million

The Compensation program is intended to deliver a host of technical improvements to existing mission critical tools used in the daily activities surrounding the adjudication of Veterans disability compensation claims.

FY2017 Request

In FY2017, the principal focus of this program is to improve the quality of claims adjudication and to establish improvements for monitoring quality across the compensation program. Upgrading the quality control database and Systematic Technical Accuracy Review (STAR) application is critical to that aim. Enhancing these abilities provides up-to-date information to all field claims adjudicators and improving regulatory systems will provide the cumulative effect of increased productivity and improvement in the quality and efficiency of the delivery of Veteran benefits and services.

Funding for these efforts would provide streamlined services for Compensation Service employees and field employees. Compensation Service Quality Assurance staff currently use a

combination of tools to track monthly quality reviews. This project entails combining these disparate tools into one, central system, which will decrease duplication of effort and allow for more timely and accurate reporting for error

Vocational Rehabilitation and Employment – $1.8 million/Corporate Waco-Indianapolis-Newark-Roanoke – Seattle (CWINRS) - $1.2 million

The Vocational Rehabilitation and Employment (VR&E) program assists Veterans with service-connected disabilities that contribute to an employment handicap (an impairment in substantial part from a service-connected disability) to prepare for, find, and maintain suitable employment. The VR&E program provides guidance and advocacy to Veterans as they complete their training and college programs and throughout the job-placement process. For Veterans with service-connected disabilities so severe that they cannot immediately consider work, the VR&E program offers services to improve their ability to live as independently as possible in their homes and communities.

Currently, VR&E uses a system called Corporate WINRS (CWINRS) to assist Vocational Rehabilitation Counselors with the management of caseloads, program data and associated costs. Since the development of CWINRS in 1996, VR&E has made minor, incremental changes to the system as feasible with minimal additional resources provided. The VR&E program continues to serve a rapidly growing Veteran population and the needs of Veterans have significantly increased. Without this system, VR&E would not be able to carry-out its legally required mission.

The scope of VR&E QAWeb is to provide a means to enter national Systematic Technical Accuracy Review (STAR) findings and generate reports on this data. Analysis of the data from STAR reviews assists VR&E Service in determining training and policy clarification needs, and identifying areas of concern at the national and Regional Office levels. Public Law 106-117, The Veterans Millennium Health Care and Benefits Act, mandates that the Veterans Benefits Administration (VBA) establish and execute a Quality Assurance (QA) program that meets applicable governmental standards for independent and internal controls for the performance of quality reviews in compliance with the Government Performance and Results Act (GPRA). Without QAWeb, VR&E would be noncompliant with the above and would not be able to ensure quality provision to VR&E service delivery.

FY2017 Outcomes

With the FY17 Expenditure for sustainment, VR&E anticipates the following results with the Sustainment of CWINRS and QAWEB.

Business Requirements

- Maintain system operability as a secure, reliable, and accessible system for all 58 Regional Offices, Central Office leadership, and out-based contract counselors.
- Maintain quality of services delivery better analyze trends and identify areas of concern at the national and Regional Office levels.

- Address adaptive, corrective, and perfective maintenance activities as needed.
- Maintain Veterans Benefit Administration (VBA) standards.
- Maintain 508 compliance.
- Maintain NIST –National Institute of Science and Technology standards.

Business Processes Enabled

- Sustainment of VR&E's Chapter 31 case management and payment processing system
- Data sharing with Financial Accounting System for subsistence payment.
- Data retrieval from Benefits Delivery Network and Compensation & Pension.
- Payment extract from Financial Management System.

Information and Technology

Improve Veterans Experience with VA

Veterans Experience (Dollars in Thousands)											
	2015 Actuals		2015/2016 Carryover	2016 Budget Estimate		2016 Current Estimate		2017 Budget Request		2016-2017 Increase / Decrease	
	DME	OM	DME	DME	OM	DME	OM	DME	OM	DME	OM
Veteran Customer Experience (aka VRM)	$ 70,516	$ 67,786	$ 6,084	$ 67,233	$ 114,550	$ 67,233	$ 114,550	$ 67,972	$ 97,640	$ 739	$ (16,910)
Veterans Identification Card Act 2015	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,652	$ -	$ 5,652	$ -
Interactive Customer Evaluation (ICE)	$ -	$ -	$ 2,577	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotals	**$ 70,516**	**$ 67,786**	**$ 8,661**	**$ 67,233**	**$ 114,550**	**$ 67,233**	**$ 114,550**	**$ 73,624**	**$ 97,640**	$ 6,391	$ (16,910)
TOTAL DME and OM	**$**	**138,302**	**$ 8,661**	**$**	**181,783**	**$**	**181,783**	**$**	**171,264**	**$**	**(10,519)**

Total Improve the Veterans Experience with VA - $171.3 million

IT investments in this area focus on integrated service delivery and streamlined identification processes.

Veteran Customer Experience (VCE) - $165.6 million

VCE will assume responsibility for The Veteran Experience (VE) Team's Enterprise Access and Integration (EA&I) functions and supports the mission to build trusted, lifelong relationships with Veterans and their families. The goal for EA&I assuming this responsibility is to provide the collaborative processes, tools, resources and management-construct to deliver high touch technology enabled customer service capabilities throughout the VA enterprise. In order to accomplish this, EA&I will partner with the administrations to design and implement excellent care and benefit experiences that prioritize the perspectives and needs of Veterans, their families, supporters and communities. This will enable Veterans, Servicemembers and their families to access information, benefits and services anywhere, anytime.

EA&I will deliver and execute an enterprise wide scalable, commoditized, Veteran-centric, services-based technology environment that will be the foundation for how Veterans are served and how benefits and services are delivered. This new model will provide VA, with an integrated services delivery platform with the approach of placing the Veteran at the center, and will provide the best in class and industry standard customer service with clear satisfaction and delivery measures. Continuing the work that the Veterans Relationship Management (VRM) Project Management Office began as a Major Initiative (MI), EA&I will improve Veteran, beneficiary, and partner access to the VA using state of the art CRM and Self-service tools. These tools will be enabled by an enterprise platform that will provide Veterans their choice of access. EA&I will eliminate the potential for redundant and duplicative capabilities under VE's purview reducing IT development and maintenance costs. By investing in EA&I, the VA will be able to expand on the existing capabilities which include self-service tools such as eBenefits, the

Stakeholder Enterprise Portal (SEP) and Digits-to-Digits (D2D) and; tools used by VA frontline employees to provide excellent customer service which includes the CRM and Knowledge Management (KM) capabilities at service centers, contact centers, and in support of non-clinical case management. This investment will help the VA in expanding and improving access for additional stakeholders and partners.

EA&I will establish and maintain an integrated framework allowing VA Customers to reliably access and obtain authoritative and uniform data information on VA benefits and services based on work accomplished under the VRM Program. EA&I will provide a single authoritative Veteran view for use across the VA. EA&I will provide interactive and technical support to the helpdesks and those that directly support VA Customers and serve as liaisons between VA Line of Business (LOB) and VA Clients (those external to VA). EA&I will combine Business and IT staff working towards common goals and metrics to support world class Customer Service (agent assisted and self-service) common reusable platforms. With Business and IT staff supporting these common reusable platforms it will allow for greater integration across the enterprise and enable all systems to consistently provide a single view of the Veteran within VA and a single view of the VA to the Veteran.

Through a unified Veteran experience, Veterans and Customers will be able to:

- Enroll and Register with the VA in one seamless transaction.
- Effortlessly navigate VA and the entire portfolio of VA services.
- Be able to utilize a single VA website and phone number which enables Veterans and customers to meet their needs with the VA through the earliest point of resolution.
- Be confident that the VA knows who they are and simplifies the ability to update and share their information across the organization

FY2017 Request

Development funds of will be used to continue to develop enterprises services through the following projects.

<u>Customer Gateway Services (CGS)</u> project to build and share enterprise services, including those necessary for the implementation of services necessary to support MyVA and Customer Data Integration (CDI).

<u>Integrated Access Management (IAM)</u> provision of Identity and Access Services for Veteran information security and access is another integral part of CDI. Identity Services (IdS) focuses on the improvements and enhancements to management of identities and associated system records that are linked through a unique enterprise identifier will continue in FY17. This includes managing and maintaining all linkages to systems of interest for each individual. These services include:

- Master Veteran Index (MVI) which serves as an authoritative source for persons' identity traits, known as the Primary View of Master Data for VA and provides initial VA/DoD identity correlation with external partners. A MVI Hot/Warm reengineering is also planned for FY17.

- Veteran Health Identification Card (VHIC) which provides ongoing development services for Veteran's Identification Card.
- Identity Integration which ensures application integration and consumption of identity services is configured to ensure identity data remains current and accurate.

IAM Access Services (AcS) Phase 2 provides enterprise level authentication and authorization services that provide capabilities to automate the granting and removing of electronic permissions that simplify accessing VA technology systems, resources and data. Access Services focus on improvements and enhancements for ensuring that the correct individuals have access to the correct resources and includes the process of controlling and granting privileges to satisfy requests for access to resources will continue in FY17. Key capabilities for FY17 include:

- Enhancements to the following enterprise services: Single-sign On, AccessVA, Provisioning, Specialized Access Control, and Compliance Audit Reporting.
- Integration and consumption of these enterprise services by consuming applications.
- An AcS Hot/Warm reengineering is also planned for FY17.

Customer Relationship Management (CRM): enablement of the Health Enrollment Center (HEC) to answer inquiries on Health eligibility and enrollment, and income verification to ensure those enrolled in in category 5 and up meet the income thresholds for those Health benefits.

Veteran Identification Cards (VIC) - $5.7 million

Public Law 114-31, the Veterans' Identification Card Act of 2015 (the Act) was enacted on July 20, 2015. The identification card will enable Veterans to demonstrate their status as a Veteran and eliminate the need to carry discharge papers (i.e. DD214) with them so they can access goods services and promotional activities offered by private and public institutions to Veterans.

The Act requires VA to charge a fee to each Veteran who receives an identification card issued under the Act, including a replacement identification card. The Act also provides for VA to set the fee at a rate that equals an amount necessary to carry out the Act, including costs related to any additional equipment or personnel required to carry out this Act. Fees are to be deposited in an account, subject to the same conditions and limitations otherwise in such an account.

The VA identification card shall not serve as proof of any benefits the Veteran is entitled to under title 38, and the Veteran shall not be entitled to any benefits by reason of possessing a VA ID Card.

2017 Outcomes

It is expected that in FY2017 the VA Identification Card program will be implemented. Per the Act, funds collected will be used to fund the operations of the program including FTE however it is expected that startup costs will be funded from existing operating funds.

FY2016 Deliverables

A draft regulation to implement this program and allow collection of the required fees is in VA concurrence. OMB must clear the regulation and the proposed collection of information in a new application. Estimated implementation is in 2017.

Information and Technology

Improve the Employee Experience

Employee Experience (Dollars in Thousands)											
	2015 Actuals		2015/2016 Carryover	2016 Budget Estimate		2016 Current Estimate		2017 Budget Request		2016-2017 Increase / Decrease	
	DME	OM	DME	DME	OM	DME	OM	DME	OM	DME	OM
Human Capital Corporate Core (includesTMS)	$ 972	$ 17,361	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,428	$ -	$ 10,428
General Counsel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,620	$ -	$ 1,620
Construction, Financial & Integrated IT Management Systems	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,000	$ -	$ 1,000
eDiscovery Platform (General Council)	$ 2,522	$ -	$ 570	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotals	**$ 3,494**	**$ 17,361**	**$ 570**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 13,048**	**$ -**	**$ 13,048**
TOTAL DME and OM	$ 20,855		$ 570	$ -		$ -		$ 13,048		$ 13,048	

Total Improve the Employee Experience - $13.0 million

Talent Management System (TMS) – $10.4 million

The VA Talent Management System (TMS) satisfies the federal government mandate for agencies to maintain a single system of record for employee training. It is the VA's system of record for learning and employee development. The TMS has been in operation, in various iterations, since 2007. It serves the training delivery needs of VA's 360,000 veteran and non-veteran employee population. The TMS is also accessible to an additional 200,000 veteran and non-veteran VA volunteers, contractors, medical interns and DoD employees. TMS has offered, delivered and tracked learning, performance, competency management, accreditation, and career development activities for nearly ten years, providing the ability for VA staff to better serve our nation's veterans.

FY2017 Request

- TMS supports VA's enterprise-wide education, leadership development, learning, and training efforts.
- TMS delivers, and tracks compliance with mandatory training in support of many programs including the Continuous Readiness in Information Security Program (CRISP), assisting in closing the VA's material weakness related to Federal Information Security Management Act (FISMA) compliance.

FY2017 Outcomes

- Continued capability as the single system of record for employee training.
- Enable VA transformation through strategic human capital development and sustain a culture of performance excellence.

General Counsel - $1.6 million

This Symantec Clearwell system supports the OGC by enhancing their searching capabilities to effectively preserve, collect, process, review, analyze, and produce Electronically Stored Information (ESI) in compliance with its legal obligations under Freedom of Information Act (FOIA) and the Federal Rules of Civil Procedure (FRCP). This program benefits the Veteran by providing a secure solution that allows the OGC to securely identify, collect, preserve, process, review, analyze, and produce the responsive documents. The current capability allows multiple VA Staff Attorneys to process a larger and increasing litigation caseload in support of the VA and its Veterans.

This program benefits the Veteran by enhancing the existing eDiscovery solution to better identify, collect, preserve, process, review, analyze, and produce the responsive documents. The Symantec Clearwell System needs to be enhanced in order to keep up with the increasing case load and to support additional VA attorneys and other legal staff who will be granted access. The enhancement better enables the Department of Veterans Affairs (VA) to meet the Congressional Freedom of Information Act (FOIA) mandate that "all federal agencies, upon a request from any member of the public, search its files and disclose all non-exempt segregable records to that member". The statute explicitly addresses ESI when it mentioned "automated information systems" and required agencies to "search for records in electronic form or format." Both the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule require the release of information about an individual pursuant to a request for access from that person. Freedom of Information Act (FOIA), Privacy Act, and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules for the request for information for and from Veterans and Veterans Service Organizations are extensive. The Clearwell system provides a secure place for the Electronically Stored Information (ESI) to be analyzed while also preserving the entity or veteran's personal information.

FY2017 Request

- Mandatory Sustainment of the Symantec Clearwell software maintenance and hosting services is required to provide continued Operation & Maintenance support for the Symantec Clearwell software, as well as telephonic support for the eDiscovery Symantec Clearwell Administrators and Attorneys.
- Mandatory Sustainment funds will fund the Symantec Clearwell (SCW) Software Maintenance contract options, which ensures the SCW software will be available to VA attorneys and other staff to perform their duties to effectively preserve, collect, process, review, analyze and produce Electronically Stored Information (ESI) in compliance with VA's legal obligations.

FY2017 Outcomes

- FY2017 Mandatory Sustainment funds are required to provide for the continued support and maintenance of the eDiscovery for OGC tool.
- The FY2017 budget request will allow the Office of General Counsel (OGC) to fulfill its Litigations Obligations under the under the Federal Rules of Civil Procedure (FRCP). The FRCP states explicitly that a party must provide a copy of all documents, including electronically stored information (ESI), that the disclosing party has in its possession, custody, or control and may use to support its claims or defenses

(Rules 16, 26(a) and 34). Failure to meet obligations exposes the Department of Veterans Affairs to an array of judicial sanctions (Rule 37). In addition to sanctions and inability to manage, ESI leads to unnecessary settlement.

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Information Security

Information Security*					
(Dollars in Thousands)					
	2015	2016		2017	2016-2017
	Actuals	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Cybersecurity Strategy Implementation	$ -	$ -	$ -	$ 125,000	$ 125,000
Security Program (CRISP) Support	$ 70,879	$ 30,160	$ 30,160	$ 64,000	$ 33,840
Cyber Security Program	$ 53,516	$ 53,061	$ 53,061	$ 52,575	$ (486)
Network Operations Center (NOC)	$ 38,020	$ 45,630	$ 45,630	$ 75,907	$ 30,277
Security Operations Center (SOC)	$ 27,063	$ 24,000	$ 24,000	$ 30,525	$ 6,525
Privacy & Records Management	$ 6,804	$ 10,340	$ 10,340	$ 10,600	$ 260
Business Continuity Support	$ 6,373	$ 6,850	$ 6,850	$ 6,900	$ 50
Field Security Services	$ 7,047	$ 5,180	$ 5,180	$ 4,560	$ (620)
Information /Data Security	$ -	$ 3,900	$ 3,900	$ -	$ (3,900)
ICAM development	$ -	$ 800	$ 800	$ -	$ (800)
Identity, Credential and Access Management (ICAM)	$ -	$ 380	$ 380	$ -	$ (380)
Total	**$ 209,702**	**$ 180,301**	**$ 180,301**	**$ 370,067**	**$ 189,766**

*Information Security funding is categorized as mandatory sustainment with the exception of ICAM development in 2016.

Total Information Security - $370.1 million

Cybersecurity Strategy Implementation - $125.0 million

In FY2017 the Office of Information Security (OIS) will support the VA Enterprise Cybersecurity Strategy and Implementation Plan (VA-ECSIP), which defines the comprehensive set of actions, processes, and emerging security technologies that will further enhance the cybersecurity of VA's information and assets and improve the resilience of VA networks. The VA-ECSIP is aligned with the Federal government-wide cybersecurity strategy efforts and was developed to identify and address critical cybersecurity gaps and emerging priorities, with specific recommendations to address those gaps and priorities. VA will resolve any remaining issues that have resulted in VA's material weakness condition in cybersecurity.

The VA-ECSIP emphasizes the need for a defense in depth approach that relies on the layering of people, processes, technologies, and operations, to achieve more secure VA information systems. VA's high value assets and information technology systems have been identified and inventoried, and must be protected with a variety of policies, processes, and tools, consistent with applicable OMB guidance and National Institute of Standards and Technology (NIST) standards. VA will implement effective protection activities to include reducing the attack surface and complexity of VA's IT infrastructure; minimizing use of administrative privileges; using strong authentication; safeguarding data at rest and in-transit; training personnel; ensuring repeatable processes and procedures; adopting innovative and modern technology; ensuring strict domain separation of critical/sensitive information and information systems; and ensuring a current inventory of hardware and software components.

Strong cybersecurity and privacy controls are critical to improving Veterans experience and will enable the VA to securely provide seamless, integrated, and responsive services for Veterans. Strengthening secure access by veterans to VA healthcare is a cornerstone of the MyVA Initiative, and will optimize VA's unique competencies in health care, benefits delivery, & memorial affairs, while enhancing secure information sharing with external partner to support service delivery. Implementation of the VA-ECSIP will enable VA to better respond to and recover from the ongoing sophisticated attacks against government systems and will ultimately strengthen the VA's overall security posture.

The VA-ECSIP includes actions to improve capabilities for identifying and detecting vulnerabilities and threats, enhance protections of VA assets and sensitive information, and further develop rapid response and recovery capabilities while ensuring readiness and resilience when incidents inevitably occur. Efforts to resolve VA's material weakness have resulted in identification of ongoing actions that must be completed to fully implement an enterprise-wide cybersecurity program that is fully compliant with the requirements of the Federal Information Security Management Act (FISMA). Sustainment funds are necessary to enable the VA to achieve the performance measure targets specified in the Cross-Agency Priority Goals.

VA will continue to implement robust security protections and controls for all high value assets and systems. VA will work with the Department of Homeland Security (DHS) to accelerate the deployment of EINSTEIN capabilities to enhance the detection of cyber vulnerabilities and protection from cyber threats and to provide for enhanced network perimeter protection. VA will also accelerate the implementation of capabilities and tools to include, but not limited to DHS's Continuous Diagnostics and Mitigation (CDM) program. This will enable VA to better understand the risks to VA IT systems and networks through improved identification and detection of cyber threats. Through CDM Phase 1, VA will implement sensors and tools that will provide a more accurate picture of the inventory of hardware and software assets under management, and the ongoing security posture of each of those assets. Leveraging the CDM solution set, VA will also implement a network access control (NAC) solution to enable VA to more effectively maintain security configuration control over the VA network and to prevent the installation of unauthorized software. VA will also implement the security dashboard solution that is available through the CDM effort. Additional sustainment funds will enable VA to implement CDM Phase 2 capabilities that will help ensure all employees and contractors are using appropriately secure methods to access VA systems.

VA will improve the access management and identity management of user accounts on VA information systems to drastically reduce vulnerabilities and successful intrusions. Ongoing actions and processes to enable the VA to monitor and limit the number of privileged user accounts will continue to be an area that will require priority attention.

VA will continue to implement strong user identity authentication, and support VA major applications to be enabled to make use of the Homeland Security Presidential Directive 12 (HSPD-12) Personal Identity Verification (PIV) card in order to access the VA network and systems. Improving the access management of user accounts on VA information systems includes implementing stronger authentication mechanisms to verify the identity of users, advancing capabilities to manage and enforce access privileges and monitoring to ensure access is properly executed. Privileged user accounts will be protected by continued implementation of two-factor Personal Identity Verification (PIV) credentials, as directed

HSPD-12 and Federal Information Processing Standard (FIPS) 201-2, which are cost-effective and immediate action that VA will take to drastically reduce risk profiles. VA will continue efforts to attain and sustain performance measure targets for the use of strong authentication for privileged and unprivileged users.

VA will continue actions to sustain compliance with Trusted Internet Connections (TIC) requirements, and will refresh TIC infrastructure components, tools, and technologies. This will ensure that VA can continue to support ensuring all possible traffic, including mobile and cloud, goes through the VA TIC. VA will also implement solutions identified by DHS to allow external vendors and medical organizations such as research hospitals that store, process, and transmit agency data for or on behalf of the VA, to have their traffic securely encapsulated within the VA TIC connectivity.

VA will also implement enhanced cybersecurity incident management and response capabilities and processes, to include implementation of OMB's Incident Response Playbook to ensure future incidents are mitigated in a consistent and timely manner, and to allow for timely recovery from cyber incidents. Incident management and responses processes will be enhanced to include formalizing the role of an on-scene coordinator, assigning incident response work streams, and establishing entry and exit criteria for the response phase. VA will comply with new requirements to notify US-CERT, Congress, and victims of a cyber-incident, and VA will improve agency plans and procedures to ensure that relevant authorities are documented and understood, and will enhance inter-agency communication and coordination procedures to ensure incidents are mitigated appropriately and in a timely manner. The VA will implement an enterprise-wide centralized security auditing log solution that will enable VA to effectively coordinate response actions to VA security incidents. This will include the full implementation of security information and event management solutions (SIEM) across the VA enterprise.

VA will strengthen processes for vulnerability management to support the rapid patching of any critical system vulnerabilities, while also implementing enhanced scanning for cyber threat indicators. Sustainment funds will enable the VA to patch all critical vulnerabilities immediately or at a minimum within 30 days of patch release. VA will enhance vulnerability scanning efforts to ensure all assets are scanned for critical vulnerabilities and for emerging indicators of compromise within 24 hours of receipt of the indicators from DHS. VA will implement network segmentation and strengthen the design and security of VA's next generation network to limit lateral movement across networks while also securely supporting the high bandwidth requirements associated with supporting patient care and telemedicine.

VA will significantly improve the security of medical devices on VA networks. VA has over 60,000 medical devices that directly support patient care and other critical functions and services at VA medical centers. These medical devices are connected to the VA network and are subject to FDA certification which introduces challenges when security patches and other security upgrades must be implemented to protect the security posture of the devices. VA has partnered with the private sector and is working to define and implement actions to strengthen the security posture of medical devices to include activities such as network segmentation and the implementation of medical device isolation architectures. Like all other asset connected to the VA network, medical devices and special purpose devices will need to safely scanned and continuously monitored for security, with appropriate actions taken to mitigate and remediate any security vulnerabilities detected on the medical devices and systems.

VA will implement federal-wide information sharing processes on critical vulnerabilities/threats, indicators of compromise and best practices. This information helps VA understand emerging risks and develop effective protective measures to block threats before incidents occur. Information sharing is essential not only for detecting and blocking intrusions on a specific targeted organization, but for understanding the broader landscape of cyber risk. VA will strengthen collaboration with DHS to identify when adversaries appear to be targeting VA and share such information proactively. VA will implement actions to more fully develop the insider threat program at VA.

VA will implement or augment shared services in offerings such as Mobile Security, Network Segmentation Services, Digital Rights Management, Encryption Services, and Public Key Infrastructure (PKI) technologies.

VA will also implement OPM and OMB initiatives to improve VA cybersecurity workforce recruitment, hiring, and training and ensure a future pipeline for talent is put in place. Sustainment funds will enable VA to the Senior Agency Official for Privacy to ensure that VA's high value assets are covered by the Privacy Act Systems of Records Notice and Privacy Impact Assessments that are current and accurately addresses risks to personally identifiable information and implements the steps necessary to mitigate those risks.

FY2016 Deliverables

In FY2016 VA will:

- Achieve compliance with the requirements of the Trusted Internet Connections (TIC) initiative to include achieving the performance measure targets specified for consolidating all network traffic behind a TIC.
- Implement CDM Phase 1 with an emphasis on achieving full accountability for all IT assets connected to the VA network.
- Implement two factor authentication for all remote access requirements and will also enable all privileged users to use the PIV card in the performance of system administration functions.

Network Operations Center (NOC) - $75.9 million

The Network Operations Center (NOC) is responsible for reliable and secure transport of voice/video/data to/from the Internet Edge to the Enterprise Regional demarcation points for the Department of Veterans Affairs. The NOC provides services for a globally distributed network gateway architecture that provides services to more than 330,000 employees and more than 1,400 outpatient clinics, supporting more than 21 million veterans. The Gateway architecture interconnects the VA's computing infrastructure to the outside world, including to the Internet, other Government agencies (i.e. Department of Defense), and business partners (i.e. VBA – Payment to Portal etc.). These interconnections are integral to the VA's business of providing services to Veterans.

VA's Trusted Internet Connection (TIC) architecture enables secure and reliable computer network connectivity between the VA and the Internet, other Government agencies, and business partners. The protection of Veterans' data is of paramount importance. The capabilities of this program directly support current and projected future Department of Homeland Security (DHS) Trusted Internet Connection (TIC) requirements, as outlined in the

DHS TIC Reference Architecture Document, Version 2.0, and Appendix B.

VA is increasingly relying on information technology to reach and provide services the more than 21 million veterans in this country. Those services include but are not limited to: Patient care, benefits, and internment. VA's TIC architecture enables secure and reliable computer network connectivity between the VA and the Internet, other Government agencies, and business partners. The protection of Veterans' data is of paramount importance. Ensuring the TIC provides this level of security is of the utmost importance.

The NOC also implements and performs operations and maintenance on all devices that make up the TIC security Stack. This ensures all data bound for the internet does not contain PII or PHI and that all inbound data is safe and secure as it traverses VA circuits. Per VA 6500 Handbook, information systems must be deployed in a manner that protects data confidentiality, integrity, and availability. The TIC must be able to scale to support up to 100 Gbps (gigabits per second) of mixed IP (Internet protocol) traffic throughput to meet projected operational needs. FIPS 200, Minimum Security Requirements for Federal Information and Information Systems, section 3, requires the following: Organizations must implement plans for backup operations in case of an emergency; Organizations must monitor, control, and protect organizational communications at the external boundaries of the information system; Organizations must employ architectural designs that promote effective information security within organizational information systems

FY2017 Request

In 2017, the program is requesting $75.9 million in funding to continue upgrading and expanding the network to meet the ever increasing demand for more and faster data and connectivity. Enhance and build a dynamic, survivable, and strong VA network infrastructure to counter the constantly expanding number of cyber threats. Maintain and continue providing high quality Information Technology & Cyber services and support to the VA's missions as highlighted in the FY2016 deliverables.

FY2016 Deliverables

Interconnect the VA's data infrastructure to other federal agencies, business partners, and commercial service providers. Provide a robust and resilient united network to survive the current and future cyber threats. Maintain high availability and redundant internet connectivity between VA locations. Operate and maintain the core gateways and a secure network parameter. Detect and prevent veterans' medical and privacy data from being released to the public or unauthorized access. Deliver critical connectivity and communications capabilities during emergency situations.

Security Program (CRISP) Support - $64.0 million

The Continuous Readiness in Information Security Program (CRISP) is designed to reduce information security risks across VA programs and systems. The Office of Inspector General (OIG) has highlighted a number of weaknesses in the VA's Information Security Program, and the OIG has noted that the Program has not yet been fully implemented in accordance with requirements specified in the Federal Information Security Management Act (FISMA). Program funding is needed to specifically address the full implementation of FISMA

requirements in systems located at all VA facilities. Funding will primarily be applied to a support contract that will bring the additional staff and resources needed to continue to resolve security vulnerabilities and weaknesses. This will support the VA's efforts to accelerate compliance with Federal security and privacy regulations.
Strong cybersecurity and privacy controls are critical to improving Veterans experience and will enable the VA to securely provide seamless, integrated, and responsive services for Veterans. Strengthening secure access by veterans to VA healthcare is a cornerstone of the MyVA Initiative, and will optimize VA's unique competencies in health care, benefits delivery, & memorial affairs, while enhancing secure information sharing with external partner to support service delivery. The CRISP efforts will enable VA to better respond to and recover from the ongoing sophisticated attacks against government systems and will ultimately strengthen the VA's overall security posture, while ensuring that the material weakness issues are resolved.

FY2017 Request

Funding for CRISP support will provide contractor staffing and security solution implementation at all major VA facilities such as the medical centers and regional offices. The staffing is critical to VA being able to maintain the security of veteran information and other sensitive information that is processed and stored in VA computers and networks. The expert CRISP support contractors will perform a large set of day-to-day on-site security operations processes such as installing critical security patches to resolve weaknesses in VA software and applications, assisting with security audit log analysis, conducting security incident forensics investigations, updating security plans and other security documents such as information system contingency plans and disaster recovery plans, and performing security controls implementation, monitoring, and testing.

It is critical that the CRISP support efforts be funded in order to ensure that Veteran data remains secure in VA systems, and also to ensure that the material weakness issues identified in past audits by the OIG are fully resolved. The daily workload will be performed by a staff of over 300 contractors with performance measure goals that included resolving over 90 percent of all critical and high-security vulnerabilities identified each month by vulnerability scans conducted by the Department of Homeland Security and the VA's Network and Security Operations Center (NSOC). Other performance measure improvement targets include the updating 95 percent of contingency plans, disaster recovery plans, and other security documentation as required by FISMA.

FY2017 Outcomes

The CRISP Support funding will enable the VA to bring expert technical support to all major VA facilities that will enable the systems to be properly patched to address any identified security weaknesses, and to ensure that all security operations processes are completed to continuously maintain the security of Veterans data and VA systems. The daily security operations process workload will be performed by a staff of over 300 contractors with performance measure goals that included resolving over 90 percent of all critical and high-security vulnerabilities identified each month by vulnerability scans conducted by the Department of Homeland Security and the VA's Network and Security Operations Center (NSOC). Other performance measure improvement targets include the updating 95 percent of contingency plans, disaster recovery plans, and other security documentation as required by

FISMA.

FY2016 Deliverables

FY2016 funds will deliver and maintain an effective vulnerability and patch management program that will ensure that at least 90 percent of any identified vulnerabilities in VA systems are patched and remediated in a timely manner. Other deliverables in FY 2016 include updated and accurate security documentation for over 95 percent of VA systems, to include documents such as information system contingency plan and disaster recovery plans.

Cyber Security Program - $52.6 million

The Office of Cyber Security Policy and Compliance (OCSPC) in the Office of Cyber Security (OCS) is responsible for advancing the overall cyber security posture of VA through enhanced visibility in VA IT systems and networks, and with leading edge guidance, support and tools. From this perspective, OCSCP is instrumental in reviewing and assessing the Department's and its mission partners' successful implementation of that policy to ensure the VA information systems, practices, policies, processes and procedures comply with federal mandates. To support this objective, OCSPC develops and continually evaluates Department-level information security policies to ensure consistency with Federal mandates, supports full-spectrum Accreditation and Authorization (A&A) related activities, manages the Enterprise Visibility and Vulnerability Management (EVVM) function that continually assesses the VA's environment consistent with Federal Continuous Monitoring requirements, performs software assurance related activities and is the primary entity responsible for coordinating FISMA and other external requirements -related to the Department's information security related control status. OCSCP also provides reporting to, and serves as a liaison with oversight bodies, such as the GAO, OMB, and Congress regarding the Department's security posture.

FY2017 Request

The 2017 request of $52.6 million in mandatory sustainment will support the operations and maintenance of the Cyber Security Program. Implementation of cyber security will continue past efforts designed to evolve the VA cyber posture, while improving service delivery, collaboration and risk awareness across VA information systems. In addition, the 2016 request will assist the Department continue to improve the security and resiliency of the underlying VA infrastructure facilitating enhanced visibility, access and functionality across the spectrum of VA services for the Veteran.

FY2017 Outcomes

- Develop and implement policy and program activities that provide Cyber Security services and products to support the VA's requirements;
- Maintain existing policy mandated roles and functions, such as A&A, inclusive of tools, workflows and support.
- Enhance existing Continuous Monitoring capabilities using existing tools and the procurement of additional tools;
- Expand "visibility to everything" efforts to enforce security;

- Implement Big Data and Predictive Analytics capabilities to enhance the distillation of security related data to support enhanced awareness of security related events and support real-time decision-making.
- Share information and collaborate more closely with federal partners to build a more comprehensive understanding of advanced cyber threats.

2016 Deliverables

In 2016, OIS will:

- Maintain information security related directives and handbooks so that VA is compliant with all applicable Federal requirements and standards;
- Develop security assessments that identify IT related deficiencies, then recommend and monitor the successful implementation of any corrective actions or compensating controls to enhance the security posture of the Department;
- Develop security related corrective actions list, strategic, operational and tactical guidance and plans;
- Enhance VA's Continuous Monitoring (CM) capability by expanding functionality, accessibility as well as pursing enhancements to meet the policy mandates associated with CM;
- Assist in the remediation of malware and threats;
- Ensure internal and external (e.g. IG, DHS, OMB, GAO) reporting requirements are maintained;
- Develop a Risk Management capability designed to enforce rigor and discipline within the VA's information security program, thereby providing a disciplined and structured process that integrates information security and risk management activities into the system development life cycle;
- Advance the resiliency of the VA's software by reviewing and assessing the underlying code for vulnerabilities and then recommending resolution options.

Security Operations Center (SOC) - $30.5 million

The Security Operations Center (SOC) provides continuous around-the-clock monitoring of VA's network – protecting, responding to, and reporting threats. SOC personnel deter, detect, and defeat potential threats that may adversely affect VA networks and systems. The capabilities of this program directly support current and projected future Department of Homeland Security (DHS) Trusted Internet Connection (TIC) requirements, as outlined in the DHS TIC Reference Architecture Document, Version 2.0, and Appendix B. The VA's Network and Security Operations Center has been assigned as the TIC Access Provider for the VA and must maintain a defense in depth architecture that meets the challenges of an ever evolving threat landscape. Each year, additional requirements are levied on SOCs to meet federal mandates in regards to Continuous Monitoring, reporting and compliance.

The SOC supports VA employees, Veterans and their beneficiaries. Proper monitoring of the VA network and its assets ensures that sensitive VA data is safe from malicious viruses/worms and other cyber threats. SOC activities support VA's security workforce, as well as general VA employees, whose day-to-day activities may be severely impacted by cyber threats, security breaches, and compromise of the VA network. Continuous

monitoring ensures VA can continue mission-essential functions needed to provide critical services to Veterans and their beneficiaries, as well as safeguard sensitive VA information, in the event of a cyber-attack.

The SOC serves as VA's security operations element. The SOC manages, protects, and monitors the cyber security posture of VA, coordinates externally with government incident response centers, performs threat and vulnerability analyses, reports cyber security deficiencies, develops concept of operations (CONOPS) documents and guidelines relating to cyber security incidents, performs analyses of cyber security events, maintains detailed logs and databases of VA cyber security incidents and responses, and generally performs the full range of functions across the spectrum of activities relating to incident management and response, vulnerability scanning, event correlation and analysis, audit log analysis, and remediation planning. The spectrum of activities typically encompasses detection, pre-emption, prevention, reaction, response, and recovery.

FY2017 Request

In 2017, the program is requesting $30.5 million in funding to continue upgrading and expanding the network security monitoring, detection, and scanning to meet constantly expanding number of cyber threats.

FY17 Outcomes

Mitigate and deter cyber incidents through upgrading and enhancing a layered defense in depth architecture. Maintain and continue providing high quality Information Technology & Cyber services and support to the VA's missions as highlighted in the FY2016 deliverables.

FY2016 Deliverables

Continuously monitor internal and external threats to the VA's infrastructure and computer systems. Detect and respond to network and computing threats in an ever changing cyberspace. Mitigate high risk incidents and vulnerabilities on the VA's electronic systems. Protect VA's data and hardware by using industry and federal security standards and best practices. Detect and prevent Veterans' medical and privacy data from being released to the public or unauthorized access. Provide a robust and resilient unified network to survive the current and future cyber threats.

Privacy and Records Management - $10.6 million

The objective of the Office of Privacy and Records Management (OPRM) is to ensure provisions are in place to protect all personally identifiable information, protected health information and sensitive personal information (SPI) of the Veteran and the employee. Privacy Impact Assessments and data validation processes are used to ensure Veteran data is protected and used in accordance with applicable laws and statutes. Current and proposed systems to accurately process and track Freedom of Information Act (FOIA) requests, legally release names and addresses, enhance role based training, and provide Veteran services within the law and as allowed by policy. OPRM provides tools required to successfully track and investigate privacy/security incidents, to include HIPAA and HITECH, across the VA. The compliance requirements are set forth by various statutes

and regulations to include the Privacy Act, Health Information Portability and Accountability Act (HIPAA), Federal Information Security Modernization Act (FISMA), Freedom of Information Act (FOIA), Clinger Cohen Act, OMB Circular A130, and various OMB mandates for Records Management activities to include Electronic Recordkeeping capabilities by close of calendar year 2019.

FY2017 Request

In FY2017, the primary objective of the program is to ensure all Veteran and employee information is adequately identified and protected against fraudulent release or breach. This includes scheduling and retention of official government records. The budget request will allow OPRM to implement new and enhanced procedures and processes that identify and protect all Veteran and employee information from any entity without the appropriate "need to know". This includes protection for information at rest as well as in motion. It also includes enhanced processes and improvements to the mandated Privacy Impact Assessment (PIA) process to ensure they are completed in a timely and efficient manner. OPRM will also identify and ensure Privacy Act Systems of Records are updated accordingly and posted to the Federal Register. OPRM also chairs the Data Integrity Board and provides oversight with the various VA Computer Matching programs that share PII across the federal government under the auspices of the Computer Security Act.

Business Continuity Support (COOP) - $6.9 million

Business Continuity (BC) provides liaison between the VA Office of Operations, Security, and Preparedness (OSP) and the Office of Information and Technology (OIT) on matters concerning Continuity of Operations and operational situational awareness. BC is responsible for developing and implementing managing emergency management/continuity programs that help ensure resiliency of critical IT tasks that support the Department of Veterans Affairs' ability to perform its Mission Essential Functions (MEFs) and Primary Mission Essential Function (PMEF). BC maintains the OIT Continuity of Operations Plan in accordance with Departmental Federal Continuity guidance and policies, and is responsible for ensuring that OIT Emergency Relocation Group (ERG) members, Reconstitution Emergency Relocation Group (RERG) members, and Devolution Emergency Response Group (DERG) are properly trained to assume their positions on designated teams.

Members of the BC OIT Liaison Watch Officer team provide coordination across VA's administrations and staff offices within the Integrated Operations Center, providing situational awareness to OIT leadership and support OIT emergency management activities. BC also develops tests and exercises, aimed at testing evaluating OITs ability to respond to events and continue operations. BC provides the specific procedures and operational requirements for implementing Information System contingency planning in accordance with VA Directive and Handbook 6500, Information Security Program, ensuring Department-wide compliance with the Federal Information Security Management Act of 2002 (FISMA), 44 U.S.C. §§ 3541-3549. Plans are created by system owners using the ISCPA tool application a National Institute of Standards and Technology (NIST) Compliant template, which creates contingency and disaster recovery plans used in the event of emergencies, and stores these plans in servers owned by Business Continuity and maintained by Enterprise Operations' Governance, Risk and Compliance

(GRC) tool. These servers also house other critical IT systems information for OIT Leadership.

The OIT Enterprise is the backbone of the Departments ability to provide continual, quality service to its customers. Highly trained team members provide leadership with timely, accurate information that enables VA leaders to make decisions affecting systems and applications in a seamless manner, minimizing adverse impact to customers during an event or crisis.

Business Continuity Support (COOP) provides OIT a higher state of readiness by providing trained staff members ready to respond during crisis events. Whether it is an ERG, RERG, or DERG member responding to an activation of the departments Continuity of Operations plan, or an OIT Liaison Watch Officer providing critical situational awareness information to OIT leadership, OIT stands ready to act on its responsibilities to ensure that primary mission and mission essential functions continue and we provide uninterrupted services to customers. Information Systems contingency and disaster recovery plans stored on BC servers in GRC insure ensure critical OIT systems are quickly restored in the event of an emergency or disaster.

FY2017 Request

Mandatory sustainment funds of $6.9 million will be used to fund support of the efforts listed below. These areas are critical in maintaining the department's ability to support its Primary Mission Essential Functions.

FY2017 Outcomes

- Provide continuous review of system Contingency Plans (CP), Disaster Recovery Plans (DRP) and Incident Response Plans (IRP) on an annual basis to ensure compliance with VA Policy 6500.8 and NIST SP 800-34.
- Provide annual review and update of OIT Continuity Plan.
- Developing information correlation and display for an OIT Common Operating Picture (COP) automation and Geographic Information System (GIS).
- Provide continuous support of OIT participation in National Level Exercises and support to VA exercise efforts with emphasis on external communications between other federal, state, and local agencies responsible for Cyber security. Continued development of OIT exercises to test the coordination of incident response efforts across VA OIT.

FY2016 Deliverables

- Compliance of system CP, DRP and IRP plans.
- Conduct annual review of OIT Continuity Plan.
- Manage and support OIT participation in National Level Exercises.

Field Security Services – $4.6 million

Field Security Service (FSS) is a virtual organization that includes the Information Security Officers (ISOs) that support our VA Medical Centers, Regional Offices, Data Centers, Field Program Offices, and VA Central Offices including (VACO), Veterans Health Administration (VHA), and Veterans Benefits Administration (VBA). FSS is the

“face” of information security at VA. Information Security Officers (ISOs) are the on-site experts in security plans, policies and controls, and play a critical role in VA s Continuous Readiness in Information Security Program (CRISP).

VA’s Medical Device Protection Program (MDPP) is a collaborative, VA-wide initiative managed and developed by the Health Information Security Division (HISD) that fosters collaboration between VHA Healthcare Technology Management Office and the Office of Information and Technology (OIT) with the primary goal of providing a safe and secure operating environment for the more than 50,000 networked medical devices that provide direct care to our nation’s Veterans. MDPP is a comprehensive program with two major areas, Communications and Risk Management, which encompass all phases of the medical device life cycle from procurement to disposal.

Field Security Services provides the following benefits to our Veterans:

- Ensures the confidentiality, integrity, and availability of Veteran and beneficiary sensitive information, networks, and systems
- Strengthens Veteran and public confidence in the quality of VA services
- Decreases risks to healthcare operations and benefits processing by prevention and remediation of security breaches
- Reduces the likelihood of legal action against employees and VA as a result of a security breach

The consistent presence and availability of Information Security Officers throughout the VA decreases the risk of information security breaches. Through the MDPP, VA is working to secure medical devices and the enterprise network in order to maintain data confidentiality, integrity, and availability and to prevent clinical service malfunction or the loss of device functionality that may negatively impact patient safety.

FSS has a major role in participating in many national committees, projects, and initiatives. FSS managers provide leadership in committees such as the National Change control Board (NCCB), Security Improvement Program (SIP), Field Operations Council, VHA Business Relationship Management (BRM), and VHA/OIS Joint Security Call, etc. FSS staff provides ISO support and guidance to system owners, information owners, programs, projects, etc.

FSS also:

- Expands capabilities to improve Continuous Monitoring capabilities across the Department
- Expands “visibility to everything” and “Security Situational Awareness” efforts to enforce security.
- Manages the Information Security Programs and servers as the Principle Security Advisor for VA Medical Centers, Clinics, VBA Regional Offices, Field Program Offices, NCA and VHA/VBA Central Offices.

In support of MyVA, ISO resources will be distributed according to OIT guidance and new District boundaries.

FY2017 Request

The FY2017 sustainment request of $4.6 million will allow the program to increase field awareness of critical security information in numerous technical communications to the geographically dispersed Information Security Officers. Outcome will be to increase field awareness of critical security information.

FSS will also; enhance the OIT Security Calendar to improve the compliance of FISMA/FISCAM related activities. The objectives of the OIT Security Calendar are to:

- Create a centralized location to view and manage annual security-related activities and events,
- Provide OIT leadership visibility into upcoming security events, with corresponding business drivers, required training, and communications,
- Aide in maintaining VA's compliance with FISMA/FISCAM, VA Directive and Handbook 6500, and other security governance,
- Prevent overlapping activities between multiple groups within OIT, and (e) sustain effort to remediate and address issues identified in the 2015 OIG audit.

VA's Assessment and Authorization (A&A) process is transitioning from a fully manual process to enable the automation of many steps of the A&A process. The Office of Cyber Security (OCS), Field Security Service (FSS), and Service Delivery and Engineering (SDE) are working together to move the A&A and Authority to Operate (ATO) processes to the Agiliance RiskVision Open GRC ™(RiskVision), the new Governance, Risk Management and Compliance (GRC) tool. RiskVision will automate many steps of the A&A process.

Other efforts in 2017 include providing, support to the Enterprise Cyber Security Team (ESCT) for the Medical Cyber domain to secure medical devices, telemedicine and special purpose systems, continuing to provide and improve communications to all of VA regarding information security practices, policies, procedures and how to locate an ISO and implement an enterprise wide security situational dashboard.

FY2016 Deliverables

- Provide numerous communications to the field on critical security initiatives.
- Fully implement two factor authentications for all system administrators.
- Implement the 2016 OIT Security Calendar with compliance measure to reduce FISMA/FISCAM findings and increase compliance with VA policies.
- Create and implement the initial security awareness dashboard
- Provide outstanding Information Security Officer support to our VA medical Centers, Regional Offices, Field Program Offices, VA Central Office, Data Centers and other Program Offices.
- Provide support to the Enterprise Cyber Security Team (ESCT) for the Medical Cyber domain to secure medical devices, telemedicine and special purpose systems.
- Implement specialized standard operating procedures and training for Information Security Officer Staff and other specialized groups.

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Information and Technology

Maintain the IT Infrastructure

Maintain the IT Infrastructure[1]

(Dollars in Thousands)

	2015 Actuals	2015/2016 Carryover	2016 Budget Estimate	2016 Current Estimate	2017 Budget Request	2016-2017 Increase / Decrease
Mandatory Sustainment	**$ 1,741,749**	**$ -**	**$ 1,629,731**	**$ 1,629,731**	**$ 1,450,677**	**$ (179,054)**
Software License Maintenance	$ 437,138	$ -	$ 132,500	$ 132,500	$ 373,696	$ 241,196
Telecommunication	$ 259,884	$ -	$ 297,161	$ 297,161	$ 297,161	$ -
Enterprise Operations[2]	$ 308,236	$ -	$ 369,900	$ 369,900	$ 198,022	$ (171,878)
IT Support Contracts	$ 285,842	$ -	$ 376,170	$ 376,170	$ 195,000	$ (181,170)
Hardware Maintenance	$ 98,204	$ -	$ 100,000	$ 100,000	$ 100,000	$ -
Acquisition Fees	$ 104,961	$ -	$ 80,000	$ 80,000	$ 88,678	$ 8,678
National Service Desk	$ 52,744	$ -	$ 59,000	$ 59,000	$ 67,118	$ 8,118
Activations	$ 49,439	$ -	$ 90,000	$ 90,000	$ 47,700	$ (42,300)
Mobile Technology and Applications	$ 20,366	$ -	$ 25,000	$ 25,000	$ 25,000	$ -
Remediation of Section 508 Compliance	$ 10,970	$ -	$ -	$ -	$ 20,000	$ 20,000
Enterprise Voice System (EVS) Program	$ 11,812	$ -	$ 20,000	$ 20,000	$ 20,000	$ -
Enterprise Architecture Program Execution Support	$ -	$ -	$ -	$ -	$ 7,538	$ 7,538
Product Development Tools	$ 25,195	$ -	$ 5,000	$ 5,000	$ 5,000	$ -
ASD PPM Health Portfolio	$ -	$ -	$ -	$ -	$ 4,434	$ 4,434
EA Tools Suite- Licenses and Hosting	$ -	$ -	$ -	$ -	$ 1,330	$ 1,330
CRISP - Removal of Material Weakness[3]	$ -	$ -	$ 39,000	$ 39,000	$ -	$ (39,000)
RTLS Hosting	$ -	$ -	$ 12,000	$ 12,000	$ -	$ (12,000)
Guardian Edge and Anti Virus Maintenance	$ -	$ -	$ 22,000	$ 22,000	$ -	$ (22,000)
Server Virtualization	$ -	$ -	$ -	$ -	$ -	$ -
Enterprise Architecture (EA Tools and Support)	$ -		$ -	$ -	$ -	$ -
Divesture of Systems/Application	$ -	$ -	$ 2,000	$ 2,000	$ -	$ (2,000)
Major Transformation Inititaves (MTI)	$ 76,958	$ -	$ -	$ -	$ -	$ -
Regular Infrastructure Upgrades	**$ 29,806**	**$ -**	**$ 180,000**	**$ 180,000**	**$ 102,822**	**$ (77,178)**
Enterprise Voice System (EVS) Program	$ 6,789	$ -	$ 60,000	$ 60,000	$ 58,366	$ (1,634)
Data Access, Archiving and Disposition	$ -	$ -	$ -	$ -	$ 25,000	$ 25,000
National Tapeless Backup Solution (CRISP)	$ -	$ -	$ -	$ -	$ 19,456	$ 19,456
Enterprise IT Lifecycle Management (Desktops/Laptops)	$ 1,104	$ -	$ 50,000	$ 50,000	$ -	$ (50,000)
Network Lifecycle HW Refresh (Servers/Routers/Storage)	$ 21,913	$ -	$ 50,000	$ 50,000	$ -	$ (50,000)
Section 508 Compliance - Legacy Sys/Apps	$ -	$ -	$ 15,000	$ 15,000	$ -	$ (15,000)
RTLS Hosting Expansion	$ -	$ -	$ 5,000	$ 5,000	$ -	$ (5,000)
Critical Infrastructure	**$ -**	**$ -**	**$ -**	**$ -**	**$ 102,178**	**$ 102,178**
Sustaining Infrastructure Program	$ -	$ -	$ -	$ -	$ 102,178	$ 102,178
Infrastructure Development	**$ 2,278**	**$ 22**	**$ 18,000**	**$ 18,000**	**$ 25,000**	**$ 7,000**
Data Access, Archiving and Disposition	**$ -**	**$ -**	**$ -**	**$ -**	$ 25,000	$ 25,000
Divesture of Systems/Application	$ -	$ -	$ 18,000	$ 18,000	$ -	**$ (18,000)**
Safety & Security Initiative (PIV for HSPD-12)	$ 2,278	$ 22	$ -	$ -	$ -	**$ -**
Total to Maintain the IT Infrastructure	**$ 1,773,834**	**$ 23**	**$ 1,827,732**	**$ 1,827,732**	**$ 1,680,677**	**$ 53,898**

[1] The table above only reflects IT Infrastructure Operations and Maintenance (O&M), the full O&M table is in the Budget Appendix; [2] Financial Management System Modernization is categorized as Enterprise Operations, but shown in Other Development Efforts; [3] CRISP is part of the Information Security Funding in 2017 .

Total Maintain the IT Infrastructure - $1.681 billion

The table above represents the Operations and Maintenance (sustainment) funding necessary to maintain the IT Infrastructure. Total Operations and Maintenance can be found in the IT Budget Appendix.

The IT Infrastructure provides the backbone necessary to meet the day-to-day operational needs of VA Medical Centers, Veteran facing systems, benefits delivery systems, memorial services, and all other IT systems supporting the Departments' mission. To ensure the IT infrastructure platform is fully capable of providing for VA's data storage, transmission, and communications requirements. 2016 funding is critical to sustain essential IT requirements which have grown steadily since 2010 and are expected to continue growing into and beyond 2016.

A robust, healthy IT infrastructure is necessary to ensure delivery of reliable, available, and responsive IT services to all VA staff offices and administration customers as well as Veteran clients. A viable and reliable infrastructure supports VA's 21st century transformation as well as underlying missions and strategic plans, and service level requirements for all customers.

The infrastructure investment considers the health and capacity of the IT enterprise to be a shared resource that has far reaching, complex, and interconnected consequences across the organization. It also mitigates a risk of increased frequency and severity of system outages and major incidents that may potentially result in serious harm to Veterans (patient safety) or data loss. Without consistent annual investment in lifecycle replacement, platform modernization, and infrastructure expansion, VA runs the risk of increasingly unreliable systems and services. The cost of replacing IT equipment that is "beyond useful lifecycle" is considerable. Annual investments are required as part of a constant lifecycle replacement program, otherwise the accumulated cost of replacing obsolete equipment expands as a sizable "IT Debt" to be paid in the future or face increasing risk of degradation. Key business drivers include: (1) growth in number of users; (2) new facility activations; (3) new systems and platforms released into production; (4) increases in mobile computing and communications; (5) increase in the number and complexity of IT tools; and(6) increased security complexity and requirements.

The 2017 IT Infrastructure budget request will support the following:

- Hardware/Software refresh: Replacement of the oldest hardware that has fallen beyond its useful lifespan.
- Server/Storage Virtualization: Rehost legacy systems on modern platforms.
- Application Virtualization and Standardization: Transition to virtualized server farms and shared storage arrays to control costs and improve speed of applications.
- Desktop Support: PC refresh vehicle, Microsoft Enterprise Licensing Agreement.
- Hardware Maintenance: Regional pool/procurement of hardware commodity maintenance contracts.
- Software Licensing: Extend number of national license agreements and Enterprise Licensing Agreements. Centralize software license procurement to regional pools.
- IT Support Contracts: Regional Service Lines bring needed skill sets in line to replace contracts.
- Infrastructure Upgrades: Platform upgrades of major systems.
- Technical Solutions to implement the Agency Priority Goals: Provides resources to improve access to Veteran services, eliminate the claims backlog and support the

development of registries to track homeless Veterans

Mandatory Sustainment

Software License Maintenance - $373.7 million

Software License Maintenance is comprised of recurring payments for existing software and existing numbers of licenses in support of the Enterprise, VA Administrations and Staff Offices. Software License Maintenance is considered a "must pay" requirement to support customer service level agreements. Software License Maintenance covers the VA's Enterprise License Agreements and hundreds of applications in use within the VA. Costs are driven by the number of users and number of new applications and systems supporting these users.

Software License Maintenance supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal customers must have the ability to use their devices and applications with a standard set of performance expectations.

FY2017 Request

The VA is requesting $373.7 million for Software License Maintenance in FY2017. This is an increase over FY2016; however, it is balanced by a reduction in other program areas, specifically IT Support Contracts. Funds in 2017 will provide recurring payments for existing software license maintenance across the VA, at every point of service delivery: Hospitals and Clinics, Vet Centers, Regional Benefits Offices, Regional Loan Centers, Cemetery and VA staff offices. Funds will support software licenses in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

FY2017 Outcomes

Software License Maintenance will provide support for software licenses in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

FY2016 Deliverables

Software License Maintenance will provide support for software licenses in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

Telecommunications - $297.2 million

Telecommunications is comprised of recurring payments for voice, data, wireless and video services in support of the Enterprise, VA Administrations and Staff Offices. Telecommunications is considered a "must pay" requirement to support customer service level agreements. Telecommunication provides means for voice communications between VA and Veterans, healthcare partners, business partners, employees, local government

entities; telephone answering systems; paging system interfaces in large facilities for locating medical staff and others (paging systems are separately funded but are dependent on the voice infrastructure); and direct management of emergency "Code" calls for medical life safety and security. The Telecommunications program allows Veterans to access services, particularly Veterans in remote areas, and supports telehealth initiatives. Telecommunications provides for remote access in support of the VA telework staff.

Telecommunications support MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal and external customers expect skilled and prompt service in a variety of areas.

FY2017 Request

The VA is requesting $297.2 million for Telecommunications in FY2017. This is an increase over FY2016. The need for bandwidth is forever increasing to keep up new users, applications, technologies and modes of care. The OneVA IT infrastructure backbone network traffic has been doubling every 18 months. The OneVA Wide Area Network (WAN) IT infrastructure backbone is provided and supported under the current GSA Networx contract. In addition to the organic growth, planning has begun for transitioning to the follow-on GSA contract: Networx Services 2020 (NS2020) Enterprise Infrastructure Solution (EIS). Should the VA award to a new vendor, approximately 60-90 days of parallel operations with existing and new circuits will be required during the transition phase. The additional cost to cover this transition period is currently estimated at $18.9-$20 million based on the current usage.

Funds in 2017 will provide recurring payments for existing Telecommunications across the VA, at every point of service delivery: Hospitals and Clinics, Vet Centers, Regional Benefits Offices, Regional Loan Centers, Cemetery and VA staff offices. Funds will support software licenses in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

FY2017 Outcomes

Telecommunications will provide support for voice, data, wireless and video services in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

Enterprise Operations - $198.0 million

Enterprise Operations (EO) supports the MyVA world-class service to Veterans and their families by delivering results-oriented, secure, highly available, and cost effective information technology services.

EO manages the VA's national datacenters and operates 24 hours a day and 365 days a year, which provides standard enterprise platforms, networks, storage and facilities. EO provides the VA required enterprise services that meet the Service Level requirements of VA based on the system classification and availably requirements as defined by the business customer: Mission Critical (99.9 percent), Essential Support (99.5 percent) and Routine Support (99 percent).

EO offers the following services based on the business customers requirements: Fully Managed Environments; Hosting Services, Infrastructure Services; Platform Services; Professional Services; Security Services; Backup/Archive; Disaster Recovery; Disk Storage; Monitoring Services; Network Services; Engineering; Database Administration; Middleware and Web Server Management; and Web Hosting.

FY2017 Request

The VA is requesting $198.0 million for Enterprise Operations in FY2017. Funds in 2017 will administer approximately 350 complex IT applications that support medical care, financial payments, benefits delivery, record-keeping, research programs, and legacy systems for 31 different organizations within the Enterprise, VA Administrations and Staff Offices. Funding will provide for the management over 4,000 servers for the VA and delivery of secure, highly-available, and cost-effective IT services to medical, benefits, and memorial initiatives in support of the VA Administrations. The funding requirement is based on the actual number of professional service hours provided as required by the business customer. As mentioned in the Executive Overview, the 2017 request reflects the transfer of 599 FTE from Enterprise Operations Franchise Fund to the IT pay account. This does not change OIT's overall 2017 budget request.

FY2017 Outcomes

Enterprise Operations will administer approximately 315 complex IT applications that support medical care, financial payments, benefits delivery, record-keeping, research programs, and legacy systems for 31 different organizations within the Enterprise, VA Administrations and Staff Offices.

IT Support Contracts - $195.0 million

IT Support Contracts is comprised of recurring payments for existing contracts for services and support for implemented IT systems in support of the Enterprise, VA Administrations and Staff Offices. IT Support Contracts is considered a "must pay" requirement to support customer service level agreements. IT Support Contracts cover a variety of services including Enterprise Testing Services, Corporate Data Warehouse and support of Interagency Agreements. Costs are driven by new applications, systems and services being put in production each year.

IT Support Contracts supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal and external customers expect skilled and prompt service in a variety of areas.

FY2017 Request

The VA is requesting $195.0 million for IT Support Contracts in FY2017. This is a decrease over FY2016 as a result of reclassification of some services to other program areas, specifically Software License Maintenance. Funds in 2017 will provide recurring payments for existing IT Support Contracts across the VA, at every point of service delivery: Hospitals and Clinics, Vet Centers, Regional Benefits Offices, Regional Loan Centers, Cemetery and VA staff offices. Funds will support software licenses in use by 340,000 VHA employees,

volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

FY2017 Outcomes

IT Support Contracts will provide support for services and support for implemented IT systems in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

Hardware Maintenance - $100.0 million

Hardware Maintenance is comprised of recurring payments for extended warranty and support for critical operational hardware components in support of the Enterprise, VA Administrations and Staff Offices. Hardware Maintenance is considered a "must pay" requirement to support customer service level agreements. Hardware Maintenance also provides for emergent requirements to replace broken equipment to facilitate the timely restoral of IT operational systems.

Hardware Maintenance supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal and external customers expect skilled and prompt service in a variety of areas.

FY2017 Request

The VA is requesting $100.0 million for Hardware Maintenance in FY2017. Funds in 2017 will provide recurring payments for existing hardware maintenance across the VA, at every point of service delivery: Hospitals and Clinics, Vet Centers, Regional Benefits Offices, Regional Loan Centers, Cemetery and VA staff offices. Funds will support hardware in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

FY2017 Outcomes

Hardware Maintenance will provide support for hardware in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

Acquisition Fees - $88.7 million

The 2017 request will pay for acquisition fees, which are required for services rendered by acquisition organizations as they provide warranted contracting officers, related staff, and related functions to execute and administer contracts received by OIT. Fees from internal and external acquisition organizations vary up to approximately 5 percent of contract value. Acquisition organizations include VA's Technology Acquisition Center (TAC), General Services Administration (GSA) and Navy's Space and Naval Warfare Systems Command (SPAWAR).

National Service Desk - $67.1 million

The VA National Service Desk (NSD) serves as the single point of contact for all VA IT support requests with a focus on Tier 1 First Contact Resolution for improved VA customer satisfaction, and provides coordination of IT incident management to assure service

disruptions are expediently resolved for improved availability. The NSD operates a 24 hours a day and 365 days a year centralized help desk, accessible by use of telephone for emergent requirements and the intranet for routine requirements. NSD manages the Automated Notification Reporting (ANR) system which provides real-time reporting on all planned and emergent system outages and maintenance events, service disruptions and affected resources across the VA.

The NSD supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal and external customers must have the ability to use their devices and applications.

FY2017 Request

The VA is requesting $67.1 million for National Service Desk in FY2017. Funds in 2017 will support the NSD operations used across the VA, at every point of service delivery: Hospitals and Clinics, Vet Centers, Regional Benefits Offices, Regional Loan Centers, Cemetery and VA staff offices. Funds will support IT services in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

FY2017 Outcomes

National Service Desk will provide help desk services in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

Activations - $47.7 million

The IT Activations program funds the purchase, installation, and issuance of IT equipment for all VA Administrations. Activations funds are utilized by VA primarily to provision new IT equipment required to stand up new VA Medical Centers (VAMCs), Veterans Benefits offices, National Cemeteries, and other facilities.

This program also funds any IT expenses occurring from the renovation of any existing VA facility, and procures IT equipment required for new employees being added due to the growth in the VA's mission.

FY2017 Request

The VA is requesting $47.7 million in Activations Funding for FY2017. Because of the increased demands for care and services, the VA is continuing to expand the services and capabilities as new facilities are acquired, updated and activated.

IT Activations plays a major role in the expansion of services and capabilities and the funding of this program is a critical component in the delivery of quality healthcare and benefits that improve the Veterans access to all of VA's services.

This funding request will provide for the acquisition of the required IT equipment that will support the following:

- 14 major facility construction, lease, and renovation projects which are identified to be operational in FY2017 in order to meet the expansion of access to service for Veterans. These projects are projected to add more than 3.2M square feet to the overall VA footprint.
- 153 planned Minor construction projects representing over 6M square feet of new space and 3.5M square feet of renovated space.
- Planned on-boarding of new personnel who are required to support the continuing increase in the demand for Veteran access to services and care.

Funding for the IT Activations Program will procure and install supporting IT infrastructure for planned construction projects scheduled to begin in FY2017 which consequently secures the opening of medical facilities with a corresponding improvement in Veteran access to care and services.

FY2016 Deliverables

In FY2016, the IT Activations Program intends to deliver the following:

- Continue working with the Orlando and New Orleans VAMC leadership to ensure that the IT equipment is provisioned in order to open their respected facilities on schedule.
- Prepare the required IT infrastructure to activate the following:
    - 1 new CBOCs
    - 4 CBOCs Expansions
    - 5 Renovations (Bay Pines VAMC, Biloxi VAMC, Long Beach VAMC, Manhattan VAMC, San Juan VAMC)
    - 3 Major Additions (Seattle VAMC and Palo Alto VAMC)
    - 1 Replacement Hospital Expansion (Louisville VAMC)
- Enable the 193 Minor construction projects representing over 5.6M new square feet and 1.5M renovated square feet are able to complete on schedule.

Mobile Technology and Applications - $25.0 million

The Mobile Technology and Applications Program is comprised of recurring payments for existing Mobile Device software and existing numbers of licenses in support of the Enterprise, VA Administrations and Staff Offices. The Mobile Technology and Applications Program is considered a “must pay” requirement to support customer service level agreements. Mobile Technology and Applications covers the VA’s Enterprise level contracts for Mobile Device Management, Mobile Email Clients, Mobile Security and Mobile License Management.
Mobile Technology and Applications supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA’s operational IT systems. OIT’s internal customers must have the ability to use their devices and applications within a secure environment.

FY2017 request

The VA is requesting $25.0 million for Mobile Technology and Applications in FY2017. Funds in 2017 will provide recurring payments for existing Mobile Technology and Applications solutions used across the VA, at every point of service delivery: Hospitals and Clinics, Vet Centers, Regional Benefits Offices, Regional Loan Centers, Cemetery and VA staff offices. Funds will support security software licenses in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

FY2017 Outcomes

Mobile Technology and Applications will provide support for mobile technology and applications in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers.

Remediation of Section 508 Compliance - $20.0 million

VA 508 compliance staff is responsible for ensuring that VA is in compliance with Section 508 of the Rehabilitation Act (29 U.S.C. '794 d). 508 Program Office provides accessibility guidance and support for all projects under the Secretary's Initiatives including: Hyper Text Markup Language (HTML) Web, SharePoint environments, and provide support, training, and tools to help developers achieve 508 compliance in application development.

Specifically:

- Empower Veterans to Improve their Well-Being
- Enhance and Develop Trusted Partnerships
- Manage and Improve VA Operations to Deliver Seamless and Integrated Support for Disabled Employees and Disabled Veterans

FY2017 Request

VA 508 compliance staff are responsible for ensuring that VA is in compliance with Section 508 of the Rehabilitation Act (29 U.S.C. '794 d). The FY2017 budget request of $20 million in sustainment funding will allow the program to deploy efforts that will increase access to electronic and information technology (EIT) for VA stakeholders and disabled Veterans. EIT accessibility increase employability of the disabled population and helps to integrate them into an effective workforce. 508 compliance office provides VA-wide policy to ensure that VA employees and members of the general public with disabilities have access to and use of VA's EIT comparable to that provided to non-disabled persons. This is in compliance with Section 508 of the Rehabilitation Act of 1973 (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 (Public Law 105-220).

VA has a legal mandate for meeting the Section 508 Requirements for all EIT procured, used, maintained or developed by VA. If this program does not receive funding, the Department may be in violation of 508 requirements and will be at risk of Congressional scrutiny.

FY2016 Deliverables

The Office of information Technology requires services and tools to provide governance, tools and technical support to insure VA meets Section 508 compliance requirements. Contracts under this effort provide maintenance and support of Adaptive Technology (AT) and technical resources to: plan and execute 508 compliance audits; produce training on how to use AT; produce training on how to develop 508 compliant solutions; and provide other subject matter experts (SME) for technical analyses and planning.

Business Processes Enabled
- 508 Conformance Testing
- 508 Outreach and Training
- Web analysis review and remediation

Enterprise Voice System (EVS) - $20.0 million

The Telephony Emergency Replacements Program provides for the critical replacement of existing Private Branch Exchange (PBX) telephone systems at VA medical centers (VAMC) and Community-Based Outpatient Clinics (CBOCs). The Telephony Emergency Replacements (PBX) Program improves reliability of telephony and reduces risk associated with medical facilities' telecommunications switches that are at end of life, no longer supported by the manufacturer, and are in some state of disrepair. These systems require sustainment while the VA progresses toward the enterprise unified communication strategy (Enterprise Voice System (EVS)).

PBXs provide the means for voice communications between VA and veterans, healthcare partners, business partners, employees, local government entities; provides telephone answering systems; provides paging system interface in large facilities for locating medical staff and others (paging systems are separately funded but are dependent on the voice infrastructure); direct management of emergency "Code" calls for medical life safety and security.

Telephony Emergency Replacements (PBX) supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal customers must have the ability to use their devices and applications within a secure environment.

FY2017 Request

The VA is requesting $20.0 million for the Telephony Emergency Replacements (PBX) program in FY2017. Funds in 2017 will provide for the replacement or upgrade of PBXs as determined by the Telephony Critical Sustainment prioritization model.

FY2017 Outcomes

Private Branch Exchange (PBX) Replacement projects are planned to be completed at over 100 VA facilities beyond those addressed in FY 2016.

Enterprise Architecture Program Execution Support – $7.5 million/Product Development Tools - $5.0 million

This program provides support for the Product Development Open Source, Configuration Management and Tools Management Division (OSCTM) and the Product Development Product Assessment Competency Division (PACD).

FY2017 Request

This budget request of $12.5 million includes funding for following sustainment projects:

- VISTA Open Source and FOIA Management Services to oversee processes to enable VA to comply with FOIA regulations for release of VA software and to coordinate with the open source community on collaborative product development efforts and introduction of a larger body of open source software into VA's electronic health record system
- Software Configuration Management Services to obtain adequate configuration and change management resources to place all software released by Product Development under secure, trusted and traceable software engineering disciplines for configuration and change management.
- One-VA Technical Reference Model Services to provide a solutions infrastructure for, and architectural analysis of recommended content, for approved components of the VA required enterprise architecture to implement Federal Enterprise Architecture requirements.
- Development Tools Licensing, Infrastructure and Support Services to provide enterprise software licensing, centralized platform, and technical support services to several thousand VA users of a comprehensive suite of standardized agile project management and software engineering tools that place all Product Development software enhancement and sustainment projects under architecture and design, business rules management, requirements management, change and configuration management, database management and test execution management and quality assurance under standardized and traceable processes using centralized project data repositories and tools.
- Section 508 American Disability Act Accessibility Compliance Services to administer the legislatively mandated accessibility assurance and compliance processes for all VA software, electronic media, and commercially-procured software, and to provide software and electronic media analysis remediation services where necessary to improve a non-compliant implementation.

FY2017 Outcomes

- VISTA Open Source and FOIA Management Services – Allows successful completion of all additional workload burden to anticipated increase in volume of software to be released to FOIA/Open Source based on increasing numbers of new software programs for VA.
- Software Configuration Management Services – Allows successful completion of anticipated additional new FY2017 project activations requiring additional identical resource allocations.
- One-VA Technical Reference Model Services – Allows timely and successful completion of increase in required architectural analyses due to annual refresh requirements

necessary to keep the steady volume of content, currently over 3000 entries and growing by 10 percent on a monthly basis, to be kept current in out-years.

- Development Tools Licensing, Infrastructure and Support Services - The increase in Platform cost for FY2017 is attributed to replacement of select hardware due to age and expected non-compliance or compatibility to security and configuration requirements in FY2017. The increase in Support Services is due to the gradual increase in the numbers of end users supported by use of these products in VA and the number of projects implemented over time.
- Section 508 American Disability Act Accessibility Compliance Services – The proposed increase is due to inadequacy in the VA Section 508 program to accomplish timely project assessments for all veteran-facing and customer-driven priorities over the last few years as the number of released software projects have increased and the number of veteran-facing or employee-facing electronic forms, and other electronic media distributions have increased and accelerated in schedule demands.

FY2016 Deliverables

- VISTA Open Source and FOIA Management Services – Satisfaction of mandated FOIA releases; establishment of open source development policies, protocols, standards and procedures; and coordination of joint development activities with the open source community.
- Software Configuration Management Services – Software configuration, change and build management engineering processes for projects resourced by this program.
- One-VA Technical Reference Model Services – Completion of refreshes of architectural analyses and application platform support of 1,700 approved or constrained products and the creation of an average of 200 additional new analyses on a monthly basis.
- Development Tools Licensing, Infrastructure and Support Services – Licensing maintenance, hardware sustainment, and technical/application support and configuration services for over 50 project control and software engineering tools implemented for 4,000 users, 300 active projects enhancing or sustaining 200 products in the VA product portfolio with data in 300 databases.
- Section 508 American Disability Act Accessibility Compliance Services – Accessibility testing services for several thousand custom-built VA software products, 3000 acquired commercial and open source products, and a comprehensive list of Internet and Intranet web sites and electronic forms that are subject to 508 accessibility compliance reviews.

Regular Infrastructure Upgrades

Enterprise Voice System (EVS) Program)- $58.4 million

The Enterprise Voice System (EVS) Program, (formerly Voice as a Service - VaaS), defines the approach by which VA will transition telephony services from the current decentralized, non-standard environment to a modern, standards-based and centrally managed Unified Communications (UC) infrastructure based upon technologies that provide a greater degree of flexibility and opportunities to reduce operating costs. A UC environment merges voice, video, data, messaging, etc. into a single integrated user interface. EVS, as the backbone for UC, will allow VA to further leverage common services through the convergence of facility voice, contact center, video, audio conferencing and collaboration environments into a single platform and operational model.

A focal point of the EVS migration will be delivery of a unified and centrally managed voice services capability, addressing the issues with aging, legacy private branch exchange (PBX) systems at VA's facilities and current gaps in the contact center functionality used in direct telephonic interaction with our Veterans. The continued demand placed on the infrastructure with the growth of key programs such as Telehealth increases the burden on the existing architecture. EVS supports the Office of Information and Technology (OI&T) strategies such as datacenter consolidation, eliminating infrastructure duplication, and maximizing virtualization.
The EVS Program supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal and external customers expect skilled and prompt service in a variety of areas.

FY2017 Request

The VA is requesting $58.4 million for the EVS Program in FY2017. Funds in 2017 will provide recurring payments for the existing EVS proof of concept sites (Ft. Harrison, MT; Charleston, SC; and Tennessee Valley Health Care System, TN, including all of their dependent satellite facilities) and the Enterprise Voice System (EVS) Phase 1 project sites planned to be deployed in FY2016.

FY2017 Outcomes

The Enterprise Voice System (EVS) Phase 1 project will focus on preparing a multi-year acquisition to implement a roadmap for transitioning facilities to EVS. The project is planned to utilize a Virtualization Infrastructure to build out geographically aligned distribution layer cores to support the MyVA structure and begin transitioning multiple sites to the EVS design. This effort will also require site readiness assessments and procurement of hardware needed to augment local site infrastructure in support of EVS.

Data Access, Archiving and Disposition Program - $50.0 million

The Data Access, Archiving and Disposition program is within OIT and it develops the strategy, guidance, and implementation for VA's "to-be" environment in support of strategic information management, data mining, and data warehousing. In addition, this program will assess the quality of data and ensure consistency across platforms, products, and geographical areas. By ensuring consistency, reliability, and availability of data, OIT will have a dramatically improved posture in safeguarding and administrating the information and records of our nation's Veterans and enterprise data. The Data Access, Archiving and Disposition Program enables OIT to provide a high caliber of service that supports the MyVA vision by ensuring that VA's administrations have the tools to store, access, and present data in an efficient manner.

FY2017 Request

The 2017 request consists of $25 million in discretionary sustainment and $25 million in marginal sustainment funds. VA's current posture in data management is fragmented with various administrations and program offices that have full autonomy over how data is

collected, stored, accessed, and disposed. This presents problems in the Freedom of Information Act (FOIA), records management lifecycle, and e-discovery process since archiving methods and policies vary significantly between organizations. The program will use funding to provide the organization with the initial infrastructure and systems that are centralized and overseen by a single domain under OIT that is accountable for ensuring that Veteran and enterprise information is readily available.

FY2017 Outcomes

By adopting emerging trends concerning volume ("big data"), velocity, and complexity, the Data Access, Archiving and Disposition Program will provide VA with a highly effective posture that is able to proactively meet future data management needs of the enterprise. The Data Access, Archiving and Disposition Program will provide a comprehensive, unified approach to developing strategies across the enterprise and implementing the hardware, software, and management infrastructure.

In FY2017 the Data Access, Archiving and Disposition Program will begin to provide the technical resources needed to store, access, and present Veteran and enterprise data by fulling IT Infrastructure Vision; Enterprise Design Patterns; Technical Reference Model (TRM); Implementation Support; and Government, Enforcement, Assessment, and Compliance (GEAC) capabilities. By working with other IT groups to coordinate current and future plans and activities, the Data Access, Archiving and Disposition Program will facilitate a unified effort to coordinate technical assistance, project development, software upgrades, and new product installation.

Critical Infrastructure Upgrade

Sustaining Infrastructure Program - $102.2 million

The Sustaining Infrastructure Program (SIP) (formerly IT Lifecycle Management and Lifecycle Hardware Refresh) guides the on-going refresh and replacement of the IT Infrastructure that sustains VA IT operations. SIP identifies the current state of the IT Infrastructure and provides analysis for the lifecycle replacement strategy for the refresh of IT Infrastructure assets based on equipment age, expiration of warranty, support limitations, lifecycle estimates, technology roadmap, financial planning and policy changes.

Factors driving IT Infrastructure replacement decisions include: reduced risk of catastrophic failure of IT asset; new software applications will not run on existing operating systems; security requirements cannot be enforced; unsupported technology; the cost of supporting old equipment eclipses the cost of an outright new purchase; availability of parts; end of vendor support; new business services in the organization place unexpected demands on older equipment; policy changes; security requirements; technology changes (Move to VM servers or cloud computing); and improved customer satisfaction.

SIP supports MyVA service to Veterans and their families as almost every VA service to, or interaction with, our Veteran clients is supported by VA's operational IT systems. OIT's internal and external customers expect skilled and prompt service in a variety of areas.

FY2017 Request

The VA is requesting $102.2 million for the Sustaining Infrastructure Program in FY2017. The current estimated backlog of IT infrastructure based upon industry standards is over $677.0 million. Funds in 2017 will provide for the replacement of VA most critical assets across the VA, at every point of service delivery: Hospitals and Clinics, Vet Centers, Regional Benefits Offices, Regional Loan Centers, Cemetery and VA staff offices.

FY2017 Outcomes

SIP will provide for critical lifecycle replacement of IT assets in use by 340,000 VHA employees, volunteers and contract staff, 450,000 workstations, 54,000 mobile devices, and approximately 22,000 servers based on available funding.

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Information and Technology

Staffing and Administration Subaccount

Payroll & Administrative Support Highlights
(dollars in thousands)

	2015 Actuals	2016 Budget Estimate	2016 Current Estimate	2017 Budget Request	2016-2017 Increase / Decrease
Total Full Time Equivalents (FTE)	**7,309**	**7,615**	**7,631**	**8,334**	**703**
Direct	7,214	7,325	7,325	7,365	40
Direct (PL 113-146 Veterans Choice Act)	17	192	192	192	
Reimbursement 1/	78	98	114	178	64
Enterprise Operations				599	599
Obligations:					
Personal Services & Benefits	879,598	925,152	964,766	1,057,077	92,311
Travel	7,273	8,998	9,361	10,307	946
Comm., Utilities & Rent	17,994	18,880	18,593	19,003	410
Printing & Reproduction	18	22	26	56	30
Other Services 2/	133,341	207,677	190,798	199,176	8,377
Supplies & Materials	574	812	1,080	2,080	1,000
Equipment	1,102	2,652	4,394	6,894	2,500
Lands & Structures					
Other	1,547		1,200	1,200	
Subtotal	**$1,041,446**	**$1,164,192**	**$1,190,217**	**$1,295,792**	**$105,575**
Funding Sources:					
Appropriation 3/	1,039,000	1,115,757	1,115,757	**1,272,548**	156,791
Rescission	-1,066				
Transfers 4/	-3,952	-4,060	-4,060	-4,060	
Denver Hospital Transfers	0		-1,436		1,436
Pay Reimbursements	10,093	26,495	22,885	27,304	4,419
Available Balance SOY (+)	15,156		19,422		-19,422
Available Balance SOY (+) Veterans Choice Act	13,000		11,649		-11,649
Available Balance EOY (-)	-19,422				
Available Balance EOY (-) - Veterans Choice	-11,649				
Adjustments	-160				
(Expiring) Lapse	-906				
Veterans Choice Act 801	1,351	26,000	26,000		-26,000
Total Obligations	**$1,041,446**	**$1,164,192**	**$1,190,217**	**$1,295,792**	**$105,575**

1/ Added 79 for Enterprise Operations (EO) Reimbursable FTE; Added 599 regular FTE from EO.
2/ Other Services include administrative contracts such as for workforce development, architecture, engineering standards, shared cost from other organizations, etc.
3/The Appropriation line includes the Enterprise Operations Pay amount of 151.914M transferred from the IT Non-Pay.
4/ Reflects transfers from OIT to the North Chicago Facility in pay funding.

Most of the staffing and administration budget is devoted to salaries and benefits. The remaining funding is for travel, training, administrative support contracts, leases

(including those supporting data centers), as well as office equipment and supplies. Also included in this budget is funding for the mass transit benefits program and worker's compensation related to OIT employees.

OIT is the steward of VA's IT assets and resources, and is responsible for ensuring the efficient and effective operation of VA's IT Management System to meet mission requirements of the Secretary, Under Secretaries, Assistant Secretaries, and other key officials. With the requested funding, OIT will continue to provide strategy and technical direction, guidance, and policy to ensure that IT resources are acquired and managed for the VA in a manner that adheres to various federal laws and regulations.

OIT is composed of eight major organizational components; the table below displays FTE for each component:

	2015 Actuals	2016 Budget Estimate	2016 Current Estimate	2017 Budget Request	2016-2017 Increase / Decrease
Service Delivery and Engineering	5,400	5,583	5,583	6,262	679
Enterprise Program Management Office	957	997	1,021	1,005	-16
Information Security	533	564	564	564	0
Quality, Performance and Oversight	213	216	237	277	40
IT Resource Management	77	115	83	83	0
Architecture Strategy Design	98	96	99	99	0
Interagency Program Office	8	10	10	10	0
Customer Advocacy	24	34	34	34	0
Total FTE	**7,309**	**7,615**	**7,631**	**8,334**	**703**

T able includes reimbursable FTE.

FY2017 Staffing Request

The 2017 staffing and administration budget request reflects funding for the following Office of Information Technology staff offices.

Service Delivery and Engineering (SDE)

The Service Delivery and Engineering component provides all operational and maintenance activities associated with VA's IT environment. This includes the following activities: (1) overseeing and managing VA regional data centers, the IT network, and telecommunications; (2) conducting production monitoring for all information systems, production services, managing the delivery of operations services to all VA geographic locations; and (3) conducting all PBX management and maintenance. In FY2017 SDE's FTE increase includes Veterans Choice Act FTE and 599 Enterprise Operations FTE that were transferred from the VA Franchise Fund.

Enterprise Program Management Office (EPMO)

EPMO manages all enterprise application development activities. Development consists of planning, developing (or acquiring), and testing applications that meet business requirements. It provides day-to-day direction over all solutions developed by OIT for VA business units. The 2015 and 2016 budget includes funding for EPMO to hire Digital

Services staff (25 in 2015 and 50 more in 2016) that will directly perform critical and more complex IT software development projects. These are not IT program managers, but rather IT technical expert individuals in their field to provide VA with more effective IT solutions.

The success rate of government digital services is improved when agencies have digital service experts on staff with modern design, software engineering, and product management skills.

These digital service experts will bring private sector best practices in the disciplines of design, software engineering, and product management to bear on the agency's most important services. The positions will be term-limited, to encourage a continuous influx of up-to-date design and technology skills into the agency. The digital service experts will be recruited from among America's leading technology enterprises and startups, and will join with the agency's top technical and policy leaders to deliver meaningful and lasting improvements to the services the agency provides to citizens and businesses.

Information Security (OIS)

Information Security deals with matters related to information protection including privacy, cyber security, risk management, records management, FOIA, incident response, critical infrastructure protection and business continuity. The office develops, implements and oversees the policies, procedures, training, communication and operations related to improving how VA and its' partners safeguard the PII of Veterans and VA employees. Its objective is to assure the confidentiality, integrity and availability of information and information systems.

Quality, Performance and Oversight (QPO)

Quality, Performance & Oversight facilitates the establishment of performance measures and metrics related to the full range of IT program responsibilities and strategic objectives and manages associated measurement efforts. The office has an integrated enterprise-wide risk management framework to identify and manage risk. This framework is designed to anticipate, identify, prioritize, and monitor OIT enterprise risks, ensures information technology investments are managed efficiently and effectively, and provides assurance in the achievement of OIT objectives.

IT Resource Management (ITRM)

ITRM directs the financial management, multi-year programming, budget formulation and execution, workforce development, IT facility management; as well as acquisition strategy and vendor management within OIT. As such, it has the primary responsibility of linking the budgeting process with IT programs. ITRM must accomplish resource requirements validation and correlation during the annual Planning, Programming, Budgeting and Execution (PPBE) multi-year intake programming process.

Architecture Strategy Design (ASD)

ASD advises and assists the Deputy Assistant Secretary of IT in overseeing and directing the areas of IT strategy, plans, and programs for the Department. The office develops the Enterprise Architecture and IT Strategic Plan, which addresses short and long-term IT goals, objectives and performance measures necessary to support VA business lines.

Interagency Program Office (IPO)

The IPO supports the VA's efforts to implement national health data standards for interoperability with DoD - a key component to updating VistA - and will be responsible for establishing, monitoring, and approving terminology and technical standards profiles and processes to ensure seamless integration of health data between the two departments and private health care providers. Responsibility for development of requirements and execution of IT solutions remain with the respective DoD and VA organizations.

Office of Customer Advocacy (OCA)

The Office of Customer Advocacy (OCA) is a new office created in 2014 to ensure that OIT works with its customers more effectively to provide them with the best IT services possible. The OCA is still crystallizing its vision and mission while it brings together three existing program areas with years of experience in customer advocacy, collecting and analyzing customer satisfaction metrics, and responding to IT support requests.

OCA consists of the Customer Advocates for Benefits, Corporate, and Health; the Service Coordination (SC) Office; and IT Customer Relationship Management (CRM). These groups each specialize in different areas of customer service, and their combined expertise will enable the OCA to see a holistic view of the customer experience. The Customer Advocates are primarily responsible for liaising with VA's different business lines to ensure that OIT provides the services they need. They broker with the business side to see how business challenges can be resolved in order to meet desired outcomes in an effective, efficient manner. Additionally, they advocate as advisors providing insight into the business line and OIT, as well as presenting external factors that may come into play.

The SC office has historically been an intermediary between the VA business community and OIT, serving as technical IT operations advocates in such areas as IT activations resource planning, enterprise project rollout coordination, service agreement formulation, and translating technical bulletins into digestible customer communications.

The IT Customer Relationship Management program area is responsible for measuring OIT's success in serving its internal VA customers with industry-proven tools such as the American Customer Satisfaction Index (ACSI). CRM was responsible for assessing ACSI scores, National Service Desk data, and Key Performance Indicators from across the business lines to assess the consistency of the OIT customer experience. OCA is committed to ensuring that OIT provides top-notch customer service and works strategically with the various business lines to improve and develop VA IT solutions.

Funding for this program area will enhance OIT's ability to focus on delivering personal productivity to the end user not technical functionality.

Information and Technology

Other Development Efforts

Other Development Efforts (Dollars in Thousands)											
	2015 Actuals		2015/2016 Carryover	2016 Budget Estimate		2016 Current Estimate		2017 Budget Request		2016-2017 Increase / Decrease	
	DME	OM	DME	DME	OM	DME	OM	DME	OM	DME	OM
Financial Management System Modernization (FMS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 44,316	$ 21,302	$ 44,316	$ 21,302
Supply Chain Management	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,000	$ -	$ 11,000	$ -
VA Center for Innovations (VACI)	$ 10,240	$ 2,003	$ 1,760	$ 6,000	$ 1,500	$ 6,000	$ 1,500	$ 7,220	$ 4,000	$ 1,220	$ 2,500
Subtotals	$ 10,240	$ 2,003	$ 1,760	$ 6,000	$ 1,500	$ 6,000	$ 1,500	$ 62,536	$ 25,302	$ 56,536	$ 23,802
TOTAL DME and OM	**$ 12,243**		**$ 1,760**	**$ 7,500**		**$ 7,500**		**$ 87,838**		**$ 80,338**	

Financial Management System Maintenance and Modernization (FMS) - $65.6 million

The Department of Veterans Affairs core accounting system is a crucial backbone application for the agency. All aspects of agency operations depend on proper budgeting, execution of funds, payment of bills, financial reporting, and other functions performed by the core accounting system. These services are critical for VA to service Veterans effectively. They allow facilities to manage a budget, for hospitals to function, for VA supplier's to be paid, for benefits to be managed, and for cemeteries to operate. The current system in use at VA is 30 years old and clearly not sustainable long term. The Financial Management System Modernization (FMS) effort first and foremost will improve the Veterans Experience by ensuring that these essential functions continue into the future.

Secondly, this effort will allow VA to more efficiently manage its budget, improve the ability to provide fee care in the community, provide new and improved metrics for more streamlined operation, and enable better integration between other VA systems for management decision making. The result of this effort will improve the Veterans Experience by increasing the timeliness of payments to Veterans, ensuring no disruption in services to Veterans, and increasing the accuracy of billing. The Veterans Experience will improve because the overall efficiency of VA will improve. New data analytic capabilities will enable VA to perform better oversight, control costs, and eliminate waste. Each of these features permit dramatic improvement in the Veterans Experience by providing VA management much increased visibility into organizational financial data, which can then further be used in the direct improvement of the Veterans Experience with VA.

Ultimately, this project improves the Veteran Experience by making these fundamental activities invisible to the Veteran. Facility operations, financial operations, billing, and payment functions will all work as they should without inconvenience or consistent error.

FY2017 Request

The FY2017 budget of $65.6 consists of $44.3 million in development and $21.3 million in sustainment funding. VA plans to migrate its core financial system to one of the four Federal Shared Service Providers (FSSP) offering financial system solutions. During FY2016, VA will be conducting pre-discovery with the FSSPs to determine best fit, followed by a detailed discovery phase with the most appropriate offeror. In FY2017, VA anticipates selection of a FSSP and the start of implementation. Funding requests will be adjusted based on these activities.

In FY2017, first year costs are based on analogous estimates from both the Department of Homeland Security (DHS) and Housing and Urban Development (HUD) shared services initiatives. Expected Development costs include licensing, hosting, establishing VA's environment, configuration, data migration, integration and interfaces, multiple levels of testing and associated change management activities

FY2017 Outcomes

The FY2017 budget request will allow VA to begin the necessary replacement of its 30 year old financial system. Potential for FSSP to establish VA financial system environment and completion of pre-deployment activities to include licensing, gap analysis and data clean-up efforts.

Supply Chain Management - $11 million

Currently VA/VHA logistics systems are plagued by non-standardized data entry that is inconsistent, error prone and unique from facility to facility due to automated systems that are free text entry, facility specific/unique and difficult to manage. This has resulted in over 150 separate and unique approaches to supply chain and equipment management and databases that are full or errant data, inconsistent in product and equipment information from facility to facility and nearly impossible to utilize on a national basis for strategic supply chain and procurement decisions.

OIT assistance is required to acquire and implement a Future Transformational Tool (FTT) which is a VistA integrated Graphic User Interface (GUI) designed to dramatically improve logistics and supply chain data accuracy, streamline workflow processes and ensure accurate data reporting and analysis for property and consumable inventory management decision making. The FTT accurately captures and displays data during entry within the existing Automated Engineering Management System/Medical Equipment Report System (AEMS/MERS), Integrated Funds Distribution Control Point Activity, Accounting and Procurement (IFCAP) with Generic Inventory Package (GIP), and Purchase Card software packages by applying nationally standardized business rules and enforcing data formatting that meets industry standards. The proposed FTT includes user alerts, dashboard displays as well as standard and ad hoc reports that help our logistics employees manage supply chain operations throughout the VA.

With this tool, as defined by vetted business rules, certain data fields are required to be accurately entered before a property or inventory record is considered complete. The tool

maintains access levels for security purposes, and includes the ability to scan and attach paper or electronic documents to records as necessary. Dashboards are customizable at the management and end-user levels to provide measures and alerts regarding specific performance. Reports are also customizable to allow end users to extract necessary information for analysis and review.

The FTT sits "on top" of current VistA platforms as a GUI overlay and does not require any changes to current VistA software packages. The expected result of this acquisition and implementation is over 150 facility databases that are largely standard with at least 80 percent accurate data elements that allow for national data retrieval and analysis for data driven national solutions; and more importantly, facility logistics databases that are ready for conversion to any potential supply chain enterprise software solutions.

The FTT project/program aligns directly with current MyVA initiatives listed below:

- Realign internal business processes to achieve support service excellence in which organizations across VA leverage the same support services in standard ways to improve efficiency, reduce costs, and increase productivity.
- Engage employees in performance improvement teams to eliminate or improve processes that impede excellent customer service or service delivery.

FY2017 Request

The request of $11 million will enable VA to move to or develop an enterprise-wide supply chain management system solution. There are seven pilot installations of DSS's Above Par system that have been facility or VISN purchased. Each of these pilots is being implemented facility by facility without national standardization.

- Milwaukee VAMC – mature implementation in operation for over a year.
- Boston VAMC – mature implementation in operation for nearly a year.
- Five facilities in VISN 10 – purchased by not fully implemented.

Current VistA based property and consumable inventory management systems allow free text entry and incomplete record builds which has resulted in over 150 separate and distinct instances of supply chain management data repositories down to the data element level. The reality of inconsistent, inaccurate, non-standard records, data fields and data tables has made any local, regional or national data mining and analysis for supply chain management data driven decisions nearly impossible. The lack of data entry editing and business rule enforcement in our present systems has caused an increased workload applied to constantly identifying and correcting tens of thousands of data fields within thousands of records at each and every VistA site.

Studies and assessments completed over the past several years (including the PricewaterhouseCoopers (PwC) Logistics Transformation Study and the Medical/Surgical/Prosthetics – Advance Supply Chain Capability (MSP-ASCC) Assessment) have identified the lack of data accuracy as the VA's number one issue when considering efficient supply chain management solutions.

The FTT mandates improved data accuracy, allow for accurate data analysis and improve the flow of supply chain management information throughout the organization enhancing communication and decision making. This resource will help the organization implement and maintain sound nationally standardized business rules and articulate necessary data that converts into meaningful and accurate information used by front-line managers and executive leadership alike to make data-driven decisions. Visibility of our supply chain will allow us to improve our delivery times, reduce lead times, reduce working capital, manage variable costs more effectively, update customers on product availability and shipment status, and track and trace products throughout the entire supply chain. All of these stated benefits are required as the VA considers any enterprise-wide supply chain replacement systems.

FY2017 Outcomes

Expected improvements include but are not limited to: a 5 percent increase in items added to the Medical Surgical Prime Vendor supply chain, a 10 percent decrease in days of stock on hand, a dramatic shift in front line personnel focusing on improving supply chain response to customer demands instead of identifying and correcting data, an increase in standardization results at the local, regional and national level thereby reducing supply chain costs. Implementation of FTT will offer numerous benefits to VA staff and Facility Logistics Program operations in the form of direct and indirect cost avoidances including:

Direct Cost Avoidances –

- Elimination of common data entry errors such as blank field, negative values, and typos through system rules that require mandatory fields to be completed in standard formats before a record is updated or accepted.
- Enforcement of consistent data standards and business rules through GUI system logic derived from national policy and procedures.
- Electronic approval routing that minimizes the time between the turn-in request and item pickup. Additionally, fewer documents will need to be recreated due to better tracking and routing capabilities.
- Creation of local, regional, and national performance metrics and key performance indicators which can be measured quickly with confidence for data-driven decisions yielding supply chain efficiencies, potential supply and administrative cost savings and improved customer service with both standard and ad hoc reporting capabilities.

Indirect Cost Avoidances –

- Migration of data to successor enterprise supply chain management systems will be done with ease through data standards and consistency.
- Transparency and visibility of items and assets throughout VA’s supply chain through complete and accurate data fields, user-friendly navigation, data consolidation and extraction at local, regional, and national levels.
- Capture and analysis of national spend data to leverage buying power to procure items and assets at lower negotiated prices through consolidation and consistent identification capabilities.

- Adoption and implementation of industry-wide standards through national identification and the ability to add new information requirements without modifying existing inventory management software.

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Information and Technology

VistA Evolution/Interoperability and VLER Health

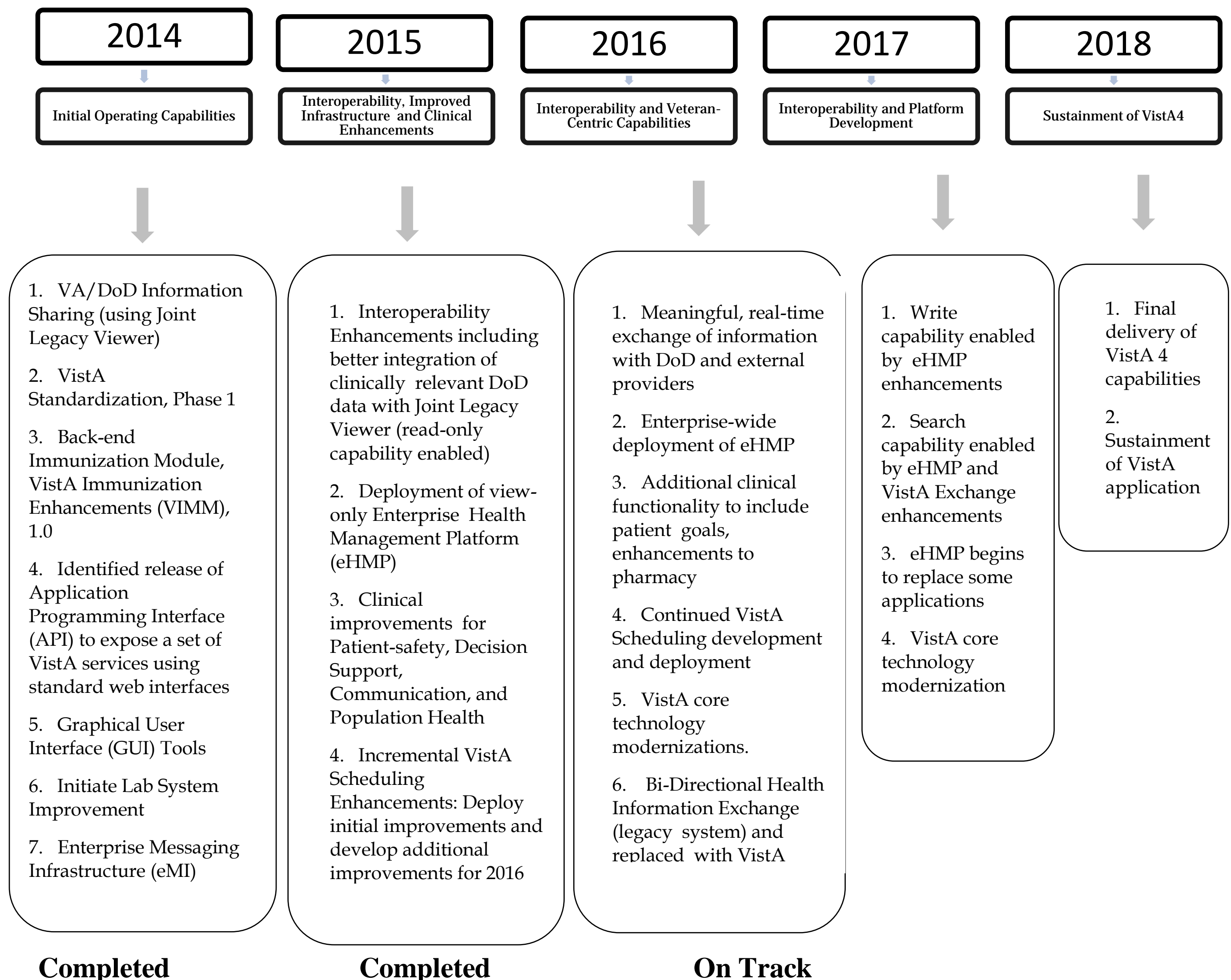
VistA Evolution/Interoperability and VLER Health (Dollars in Thousands)											
	2015 Actuals		2015/2016 Carryover	2016 Budget Estimate		2016 Current Estimate		2017 Budget Request		2016-2017 Increase / Decrease	
	DME	OM	DME	DME	OM	DME	OM	DME	OM	DME	OM
VistA Evolution	$ 168,968	$ 75,791	$ 10,954	$ 81,900	$ 100,700	$ 81,900	$ 100,700	$ 63,339	$ 104,774	$ (18,561)	$ 4,074
Interoperability	$ 31,518	$ 19,924	$ 6,985	$ 15,000	$ 15,000	$ 15,000	$ 15,000	$ 9,658	$ 65,040	$ (5,342)	$ 50,040
VLER Health	$ 10,262	$ 2,125	$ 443	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 7,664	$ 9,399	$ (2,336)	$ (601)
Total	$ 210,748	$ 97,840	$ 18,382	$ 106,900	$ 125,700	$ 106,900	$ 125,700	$ 80,661	$ 179,213	$ (26,239)	$ 53,513
TOTAL DME and OM	$ 308,588		$ 18,382	$ 232,600		$ 232,600		$ 259,874		$ 27,274	

Total VistA Evolution/Interoperability and VLER Health - $259.9 million

VA established the VistA Evolution program to deliver modernized VistA capabilities based on open standard, open architecture, non-proprietary designs. VistA 4 is the first segment of the program, with deliverables through FY 2018. VistA 4 leverages open standards endorsed by the Office of the National Coordinator, and adheres to key open architecture tenets such as open transport formats (e.g., HL7 messaging), open interface specifications, and design patterns enabling robust, scalable solutions. VistA 4 will deliver interoperable, effective, safe, and efficient health information technology that improves the lives of Veterans.

VistA Evolution is a joint program of the VA Office of Information and Technology (OI&T) and Veterans Health Administration (VHA), enabling VA providers delivering Veteran centric, team based, quality driven care. Through coordinated improvements to VA’s electronic health record system, scheduling system, population health, analytics, and point of care workflows, VistA Evolution is focused on optimizing access to care based on Veteran preference and clinical need. Tools delivered by the program will also help VA care teams work more efficiently, creating greater elasticity to respond to demand for VA services.

The enterprise Health Management Platform (eHMP) is a key deliverable for VistA 4. eHMP is a new clinical data services and application platform for VistA, which integrates Veterans’ health information from all available VA, DoD and community health partner sources. eHMP will ultimately replace the Computerized Patient Record System (CPRS) as VA’s primary point of care application.



FY2017 Request

The Office of Information and Technology is responsible for developing all VistA 4 components. This includes coding, standardization of VistA Instances, testing software, and any construction or modification of health IT systems. VHA is responsible for deployment support, training and other critical activities.

The major themes for FY2017 are Interoperability and Platform Development. The requested $80.6 million in development and $179.2 million in sustainment will fund the delivery of the capabilities or features under the VistA 4 program as outlined in the chart above. A revised VistA 4 Product roadmap is under development and is expected to be available in Spring 2016.

FY2017 Outcomes

The program supports all three of VHA's strategic goals of veteran access, employee engagement, identification and standardization of best practices, development of a high performance network, and restoration of confidence and trust in the VA system. VistA Evolution (VE) program will directly impact Veterans by transforming the electronic health record to better support care. The program will focus on improvements to interoperability, including a wider deployment/adoption of JLV, write capability enabled by eHMP enhancements, search capability enabled by eHMP and VistA Exchange enhancements, and replacement of some legacy applications. The below priority efforts are among the key activities that the program will focus on in FY 2017.

Description of Select Priority VistA Evolution Efforts for FY 2017

enterprise Health Management Platform (eHMP) 2.X

enterprise Health Management Platform (eHMP) is a new clinical data service and application platform for VistA, which integrates Veterans' health information from all available VA, DoD and community health partner sources. eHMP will provide modern decision support, activity management, support for interoperable care plans, and other advanced features in a Veteran-centric record. eHMP will ultimately replace the Computerized Patient Record System (CPRS) as VA's primary point of care application.

Collaborative Terminology Tooling & Data Management

The Collaborative Terminology Tooling & Data Management program focuses on the analysis of the Clinical Terminology and Standards Maps currently in use and preparing revised maps to meet the requirements of Interoperability and Meaningful Use. The program will also develop a Terminology Tooling Suite to provide VA Clinicians and Terminologists with Web based mapping, authoring, editing and publishing tools for standards based terminology.

Joint Legacy Viewer (JLV) - Get The Data Back (GTDB) - JLV Community

The Joint Legacy Viewer (JLV) provides a standards-based, integrated, chronological view of real-time electronic health record information from all VA and DoD facilities where a patient has received care as well as from VA external partners in a workflow configurable display. JLV has been available at all VA Medical Centers and Regional Offices since October 1, 2014 and serves as a transitional capability for VistA Evolution. VA will continue to add new users to JLV until eHMP is available across the enterprise, then JLV users will migrate to eHMP. The "Get the Data Back" (GTDB) initiative is being driven by H.R. 3230 - Veterans Access, Choice, and Accountability Act of 2014 (VACAA), which was enacted to reduce the Veteran wait time for appointments by making third party provider care more available. To enable the records presentation solution for this initiative, the JLV configuration and product baseline will be used to create a separate JLV instance capable of allowing non-VA providers read-only access to Veteran health records with whom the provider has an appropriate care relationship. JLV access for third party providers will afford limited time, and limited access to Veteran health information specified by the VA. The GTDB project will focus on three (3) areas that include: (1) Records Intake; (2)

Records Transformation; and, (3) Records Presentation for implementing technical and business process solutions that ensure interoperability between VA and non-VA clinical care providers.

Image Viewer for Enterprise Health Management Platform (eHMP)

Provide a zero footprint web image viewer for eHMP and Joint Legacy Viewer (JLV), and facilitate eHMP and JLV platforms (in addition to others) use of the Data Access Server (DAS) to become subscribers of the VistA Image Exchange (VIX) Service. The availability of the image viewer is essential in providing quality healthcare and benefits to/for Veterans and Servicemembers.

Data Access Services (DAS) Phase 2

Data Access Service is an Enterprise Shared Service that enables intra- and inter-VA data transport and storage capabilities between data producers and data consumers. Data Access Service initially will provide a system of middleware used to transport clinical and non-clinical information between Producer and Consumer applications. Later, additional capability will be added and will provide VA and DoD clinicians, care coordinators, benefits administrators, and other systems services to share Veteran health, benefits, and administrative data. DAS enables sharing of high-priority data, including disability claims processing, and provides a true "2-pass" capability, for all data domains being viewed by VA resources, that quickly returns complete, secure, dependable, standard results.

Direct Secure Messaging Enhancements

The Direct Secure Messaging Development Project is the continued development of the software systems that provide the secure exchange of medical record information between VA, DoD, private sector partners, and other federal agencies over the Internet using the Direct Project standards published by the U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology. The program will also provide a web-based interface to view patient medical record information provided by Exchange partners.

eHMP Hosting Environments

Critical Hosting Environments allow the program will to meet performance and load requirements and expand the number of users that have access to eHMP.

VistA Services Assembler Phase 2 (VSA-P2)

VSA provides the basic functionality and infrastructure necessary to support development, deployment and operations of VistA services. VSA Phase 2 increment 2 creates VSA VistA.js local and federation platforms for base prototype functionality in development/integration testing environments and will promote code for ORR and IOC Entry. The Medication Reconciliation and Allergy Review (MRAR) proposed as the first VistA clinical service deployed with VSA on local platforms and may roll out MRAR SAAS Server with the new VSA Federation platform at AITC/PITC.

FY2016 Deliverables and Goals

VistA Evolution funding in 2016 will contribute to the delivery prioritized high value aspects of seamless electronic sharing of interoperable healthcare data with DoD and community partners through implementation of interoperability standards.

FY 2016 Goals:

- Achieve interoperability consistent with the requirements of FY 2014 National Defense Authorization Act (NDAA)
- Increase in the number of JLV users by over 100 percent over FY15
- Deliver enhanced EHR consistent with FY2014 NDAA
- Deliver eHMP 1.2 enterprise availability
- Exit eHMP 1.3 IOC in calendar year 2016

FY 2016 Individual Project Goals Include:

- Delivery of various Pharmacy Enhancements (Full Operating Capability (FOC) for all):
    - Medication Order Check Healthcare Application 2
    - Pharmacy Enterprise Customization System
    - Safety Updates for Medication Prescription Management
    - Pharmacy Safety Updates - Additive and IV Strength

- VistA Immunizations Enhancements (VIMM) 2.0 – Initial Operating Capability Exit
- VistA Application Programming Interface (API) Exposure 2.0 – Full Operating Capability
- Deliver full operating capability of VistA Scheduling Enhancements
- Deliver full operating capability of FileMan 22.2
- Deliver VistA Services Assembler (VSA) Phase 2 Enterprise Availability

Details of FY 2016 Project Goals:

Medication Order Check Healthcare Application (MOCHA 2) – Full Operating Capability - The MOCHA Clinical Decision Support system provides enhanced order checking functionality for order placed through the Computerized Patient Record System (CPRS) and VistA Pharmacy. These checks include both dosing and non-dosing issues address known patient safety issues in the existing medication ordering processes.

Pharmacy Enterprise Customization System (PECS) – Full Operating Capability - The PECS component provides tools to allow customization of Commercial Off the Shelf (COTS) drug database information used in production order checks provided by the MOCHA to increase patient safety while reducing false alert fatigue to pharmacists, and improving order checks to use unique VA expert pharmacist knowledge instead of just COTS data. The customization system meets ONC requirements.

Safety Updates for Medication Prescription Management (SUMPM) – Full Operating Capability – The SUMPM project specifically addresses enhancement requests related to Pharmacy Legacy applications. The enhancements provided by this project address patient safety issues, legislative/ regulatory changes, and user/site requested changes that enhance productivity, reduce costs, and/or improve the ability to provide care.

Pharmacy Safety Updates - Additive and IV Strength – Full Operating Capability – This project addresses patient safety issues relating to VistA Outpatient and Inpatient Pharmacy by associating the appropriate IV additive with the correct orderable item and dosage strength property, and by providing the capability within VistA Pharmacy to allow a greater than 90-day fill for specified medications.

VistA Immunizations Enhancements (VIMM) 2.0 – Initial Operating Capability Exit – VIMM 2.0 will modify existing Immunization functions enabling VA to quickly and reliably document and exchange standardized immunization information on beneficiaries across services and departments. Additionally, modifications will support read/write/exchange with decision support for vaccines capability for coded immunizations data that is integrated into eHMP and certification for Meaningful Use (C/MU).

VistA Application Programming Interface (API) Exposure 2.0 – Full Operating Capability – This project is an infrastructure support project developing and testing Service Oriented Architecture (SOA) compliant enterprise services with the objective of assisting projects and the enterprise reach NDAA 2014 Compliance.

VistA Scheduling Enhancements - Full Operating Capability- This project provides critical, near-term enhancements to VA's existing scheduling system.

FileMan 22.2 - Full Operating Capability - File Manager (FileMan) is the specific part of the VistA infrastructure that handles files. It is the data access, integration engine of VistA and manages the data structures and storage for all 100+ applications of VistA. Most VHA clinical data is stored in FileMan files and is retrieved/accessed through FileMan Application Programmer Interfaces (API) and user interfaces. FileMan will provide several features for clinicians and developers. This work will develop a plan to fix core VistA database (FileMan) bugs.

VistA Services Assembler (VSA) Phase 2 – Enterprise Availability - VSA provides the basic functionality and infrastructure necessary to support development, deployment and operations of VistA services. VSA Phase 2 increment 2 creates VSA VistA.js local and federation platforms for base prototype functionality in development/integration testing environments and will promote code for ORR and IOC Entry. The Medication Reconciliation and Allergy Review (MRAR) proposed as the first VistA clinical service deployed with VSA on local platforms and may roll out MRAR SAAS Server with the new VSA Federation platform at AITC/PITC.

2015 Accomplishments

Access to Care

VHA IT Research and Development

- VINCI - Completed the Data Access Request Tool (DART) enabling automated proposal submission, routing of approvals and concurrence and provisioning of investigator workspace with permissions and data appropriate for the IRB approved protocol. Capacity expansion to support growth from ~300 concurrent users to ~600 concurrent users. Resolution of remaining system performance issues.
- RAMS – Delivered the prototype of the central IRB forms and automated recording of personnel, projects, documents and communications associated with initial grant application

Telehealth/Connected Health

- The National Telehealth programs served more than 690,000 Veterans. That total represents approximately 12 percent of the overall Veteran population enrolled for VA healthcare, and accounted for more than 2 million telehealth visits. Of that number, approximately 55 percent were Veterans living in rural areas with limited access to VA healthcare.
- A total of 3,587 Veterans received VA care using video connections directly in their homes by means of CVT into the Home. Telehealth service growth in more than 44 specialties has been supported through the National Telehealth Training Center's development of Telehealth Operations Manuals providing specific guidance for several clinical telehealth services. MHV Terramark cloud migration completed October 2014 – dramatic performance improvement results achieved including: Greater than 300 percent increase in concurrent users support capacity; greater than 450 percent improvement in database backup performance speed; and an 800 percent improvement in performance speeds, Enhancing data refresh processes for importing data from the VA Electronic Health Record into My HealtheVet to improve the user experience. Secure Messaging enhancements were developed and deployed.

Health Administrative Systems (HAS)

The HIPAA requires industry wide standardization of EDI transactions to achieve improved efficiency and cost effectiveness in US healthcare. The MCCF EDI development program extends eBilling standards to claims, claims attachments, claims

enrollment referrals, and universal healthcare identifier usage; it extends ePharmacy standards to ePharmacy compliance; and it extends eInsurance standards to eligibility, benefits and claims, data content, X12 eligibility compliance, and insurance verification. The PC EDI development program extends these standards through the following projects:

• Purchased Care (PC) Authorizations Compliance Phase 3
• Purchased Care (PC) Claims Compliance Phase 3
• Purchased Care (PC) Payments Compliance Phase 3
• Purchased Care (PC) X-12 Attachments Compliance Phase 3

The CRM FtP's initial capability was implemented with call center agents at VAMC Reno at the end of March 2015; additional agents were added at VAMC Palo Alto in September 2015.

Healthcare Efficiency

Veterans Transportation Service (VTS) continued current operational status and expanded deployment (20 sites) to VA Medical Centers. A special initiative deployed VTS to 10 SCI Centers which previously did not have a VTS Program at their VAMCs and "beefed-up" resources of VTS Programs at 15 other VAMCs / SCI Centers where VTS was already operational. Its door-to-door capabilities with ADA compliant vehicles ensured safe and timely transportation for Veterans and families who were having difficulty navigating their way to VA for their care. In addition, the proven reduction in the Missed Opportunity Rate and the demonstrated significant cost avoidance in Special Mode contracted transport costs continued to receive focused attention. Accomplished goals in FY15 included conducting 600K trips and $12.0M in BT and SMT cost avoidance, conducting five Mobility Management sessions, and training 40 Mobility Managers.

Improve Access to Benefits

VETSNET/FAS

This program is currently providing functionality to allow National Work Queue to operate, it has provided requirements for Intent-To-File and has provided two Defect Releases for the FAS, CSS, VN-Awards and Share applications. An enhancement was released on October '15 which provided additional required FAS and Share functionality for NWQ and for continued Veteran payments, as well as Cost of Living Adjustments and Automated Burial Payments.

Veterans Benefits Management System (VBMS)

VBA has processed over 1.9 million claims, 2 million awards, and 3.6 ratings in VBMS since 2012, a major success story in the delivery of mission-critical software in the federal IT space. This success is greatly attributed to the focus on delivering functionality in scheduled three-month increments, ensuring collaboration between business and IT partners and remaining dedicated to the core mission of serving Veterans. In FY2015, VBMS conducted 14 software releases (three major and 11 minor releases, and software patches) and on-boarded five new stakeholders. VBMS conducted 13 requirements rotations (resulting in over 380 requirements artifacts) and 12 design sessions. During the 14 weeks of User Acceptance Testing (UAT), VBMS executed 1,991 test runs. VBMS

maintained a successful "Train-the-Trainer" approach for new functionalities to support stakeholders during major releases, and held three Delta training sessions (one for each major release) to train on new functionalities.

Memorials Legacy Development

MBMS engaged in user acceptance testing for the following MBMS 14.1 projects listed below.

The Presidential Memorial Certificate (PMC) Processing Capability project delivered Federal Information Security Management Act (FISMA) and 508 compliant PMC applications. This allowed PMC to provide request processing functionality, request tracking, and allowed Case Managers to suspend or disapprove any received request for just cause. System reports were added for user productivity, error identification, and order tracking. PMC Requests from Hines Information Technology Center were incorporated into the enterprise database. Accomplishments include improved VA response for PMC requests. More efficient use of VA resources in eliminating errors and duplicate data entry. Enhanced order tracking and reports functionality for the PMC processing.

- The Memorials Eligibility Office Automation (EOA) Capability/Manual PreNeed provided case management processing, easier use of the Graphical User Interface (GUI), improved reporting, and corrections that enabled the Eligibility Office (EO) to accurately generate various documents. This capability allows manually entered PreNeed cases to be processed, summarized in reports, included in case management, and integrated with Time of Need processing.
- The First Notice of Death Enhancement (FNOD) Enhancement enabled users to create and store records, query, retrieve, print, and update recorded information. Users are also able to associate and save one or more document(s) to the record. This enhancement provided time saving workflow and improved quality of data. It also provided a new form of reporting capability and user creation of ad-hoc queries.

Board of Veterans Appeals (BVA) – Appeals Modernization

The Board utilized FY15 to fully plan and prepare for execution of the anticipated FY2016 Appeals Modernization funding in the amount of $19.1M. In particular, the Board conducted an end-to-end scan of the VA appeals process to understand the current state of appeals processing and future state requirements from all appeals stakeholders, to include VBA, VHA, NCA, OGC and the Board. The robust data collected from this scan informed the creation of a Business Requirements Document (BRD) which was submitted to OIT in January 2015. The Board has been fully engaged with OIT on this project since December 2014 and was assigned an OIT PM in February 2015. Moreover, Appeals Modernization was formally approved in PMAS in June 2015. In addition, in FY15, the Board, in partnership with VA's Chief Technology Officer (CTO), leveraged a Presidential Innovation Fellow (PIF), who was assigned to the Board in support of the Appeals Modernization effort for the duration of FY15. The Board also worked with the VA Digital Services Team (DS@VA) which has four members who are assigned to the project full time. DS@VA was brought on board in June 2015, and defined the technical approach to achieve the goals of Appeals Modernization and execution of funding.

Information Security

Security Program (CRISP) Support

- In FY2015, the CRISP Support efforts resulted in the delivery of an effective vulnerability and patch management program that ensures that at least 90 percent of any identified vulnerabilities in VA systems are patched and remediated in a timely manner.

Cyber Security Program

- Updated and released new Department-wide information security policy. OCSCP updated VA Directive, initially released in 2007, to reflect new and emerging Federal information security requirements.
- Increased capability to evaluate system level risk posture by introducing automated vulnerability management tools. Allowed VA visibility into vulnerabilities found across devices and systems in order to understand risk levels tied to Authority to Operate (ATO) decisions.
- Established developed Departments first Cyber tactical and strategic plan.

Network Operations Center (NOC)

- VA's NOC achieved outstanding 23.5 percent above the federal agencies average for TIC Critical Capabilities Score.
- Executed SSL decryption at gateways to enable threat detection and monitoring.
- Actively blocked more than six hundred thousand malware threats at gateway per month.
- Blocked remote access attempts based on geolocation, preventing foreign and external rogue attacks.
- Worked with DHS to installed Einstein III systems at three gateways to enhance email threat detection.

Privacy and Records Management

- Implemented mandatory use of two factor authentication (PIV card) on all government systems.
- Launched advanced filtering by only allowing approved software applications to access the infrastructure. Increased vulnerability scanned and monitored systems by 881k.
- Reduced host threat remediation time by an average of 115 days per host.

Field Security Service (FSS)

- Published many critical communications, ISO training on new processes and improved customer service.
- Complete a customer experience survey for Information Security Officer support.
- Implemented contract for security situational awareness support.
- Implemented two factor authentication processes for all system administrators to follow.

- Created a SharePoint Portal to publish the OIT Security Calendar to all OIT Pillars and provide visibility to FISMA, FISCAM and Security Events and mandatory training to VA Central Office Leadership, OIT, VHA, VBA, Chief Information Officers (CIO) and Information Security Officers.

Business Continuity Support (COOP)

- Delivered final OIT COOP Plan.
- Successful validation of over 90 percent of system CP, DRP and IRP plans.
- Support of National Level Exercise, creation of exercise injects and facilitating exercise play.

VistA Evolution

Enterprise Health Management Platform (eHMP):

- 17 Nov 2014 Development completed for eHMP 1.1 (Basic Viewer)
- 1 Dec 2014 Development initiated for eHMP v1.2.
  - Enhanced viewer with condition-based analysis and user-defined workspaces.
  - Provides longitudinal view of full patient record including all VA VistA data, DoD data and available community partner data.
  - Includes text search, multiple charts and graphs and significantly enhanced auditability.
  - Read Only Version, targeted for enterprise wide deployment.
- 4 May 2015 Development completed for eHMP v1.2
- 11 May 2015 eHMP v1.3 development initiated.
- 27 August 2015 eHMP v1.2 software successfully installed into pre-production/test environment at Hampton VA Medical Center (VAMC) for initial testing.
- Sep 2015 eHMP v1.2 installed into pre-production environment at San Antonio, Portland, San Diego and Loma Linda facilities.
- 19 Oct 2015 eHMP v1.2 installed into production environment at Hampton facility.
- 26 Oct 2015 Development of eHMP v2.0 initiated.
  - Enhanced write back capabilities, Enterprise Single Sign On (SSOi) Integration including PIV authentication.
  - Introduction of Activity Management that incorporates task management, team management, order management, CDS, forms, alerts/notifications to enable future generation of clinical workflows. Includes additional order types, consults, observations goals and problem lists.
  - IOC entry in 4th QTR FY16 and enterprise deployment for follow-on contract in 1st QTR FY17
- 16 Nov 2015 Development completed for eHMP v1.3.
  - Initial write back iteration with improved access management and comprehensive audit and reporting capabilities. Incorporates outpatient encounters, progress notes, and introduces placing lab orders using multiple integrated platform services including initial task management, clinical decision support (CDS) and notification.
  - Release for Initial Operating Capability (IOC) sites only.
- 8 Dec 2015 eHMP v1.2 installed into production environment at Portland facility.

Enterprise Messaging Infrastructure (eMI):

- 27 – 28 May 2015 Release and site acceptance for the deployment was successful at Captain James A. Lovell Federal Health Care Center (JAL FHCC).
- June 2015 Over 200,000 messages were successfully transmitted.
- 22 September 2015 successfully achieved Full Operating Capability (FOC), establishing JAL FHCC as the first site to successfully use eMI in Production.

VistA Scheduling Enhancements (VSE):

- Functionalities Deployed to 120 sites Nationwide as of 24 July 2105
  - Scheduler Facing: Reminder messages for inactive clinics and ability to display desired date after creation of a series of multiple appointments
  - Veteran Facing: Ability to print default provider and clinic location and telephone numbers on scheduling letters sent to patients, ability to print pre-appointment letter after creation of appointment
- VSE Release #1- December 2015: Limited deployment occurred at two sites within Primary Care that includes release of VSE GUI and aggregated view of VistA Clinic Profile Scheduling Grids, single queue for appointment requests, and resource management reporting.

VistA Immunization (VIMM) 2.0:

- All Veteran immunizations provided by commercial retail pharmacies (Walgreens) are now written to the VistA electronic medical record.
- Completed national deployment for PX*1*206 and 209 (native standardization of Codes for Vaccines Administered (CVX) and Manufacturers of Vaccines (MVX) codes).
- Completed association of new immunization data with Clinical Reminders, and deployed a new Immunization Health Summary application for providers.

VistA Laboratory Enhancements:

- Established a method for automatic review of test results based on lab-established set of boundaries (Rules).

Joint Legacy Viewer (JLV):

- 100 percent of VA' Veteran Crises Hotline Staff have received JLV access
- Women's Health Clinics using JLV can save up to 30 minutes on each new patient intake
- October 2014 Available at all VAMCs and VA Regional Offices.
- Continued to expand VHA and Veterans Benefits Administration (VBA) user base. As of 20 December 2015 25,382 users.

Application Programming Interface (API) Exposure Project 2.0**:**

- March to May 2015 Provided IOC testing support to the Veterans Point of Service (VPS) project.
- Delivered write back code for Consult Orders and Radiology Orders.
- Conducted and delivered Immunization Gap analysis for eHMP project.
- Began Data Cache Optimization Architectural Design analysis for eHMP.
- Began developing a Component Data Object (CDO) design pattern that will focus on creating 'building block' services.

File Manager: 22.2:

- Open Source Electronic Health Record Alliance (OSEHRA) code was tested on multiple VA systems. In 2016, the process of remediation will continue.
- Code will be released back to OSEHRA and all test cases and remediation will be posted to OSEHRA.

File Manager 23:

- Agile planning was completed for security enhancements (role-based and context-based access), enhanced meta-data dictionary, and enabling File Manager to use extensible data types.

MedCOI:

- 19 November 2014 Application transition to VA/DoD Trusted Internet Connections (TIC) Gateways completed.
- 21 February 2015 Failover testing was completed.

VistA Standardization:

- Standardization and remediation of 1620 local variances across 129 VistA sites, which had accumulated over the last 35 years.

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Information and Technology

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Appendix A

Development, Modernization, Enhancements Subaccount

Information Technology Development Activities Highlights (Dollars in Thousands)						
	2015	2015/2016	2016		2017	2016-2017
	Obligations	Carryover	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Activities						
Access to Healthcare	5,290	4,396	28,970	28,970	-	-28,970
Healthcare Efficiency IT Development	570	10,153	6,660	6,660	-	-6,660
Electronic Health Record Interoperability & VLER Health	41,780	7,428	25,000	25,000	17,322	-7,678
VistA Evolution	168,968	10,954	81,900	81,900	63,339	-18,561
New Models of Care	21,245	9,306	25,430	25,430	-	-25,430
Veterans Benefits Management System (VBMS)	78,511	1,989	86,000	86,000	85,288	-712
Virtual Lifetime Electronic Record (VLER)	18,096	504	10,000	10,000	17,857	7,857
Veterans Relationship Management (VRM)	70,516	6,084	73,333	73,333	73,624	291
Health Management Platform	242	5,504	-	-	-	-
VHA Research IT Support Development	-	-	12,250	12,250	15,066	-
Other IT Systems Development	67,822	35,977	155,200	155,200	198,773	43,573
Total Development [1/]	**$ 473,042**	**$ 92,293**	**$ 504,743**	**$ 504,743**	**$ 471,269**	**-$33,474**
Funding Sources						
Appropriation	473,042	-	504,743	504,743	471,269	-33,474
Rescission	-	-	-	-	-	-
Emergency Supplemental	-	-	-	-	-	-
Denver Hospital Transfers	-	-	-	-18,295	-	-
Reimbursements (+)	-	-	4,445	-	9,500	9,500
Available Balance SOY (+)	150,432	-	-	92,293	-	-92,293
Available Balance EOY (-)	-92,293	-	-	-	-	-
PL 113-146 Veterans Choice Act		-	43,900	151,400	-	-151,400
Total Obligations	**$ 531,181**	**$ -**	**$ 553,088**	**$ 730,141**	**$ 480,769**	**-$249,372**

1/ Numbers do not include reimbursements

Appendix B

Congressional Report Summary Development

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Total Budget Authority Development

(Dollars in Thousands)

	2015	2015/2016	2016		2017	2016-2017
	Obligations	Carryover	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Access to Healthcare	$ 5,290	$ 4,396	$ 28,970	$ 28,970	$ -	$ (28,970)
Healthcare Efficiency IT Development	$ 570	$ 10,153	$ 6,660	$ 6,660	$ -	$ (6,660)
Electronic Health Record Interoperability/VLER Health	$ 41,780	$ 7,428	$ 25,000	$ 25,000	$ 17,322	$ (7,678)
VistA Evolution	$ 168,968	$ 10,954	$ 81,900	$ 81,900	$ 63,339	$ (18,561)
New Models of Care	$ 21,245	$ 9,306	$ 25,430	$ 25,430	$ -	$ (25,430)
Veterans Benefits Management System (VBMS)	$ 78,511	$ 1,989	$ 86,000	$ 86,000	$ 85,288	$ (712)
Virtual Lifetime Electronic Record (VLER)	$ 18,096	$ 504	$ 10,000	$ 10,000	$ 17,857	$ 7,857
Veteran Customer Experience (aka VRM)	$ 70,516	$ 6,084	$ 73,333	$ 73,333	$ 73,624	$ 291
Health Management Platform	$ 242	$ 5,504	$ -	$ -	$ -	$ -
VHA Research IT Support Development	$ -	$ -	$ 12,250	$ 12,250	$ 15,066	$ 2,816
Other IT Systems Development	$ 67,822	$ 35,977	$ 155,200	$ 155,200	$ 198,773	$ 43,573
Subtotal	$ 473,042	$ 92,293	$ 504,743	$ 504,743	$ 471,269	$ (33,474)
Sustainment/O&M						
Medical Operations and Maintenance	$ 810,995	$ 41,000	$ 952,763	$ 952,763	$ 256,295	$ (696,468)
Benefits Operations and Maintenance	$ 241,801	$ -	$ 278,710	$ 278,710	$ 87,389	$ (191,321)
Enterprise Operations and Maintenance	$ 1,089,068	$ -	$ 1,143,920	$ 1,143,920	$ 2,058,062	$ 914,142
Interagency Operations and Maintenance	$ 115,291	$ -	$ 137,470	$ 137,470	$ 132,696	$ (4,774)
Subtotal	$ 2,257,155	$ 41,000	$ 2,512,863	$ 2,512,863	$ 2,534,442	$ 21,579
Veterans Access, Choice and Accountability Act (VACAA)[1/]						
VACAA Section 801	$ 53,567	$ 146,133	$ 173,400	$ 173,400	$ -	$ (173,400)
VACAA Section 802	$ 17,757	$ 50,243	$ -	$ -	$ -	$ -
Subtotal	$ 71,324	$ 196,376	$ 173,400	$ 173,400	$ -	$ (173,400)
Development[3/]	$ 473,042	$ 92,293	$ 504,743	$ 504,743	$ 471,269	$ (33,474)
Sustainment/O&M[2/;3/]	$ 2,257,155	$ 41,000	$ 2,512,863	$ 2,512,863	$ 2,534,442	$ 21,579
Staffing and Administration[2/;3/]	$ 1,017,447	$ 19,424	$ 1,115,757	$ 1,115,757	$ 1,272,548	$ 156,791
H1N1 Supplemental (P.L. 111-32)	$ 2	$ -	$ -	$ -	$ -	$ -
OEF/OIF Supplemental (P.L. 110-28)	$ 469	$ 1,586	$ -	$ -	$ -	$ -
Rescission	$ -	$ -	$ -	$ -	$ -	$ -
VACAA	$ 71,324	$ 196,376	$ 173,400	$ 173,400	$ -	$ (173,400)
Total (includes VACAA)	**$ 3,819,438**	**$ 350,678**	**$ 4,306,763**	**$ 4,306,763**	**$ 4,278,259**	**$ (28,504)**
Reconciliation (SF-133) report						
Carryover 14/15 obligations	$ 165,936					
Reimbursable Obligations	$ 39,136					
Veterans Choice Act - 802	$ (17,757)					
Captain James A. Lovell Federal Health Care Center (N. Chicago) transfer	$ (6,968)					
Prior Year Recoveries	$ 13,362					
Total	**$ 4,013,147**					

1/ In 2015 and 2016, the VACAA line represents funds allocated per the Veterans Access, Choice, and Accountability Act of 2014. In 2017, VACAA will be funded through the IT appropriation, and will be part of the Operations and Maintenance subaccount.

Appendix C

Congressional Report Detail

Information and Technology Development Detail (Dollars in Thousands)						
	2015	**2015/2016**	**2016**		**2017**	**2015-2016**
Detail doesn't include VACAA sections 801/802	**Obligations**	**Carryover**	**Budget Estimate**	**Current Estimate**	**Budget Request**	**Increase / Decrease**
Access to Healthcare	**$ 5,290**	**$ 4,396**	**$ 28,970**	**$ 28,970**	**$ -**	**$ (28,970)**
Emergency Department Information System	$ 881	$ 1,899	$ -	$ -	$ -	$ -
Mobile Development - *Health Apps*	$ -	$ -	$ 11,000	$ 11,000	$ -	$ (11,000)
Bed Management Solution Development	$ 2,392	$ 1,917	$ -	$ -	$ -	$ -
Veterans Point of Service (VPS) Kiosk	$ 2,017	$ 580	$ -	$ -	$ -	$ -
Veterans Implant Tracking Alert System (VITAS)	$ -	$ -	$ -	$ -	$ -	$ -
Access to Care	$ -	$ -	$ 17,970	$ 17,970	$ -	$ (17,970)
Healthcare Efficiency IT Development	**$ 570**	**$ 10,153**	**$ 6,660**	**$ 6,660**	**$ -**	**$ (6,660)**
Healthcare Efficiency IT Development	$ -	$ -	$ 6,660	$ 6,660	$ -	$ (6,660)
Real Time Location System (RTLS) National Middleware Data Repository	$ 165	$ 5,558	$ -	$ -	$ -	$ -
Non-VA Care Claims Processing Enhancements	$ 405	$ 4,595	$ -	$ -	$ -	$ -
Interoperability & VLER Health	**$ 41,780**	**$ 7,428**	**$ 25,000**	**$ 25,000**	**$ 17,322**	**$ (7,678)**
VLER Health	$ 10,262	$ 443	$ 10,000	$ 10,000	$ 7,664	$ (2,336)
Data Management Services	$ 31,518	$ 6,985	$ -	$ -	$ -	$ -
Interoperability	$ -	$ -	$ 15,000	$ 15,000	$ 9,658	$ (5,342)
VistA Evolution	**$ 168,968**	**$ 10,954**	**$ 81,900**	**$ 81,900**	**$ 63,339**	**$ (18,561)**
New Models of Care	**$ 21,245**	**$ 9,306**	**$ 25,430**	**$ 25,430**	**$ -**	**$ (25,430)**
New Models of Care	$ -	$ -	$ 25,430	$ 25,430	$ -	$ (25,430)
TeleHealth	$ 4,742	$ 947	$ -	$ -	$ -	$ -
PACT Primary Care Management Module Re-engineering	$ 2,045	$ 16	$ -	$ -	$ -	$ -
Enterprise Mobile Applications Store	$ 6,312	$ 4,768	$ -	$ -	$ -	$ -
My HealtheVet Integrations	$ 8,147	$ 3,575	$ -	$ -	$ -	$ -
Veterans Benefits Management System (VBMS)	**$ 78,511**	**$ 1,989**	**$ 86,000**	**$ 86,000**	**$ 85,288**	**$ (712)**
VBMS	$ 64,536	$ 790	$ 76,000	$ 76,000	$75,000	$ (1,000)
VETSNET	$ 11,532	$ 869	$ 10,000	$ 10,000	$10,288	$ 288
Benefits Gateway Services (BGS)	$ 2,443	$ 330	$ -	$ -		$ -
Virtual Lifetime Electronic Record (VLER)	**$ 18,096**	**$ 504**	**$ 10,000**	**$ 10,000**	**$ 17,857**	**$ 7,857**
Memorial/Cemetarial Legacy Development	$ 7,976	$ 502	$ 10,000	$ 10,000	$ 17,857	$ 7,857
VLER Core	$ 10,121	$ 1	$ -	$ -	$ -	$ -
Veteran Customer Experience (VCE)	**$ 70,516**	**$ 6,084**	**$ 73,333**	**$ 73,333**	**$ 73,624**	**$ 291**
Veterans Identification Card Act 2015	**$ -**	**$ -**	**$ -**	**$ -**	$ 5,652	
Veteran Customer Experience	**$ -**	**$ -**	$ 67,233	$ 67,233		$ (67,233)
VCE_ VHA 5 Readjustment Counseling (aka VRM)	**$ -**	**$ -**	$ -	$ -		$ -
Disability Exam and Assessment Program (DEAP)	$ -	$ -	$ 6,100	$ 6,100		$ (6,100)
Customer Data Integration Phase	$ -	$ -	$ -	$ -	$ 8,391	
Health Eligibility Center (HEC)	$ -	$ -	$ -	$ -	$ 4,541	
Contract Outreach Reporting Environment	$ -	$ -	$ -	$ -	$ 291	
Veteran Oriented Interactive Customer Evaluation (VOICE)	$ -	$ -	$ -	$ -	$ 500	
Enabling Infrastructure (IAM, CGS)	$ 34,464	$ 1,896	$ -	$ -	$ 54,249	$ 54,249
Web Self Service (VetSuccess, EVSS)	$ 21,350	$ 150	$ -	$ -		$ -
Agent Assisted (CRM, FBSR, VAM)	$ 14,702	$ 4,038	$ -	$ -		$ -
Health Management Platform	**$ 242**	**$ 5,504**	**$ -**	**$ -**		$ -
VHA Research IT Support Development	**$ -**	**$ -**	**$ 12,250**	**$ 12,250**	**$ 15,066**	**$ 2,816**
Genomic Information System for Integrative Service (GenISIS)	**$ -**	**$ -**	$ 4,084	$ 4,084	$ 9,166	$ 5,082
Research Administrative Mgmt. System (RAMS)	**$ -**	**$ -**	$ 4,083	$ 4,083	$ 3,500	$ (583)
Veteran Informatics & Computing Infrastructure	**$ -**	**$ -**	$ 4,083	$ 4,083	$ 2,400	$ (1,683)

Information and Technology Development Detail Continued (Dollars in Thousands)						
Other IT Systems Development	**$ 67,822**	**$ 35,977**	**$ 155,200**	**$ 155,200**	**$ 198,773**	**$ 43,573**
Customer Relationship Management (CRM) - Fix the Phones (FtP)	$ -	$ -	$ -	$ -	$ 9,860	$ 9,860
Medical Care Collections Fund (MCCF)	$ -	$ -	$ -	$ -		$ -
Veterans Transportation Program (VTP)	$ -	$ -	$ -	$ -	$ 3,100	$ 3,100
Purchased Care (PC) EDI	$ -	$ -	$ -	$ -		$ -
Health Resource Center	$ -	$ -	$ -	$ -		$ -
Prosthetics Business Environment Enhancements	$ -	$ -	$ -	$ -		$ -
Enrollment System Modernization	$ -	$ -	$ -	$ -	$ 3,301	$ 3,301
Enrollment Program	$ -	$ -	$ -	$ -	$ 19,860	$ 19,860
Chapter 33	$ -	$ -	$ -	$ -	$ 11,826	$ 11,826
Common Shared Services	$ -	$ -	$ -	$ -		$ -
Tiered Medication Copayment Structure	$ -	$ -	$ -	$ -	$ 1,540	$ 1,540
Telehealth Services	$ -	$ -	$ -	$ -	$ 4,867	$ 4,867
Computerized Patient Records System (CPRS)	**$ -**	**$ -**	**$ -**	**$ -**	**$ 6,308**	**$ 6,308**
CPRS v32	$ -	$ -	$ -	$ -	$ 750	
CPRS v32x	$ -	$ -	$ -	$ -	$ 5,558	
Connected Health/Mobile Apps	$ -	$ -	$ -	$ -	$ 14,470	$ 14,470
Medical Scheduling	$ -	$ -	$ -	$ -	$ 9,858	$ 9,858
Supply Chain Management	$ -	$ -	$ -	$ -	$ 11,000	$ 11,000
Financial Management System Modernization	$ -	$ -	$ -	$ -	$ 44,316	$ 44,316
Divestiture Strategies for IT Systems	$ -	$ -	$ 18,000	$ 18,000		$ (18,000)
Homelessness Handheld Devices	$ -	$ -	$ 1,220	$ 1,220		$ (1,220)
Identity, Credential and Access Management (ICAM)	$ -	$ -	$ 800	$ 800		$ (800)
IVMH National Clozapine Coordination	$ 1,991	$ 709	$ -	$ -	$ -	$ -
Safety and Security Initiative (HSPD-12)	$ 2,278	$ 22	$ -	$ -	$ -	$ -
Veterans Informatics and Computing Infrastructure (VINCI)/Consortium Healthcare Informatics Research	$ 3,088	$ 686	$ -	$ -	$ -	$ -
Connected Health/ TeleHealth Expansion (SPI)	$ -	$ -	$ 4,070	$ 4,070	$ -	$ (4,070)
Mental Health (SPI)	$ -	$ -	$ 2,050	$ 2,050	$ -	$ (2,050)
Appeals Modernization - BVA (SPI)	$ -	$ -	$ 19,100	$ 19,100	$ 19,100	$ -
Human Resources Information System	$ 972	$ -	$ -	$ -	$ -	$ -
Administrative Data Repository	$ 2,356	$ 232	$ -	$ -	$ -	$ -
Revenue Reporting Enhancements	$ 2,130	$ 1,054	$ -	$ -	$ -	$ -
Health Administrative Systems (ChampVA, VSS, etc.)	$ -	$ -	$ 27,800	$ 27,800	$ -	$ (27,800)
CHAMPVA Family Members Systems	$ 754	$ 506	$ -	$ -	$ -	$ -
Voluntary Service System (VSS) Enhancements	$ 2,859	$ 23	$ -	$ -	$ -	$ -
Revenue Operations - Development	$ 1,454	$ 197	$ -	$ -	$ -	$ -
Consolidated Co-Payment Process Center (CCPC) Patient Statement Enhancement	$ 979	$ 590	$ -	$ -	$ -	$ -
Class III to Class I Testing	$ 1,000	$ 0	$ -	$ -	$ -	$ -
Revenue Eligibility Enhancements	$ 575	$ 78	$ -	$ -	$ -	$ -
Innovations (VAi2, also known as VACI)	$ 10,240	$ 1,760	$ 6,000	$ 6,000	$ 7,220	$ 1,220
Caregivers Enhancements	$ 3,639	$ 3,224	$ 5,000	$ 5,000	$ -	$ (5,000)
Health Provider Systems Development	$ 239	$ -	$ 6,000	$ 6,000	$ -	$ (6,000)
Enrollment System Modernization / Affordable Care Act	$ -	$ -	$ 13,900	$ 13,900	$ -	$ (13,900)
Compensation and Pension Records Interlace (CAPRI)	$ 1,028	$ 72	$ 2,200	$ 2,200	$ 4,522	$ 2,322
Standards and Terminology Services	$ -	$ -	$ 2,000	$ 2,000	$ -	$ (2,000)
Repositories	$ -	$ -	$ 7,920	$ 7,920	$ -	$ (7,920)
Computerized Patient Records System	$ 3,224	$ 3,169	$ -	$ -	$ -	$ -
eDiscovery	$ 2,522	$ 570	$ -	$ -	$ -	$ -
Healthcare Reform/Affordable Care Act	$ -	$ 2,200	$ -	$ -	$ -	$ -
VA Medication Reconciliation	$ 263	$ 1,533	$ -	$ -	$ -	$ -
Radiology/Nuclear Medicine Order Entry Clinical Decision Support System	$ -	$ 449	$ -	$ -	$ -	$ -
Compensation	**$ 744**	**$ 6**	**$ 640**	**$ 640**	**$ 1,665**	**$ 1,025**
Centralized Administrative Accounting Transaction System (CAATS)	$ 744	$ 6	$ 640	$ 640	$ 843	$ 203
Systematic Technical Accuracy Review (STAR) 2	$ -	$ -	$ -	$ -	$ 822	$ 822
Interactive Customer Evaluation (ICE)	$ -	$ 2,577	$ -	$ -	$ -	$ -
EDI Transactions - Provider	$ 16,294	$ 6,694	$ 17,000	$ 17,000	$ -	$ (17,000)
EDI Transactions- Payer	$ 4,785	$ 6,773	$ 10,000	$ 10,000	$ -	$ (10,000)
Registries	$ 2,386	$ 1,937	$ 11,500	$ 11,500	$ -	$ (11,500)
Data Access, Archiving and Disposition	$ -	$ -	$ -	$ -	$ 25,000	$ 25,000
Annual Surgery Updates	$ 802	$ 162	$ -	$ -	$ -	$ -
Bar Code Expansion Positive Patient Identification	$ 245	$ 755	$ -	$ -	$ 960	$ 960
VACAA Section 701/702	$ 975	$ -	$ -	$ -	$ -	$ -
Grand Total	**$ 473,042**	**$ 92,293**	**$ 504,743**	**$ 504,743**	**$ 471,269**	**$ (33,474)**

1/ In 2015 and 2016, the VACAA funds were allocated per the Veterans Access, Choice, and Accountability Act of 2014. 2/ $6,698 million for Captain James A. Lovell Federal Health Care Center (N. Chicago) Transfer included in the Sustainment and Pay and Administration 2015 obligations. 3/ Lapse funding of $1,926M removed from 2015/2016 carryover column (Development $397K, Sustainment $623K, Pay $906K).

Appendix D

Operations and Maintenance Subaccount

Information Technology Operations and Maintenance Highlights (Dollars in Thousands)						
	2015 Obligations	2015/2016 Carryover	2016 Budget Estimate	2016 Current Estimate	2017 Budget Request	2016-2017 Increase / Decrease
Activities						
Medical Operations and Maintenance	810,995	41,000	952,763	952,763	256,295	-696,468
Benefits Operations and Maintenance	241,801	-	278,710	278,710	87,389	-191,321
Enterprise Operations and Maintenance	1,089,068	-	1,143,920	1,143,920	2,058,062	914,142
Interagency Operation and Maintenance	115,291	-	137,470	137,470	132,696	-4,774
Total Operations and Maintenance 1/	**$ 2,257,155**	**$ 41,000**	**$ 2,512,863**	**$ 2,512,863**	**$ 2,534,442**	**$ 21,579**
Funding Sources						
Appropriation	2,257,155	-	2,512,863	2,512,863	2,534,442	21,579
Rescission	-	-	-	-	-	-
H1N1 Supplemental (P.L 111-32)	2	-	-	-	-	-
OEF/OIF Supplemental (P.L 110-128)	469	1,586	-	-	-	-
North Chicago Facility Transfers	-3,016	-	-3,098	-3,098	-3,170	-
Choice Act 801 Transfer	-14,100	-	-	-	-	-
Denver Hospital Transfers	-240			-56,000		56,000
Reimbursements (+)	21,475	-	25,898	40,966	36,936	-4,030
Available Balance SOY (+)	747	-	-	41,000	-	-41,000
Available Balance EOY (-)	-41,000	-	-	-	-	-
PL 113-146 Veterans Choice Act		-	129,500	157,533	-	-157,533
Total Obligations	**$ 2,221,492**	**$ 1,586**	**$ 2,665,163**	**$ 2,693,264**	**$ 2,568,208**	**-$125,056**

1/Numbers do not include reimbursements

Appendix E

Operations and Maintenance Detail

Operations and Maintenance (Sustainment)					
(Dollars in Thousands)					
	2015	2016		2017	2016-2017
	Actuals	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Mandatory Sustainment	**$ 1,896,689**	**$ 1,955,431**	**$ 1,955,431**	**$ 1,822,399**	**$ (133,032)**
Software License Maintenance	$ 437,138	$ 132,500	$ 132,500	$ 373,696	$ 241,196
Telecommunication	$ 259,884	$ 297,161	$ 297,161	$ 297,161	$ -
Enterprise Operations	$ 308,236	$ 369,900	$ 369,900	$ 198,022	$ (171,878)
IT Support Contracts	$ 285,842	$ 376,170	$ 376,170	$ 195,000	$ (181,170)
VistA Evolution	$ 54,180	$ 85,000	$ 85,000	$ 103,774	$ 18,774
Hardware Maintenance	$ 98,204	$ 100,000	$ 100,000	$ 100,000	$ -
Acquisition Fees	$ 104,961	$ 80,000	$ 80,000	$ 88,678	$ 8,678
Veteran Customer Experience (aka VRM)	$ 55,643	$ 98,700	$ 98,700	$ 79,136	$ (19,564)
National Service Desk	$ 52,744	$ 59,000	$ 59,000	$ 67,118	$ 8,118
Interoperability	$ 16,593	$ 15,000	$ 15,000	$ 65,040	$ 50,040
Veterans Benefits Management System (VBMS)	$ 66,893	$ 157,000	$ 157,000	$ 60,000	$ (97,000)
Mobile Technology and Applications	$ 20,366	$ 25,000	$ 25,000	$ 25,000	$ -
Enterprise Voice System (EVS) Program	$ 11,812	$ 20,000	$ 20,000	$ 20,000	$ -
Remediation of Section 508 Compliance	$ 10,970	$ -	$ -	$ 20,000	$ 20,000
Health Provider Systems	$ -	$ -	$ -	$ 14,408	$ 14,408
TeleHealth/Connected Health	$ 8,945	$ 40,000	$ 40,000	$ 13,067	$ (26,933)
Health Administrative Systems	$ -	$ -	$ -	$ 12,240	$ 12,240
Financial Management System	$ -	$ -	$ -	$ 11,964	$ 11,964
Human Capital Corporate Core (includes TMS)	$ -	$ -	$ -	$ 10,428	$ 10,428
Enterprise Architecture Program Execution Support	$ -	$ -	$ -	$ 7,538	$ 7,538
Common Shared Services	$ -	$ -	$ -	$ 5,613	$ 5,613
Product Development Tools (PD Tools)	$ 25,195	$ 5,000	$ 5,000	$ 5,000	$ -
Pharmacy	$ -	$ -	$ -	$ 4,844	$ 4,844
Healthcare Efficiency	$ -	$ -	$ -	$ 4,570	$ 4,570
VLER Health	$ 2,125	$ 10,000	$ 10,000	$ 4,471	$ (5,529)
Chapter 33	$ -	$ -	$ -	$ 4,453	$ 4,453
ASD PPM Health Portfolio	$ -	$ -	$ -	$ 4,434	$ 4,434
Enrollment System Modernization	$ -	$ -	$ -	$ 4,381	$ 4,381
Veteran Service Network (VETSNET)	$ -	$ -	$ -	$ 4,314	$ 4,314
Laboratory	$ -	$ -	$ -	$ 3,226	$ 3,226
Registries	$ -	$ -	$ -	$ 2,323	$ 2,323
Caregiver's	$ -	$ -	$ -	$ 1,838	$ 1,838
Memorial Legacy Development Support	$ -	$ -	$ -	$ 1,824	$ 1,824
VRE	$ -	$ -	$ -	$ 1,790	$ 1,790
General Counsel	$ -	$ -	$ -	$ 1,620	$ 1,620
EA Tools Suite - Licenses and Hosting	$ -	$ -	$ -	$ 1,330	$ 1,330
CWINRS	$ -	$ -	$ -	$ 1,215	$ 1,215
Construction, Financial & Integrated IT Management	$ -	$ -	$ -	$ 1,000	$ 1,000
VHA Legacy Systems	$ -	$ -	$ -	$ 825	$ 825
MCCF (eInsurance)	$ -	$ -	$ -	$ 500	$ 500
Homelessness (Registries)	$ -	$ -	$ -	$ 428	$ 428
Access to Care Registries	$ -	$ -	$ -	$ 130	$ 130
CRISP Removal of the Material Weakness	$ -	$ 39,000	$ 39,000	$ -	$ (39,000)
Guardian Edge and Anti Virus Maintenance	$ -	$ 22,000	$ 22,000	$ -	$ (22,000)
RTLS Hosting	$ -	$ 12,000	$ 12,000	$ -	$ (12,000)
VHA Access to Care	$ -	$ 10,000	$ 10,000	$ -	$ (10,000)
Divesture of Systems/Application	$ -	$ 2,000	$ 2,000	$ -	$ (2,000)
Major Transformation Initiatives (MTI)	$ 76,958	$ -	$ -	$ -	$ -

Operations and Maintenance (Sustainment) Detail Cont.					
(Dollars in Thousands)					
	2015	2016		2017	2016-2017
	Actuals	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Information Security	**$ 209,702**	**$ 179,501**	**$ 179,501**	**$ 370,067**	**$ 190,566**
Cybersecurity Strategy Implementation	$ -	$ -	$ -	$ 125,000	$ 125,000
Security Program (CRISP) Support	$ 70,879	$ 30,160	$ 30,160	$ 64,000	$ 33,840
Cyber Program	$ 53,516	$ 53,061	$ 53,061	$ 52,575	$ (486)
Network Operations Center (NOC)	$ 38,020	$ 45,630	$ 45,630	$ 75,907	$ 30,277
Security Operations Center (SOC)	$ 27,063	$ 24,000	$ 24,000	$ 30,525	$ 6,525
Privacy & Records Management	$ 6,804	$ 10,340	$ 10,340	$ 10,600	$ 260
Business Continuity Support (COOP)	$ 6,373	$ 6,850	$ 6,850	$ 6,900	$ 50
Field Security Services	$ 7,047	$ 5,180	$ 5,180	$ 4,560	$ (620)
Information/ Data Security	$ -	$ 3,900	$ 3,900	$ -	$ (3,900)
Identity, Credential and Access Management (ICAM)	$ -	$ 380	$ 380	$ -	$ (380)
Activations (Equipment and Licenses)	**$ 49,439**	**$ 90,000**	**$ 90,000**	**$ 47,700**	**$ (42,300)**
Critical Infrastructure	**$ -**	**$ -**	**$ -**	**$ 102,178**	**$ 102,178**
Sustaining Infrastructure Program	$ -	$ -	$ -	$ 102,178	$ 102,178
Regular Infrastructure Upgrades	**$ 29,806**	**$ 180,000**	**$ 180,000**	**$ 102,822**	**$ (77,178)**
Enterprise Voice System (EVS) Program	$ 6,789	$ 60,000	$ 60,000	$ 58,366	$ (1,634)
Data Access, Archiving and Disposition	$ -	$ -	$ -	$ 25,000	$ 25,000
National Tapeless Backup Solution (CRISP)	$ -	$ -	$ -	$ 19,456	$ 19,456
Enterprise IT Lifecycle Management (Desktops/Laptops)	$ 1,104	$ 50,000	$ 50,000	$ -	$ (50,000)
Network Lifecycle Hardware Refresh - Includes Servers, Routers & Storage	$ 21,913	$ 50,000	$ 50,000	$ -	$ (50,000)
Section 508 Compliance - Legacy Sys/Apps	$ -	$ 15,000	$ 15,000	$ -	$ (15,000)
RTLS Hosting Expansion	$ -	$ 5,000	$ 5,000	$ -	$ (5,000)

Operations and Maintenance (Sustainment) Detail Cont.					
(Dollars in Thousands)					
	2015	2016		2017	2016-2017
	Actuals	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Marginal Sustainment	**$ 71,517**	**$ 107,931**	**$ 107,931**	**$ 89,276**	$ (18,655)
Veterans Customer Experience (aka VRM)	$ 12,143	$ 15,850	$ 15,850	$ 18,504	$ 2,654
Financial Management System Modernization	$ -	$ -	$ -	$ 9,338	$ 9,338
Health Informatics (Medical Core)	$ -	$ -	$ -	$ 8,288	$ 8,288
VHA Research (Medical Legacy)	$ 1,116	$ 7,340	$ 7,340	$ 8,190	$ 850
VBMS	$ 11,999	$ 30,000	$ 30,000	$ 8,000	$ (22,000)
New Models of Care	$ 1,570	$ 250	$ 250	$ 6,519	$ 6,269
Common Shared Services	$ -	$ -	$ -	$ 5,784	$ 5,784
VLER Health	$ -	$ -	$ -	$ 4,928	$ 4,928
VA Center for Innovation (VACI)	$ 2,003	$ 1,500	$ 1,500	$ 4,000	$ 2,500
Health Provider System	$ -	$ -	$ -	$ 3,905	$ 3,905
Pharmacy	$ -	$ -	$ -	$ 1,928	$ 1,928
Enrollment System Modernization	$ -	$ 5,000	$ 5,000	$ 1,752	$ (3,248)
Chapter 33	$ -	$ -	$ -	$ 1,650	$ 1,650
VistA Evolution	$ 21,611	$ 15,700	$ 15,700	$ 1,000	$ (14,700)
Health Administrative Systems	$ -	$ 1,200	$ 1,200	$ 1,000	$ (200)
Healthcare Efficiency	$ 265	$ 500	$ 500	$ 1,000	$ 500
Mental Health (Medical Legacy)	$ -	$ -	$ -	$ 1,000	$ 1,000
Memorial Development	$ 118	$ 1,496	$ 1,496	$ 862	$ (634)
VHA Research (Medical Core)	$ -	$ -	$ -	$ 742	$ 742
Compensation	$ -	$ -	$ -	$ 260	$ 260
Compensation and Pension Records Interface (CAPRI)	$ -	$ 500	$ 500	$ 250	$ (250)
TeleHealth/Connected Health	$ -	$ -	$ -	$ 250	$ 250
Registries	$ -	$ 3,200	$ 3,200	$ 126	$ (3,074)
Connected Health/TeleHealth Expansion	$ -	$ 5,980	$ 5,980	$ -	$ (5,980)
Standards and Terminology Services (STS)	$ -	$ 5,320	$ 5,320	$ -	$ (5,320)
Access to Care	$ -	$ 3,780	$ 3,780	$ -	$ (3,780)
VETSNET	$ -	$ 3,000	$ 3,000	$ -	$ (3,000)
Mental Health (SPI - VHA 16-4)	$ -	$ 2,270	$ 2,270	$ -	$ (2,270)
Caregiver's Enhancements	$ -	$ 1,750	$ 1,750	$ -	$ (1,750)
Mobile Development - Health Apps	$ -	$ 1,725	$ 1,725	$ -	$ (1,725)
Repository	$ -	$ 1,020	$ 1,020	$ -	$ (1,020)
Homelessness (Registries)	$ -	$ 300	$ 300	$ -	$ (300)
Disability Exam Assessment Program (DEAP)	$ -	$ 250	$ 250	$ -	$ (250)
Human Resources Information System (HRIS)	$ 17,361	$ -	$ -	$ -	$ -
Interoperability	$ 3,331	$ -	$ -	$ -	$ -
GRAND TOTAL	**$ 2,257,154**	**$ 2,512,863**	**$ 2,512,863**	**$ 2,534,442**	**$ 21,579**

Appendix F

Amounts Available for Obligation

Information and Technology Systems Appropriation/Obligations

(Dollars in thousands)

Description	2015 Actuals	2016 Budget Estimate	2016 Current Estimate	2017 Budget Request	2016 - 2017 Increase/ Decrease
IT Systems Appropriation: FY 2015 (P.L. 113-235)	**$3,903,344**	**$4,133,363**	**$4,133,363**	**$4,278,259**	**$144,896**
Rescission	-$1,066				
North Chicago Facility Transfers	-$6,968	-$7,158	-$7,158	-$7,301	-$143
Choice Act 801 Transfer	-$14,100				
Denver Hospital Transfer	-$240		-$75,731		$75,731
Recoveries	$13,360				
OEF/OIF Supplemental (P.L. 110-128)	$2,056				
Total IT Appropriations	**$3,896,386**	**$4,126,205**	**$4,050,474**	**$4,270,958**	**$220,484**
Reimbursements					
IT Non-Pay Reimbursements	$29,043	$30,342	$40,966	$46,436	$5,470
IT Pay Reimbursements	$10,093	$26,495	$22,885	$27,304	$4,419
Total Reimbursements	**$39,136**	**$56,837**	**$63,851**	**$73,740**	**$9,889**
Total Budgetary Resources	**$3,935,522**	**$4,183,042**	**$4,114,325**	**$4,344,697**	**$230,372**
Adjustments to Obligations					
Choice Act 801	$376,600				
Unobligated Choice Act 801 1/	-$308,933		$308,933		-$308,933
Unobligated Balance (SOY):	$166,335	$173,400	$154,300		-$154,300
Unobligated Balance (EOY):	-$154,300				
Change in Unobligated Balance (non-add)	**$79,702**	**$173,400**	**$463,233**		**-$463,233**
Unobligated Balance Expiring (Lapse)	-$2,077				
Total Obligations	**$4,013,147**	**$4,356,442**	**$4,577,558**	**$4,344,697**	**-$232,861**
Outlays, Gross	$3,855,817	$4,264,634	$4,098,348	$4,346,549	$248,201
Less Collections	-$40,185	-$56,837	-$63,851	-$73,740	-$9,889
Outlays, Net	**$3,815,632**	**$4,207,797**	**$4,034,497**	**$4,272,809**	**$238,312**
Direct	7214	7325	7325	7365	40
Direct (P.L 113-146 Veterans Choice Act)	17	192	192	192	
Reimbursable FTE 2/	78	98	114	178	64
Enterprise Operations 3/				599	599
Total Full Time Equivalents (FTE)	**7309**	**7615**	**7631**	**8334**	**703**

1/ This line reflects transfers to North Chicago in FY2015, FY2016 and FY2017.

2/ In FY2016 Budget Estimate, this line represents anticipated carryover for Veterans Access Choice Accountability Act.

3/ In FY2017 this line includes 599 FTE transferred from the Enterprise Operations Franchise Fund.

Appendix G

Obligations by Object Class and Funding Sources

Office of Information and Technology
Obligations by Object Class and Funding Sources
(Dollars in Thousands)

	2015	2016		2017	2016 - 2017
	Actuals	Budget Estimate	Current Estimate	Budget Request	Increase / Decrease
Personal Services	879,598	925,152	964,766	1,057,077	92,311
Travel	7,321	8,998	9,361	10,307	946
Rent, Communications and	847,416	753,643	841,857	844,059	2,201
Printing and Reproduction	18	22	48	56	8
Other Services	1,372,036	2,209,051	2,230,911	1,993,615	-237,296
Supplies and Materials	4,969	17,728	6,744	16,794	10,050
Equipment	890,999	438,771	511,890	410,710	-101,181
Lands and Structures	9,243	2,468	9,890	9,962	72
Other	1,547	610	2,092	2,119	27
Total Obligations	**$4,013,147**	**$4,356,442**	**$4,577,559**	**$4,344,698**	**-232,861**
Funding Sources					
Appropriation	**$3,902,278**	**4,133,363**	**4,133,363**	**4,278,259**	**144,896**
Veterans Choice Act 801	376,600				
Unobligated Choice Act 801 2/	-308,933		308,933		**-308,933**
H1N1 Supplemental (P.L. 111.32)	2				
OEF/OIF Supplemental (P.L. 110-128)	2,055				
Recoveries	13,360				
Transfers 1/	-6,968	-7,158	-7,158	-7,301	-143
Choice Act 801 Transfer	-14,100				
Denver Hospital Transfer	-240		-75,731		75,731
Non-Pay Reimbursements	29,043	30,342	40,966	46,436	5,470
Pay Reimbursements	10,093	26,495	22,885	27,304	4,419
Unobligated expiring	-2,077				
Change in uncollected orders					
Unobligated SOY	166,335	173,400	154,300		-154,300
Unobligated EOY	-154,300				
Public Law 113-146 Veterans					
Total	**$4,013,147**	**$4,356,442**	**$4,577,559**	**$4,344,698**	**-232,861**

Note: Numbers may not add due to rounding.

1/ In FY 2015, $6.9M was transferred from OIT to the North Chicago facility. This line also reflects North Chicago transfers in.
2/ In FY2016, this line represents the actual carryover for Veterans Access Choice Accountability Act (VACAA).

Appendix H

Information Technology Systems Appropriations History
(Dollars in thousands)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriations	FTE
2009	2,442,066	2,492,066	2,471,166	2,539,391 _1/	6,710
2010	3,307,000	3,307,000	3,307,000	3,307,000	6,853
2011	3,307,000	3,222,000	3,147,000	2,993,604_2/	7,004
2012	3,161,376	3,025,000	3,161,376	3,111,376	7,311
2013	3,327,444	3,327,444	3,327,444	3,323,053	7,362
2014	3,683,344	3,683,344	3,703,344	3,703,344	7,291
2015	3,903,344	3,874,344	3,913,344	3,902,278	7,419
2016	4,133,363	4,133,363	4,133,363	4,133,363	7,745
2017	**4,278,259**				8,334_3/

Note: The Information Technology Systems account was established in P.L. 109-114. FTE includes Reimbursements.

1/ Includes $50 million in emergency funding provided in P.L. 111-5.

2/ The 2011 appropriation was $3.141 billion (including ATB rescission) with an additional $147 million in unobligated balances rescinded.

3/FTE includes VACAA FTE funded by the IT Appropriation and FTE transferred from the Enterprise Operations/Franchise Fund.

Appendix I

Office of Information Technology Organization Chart