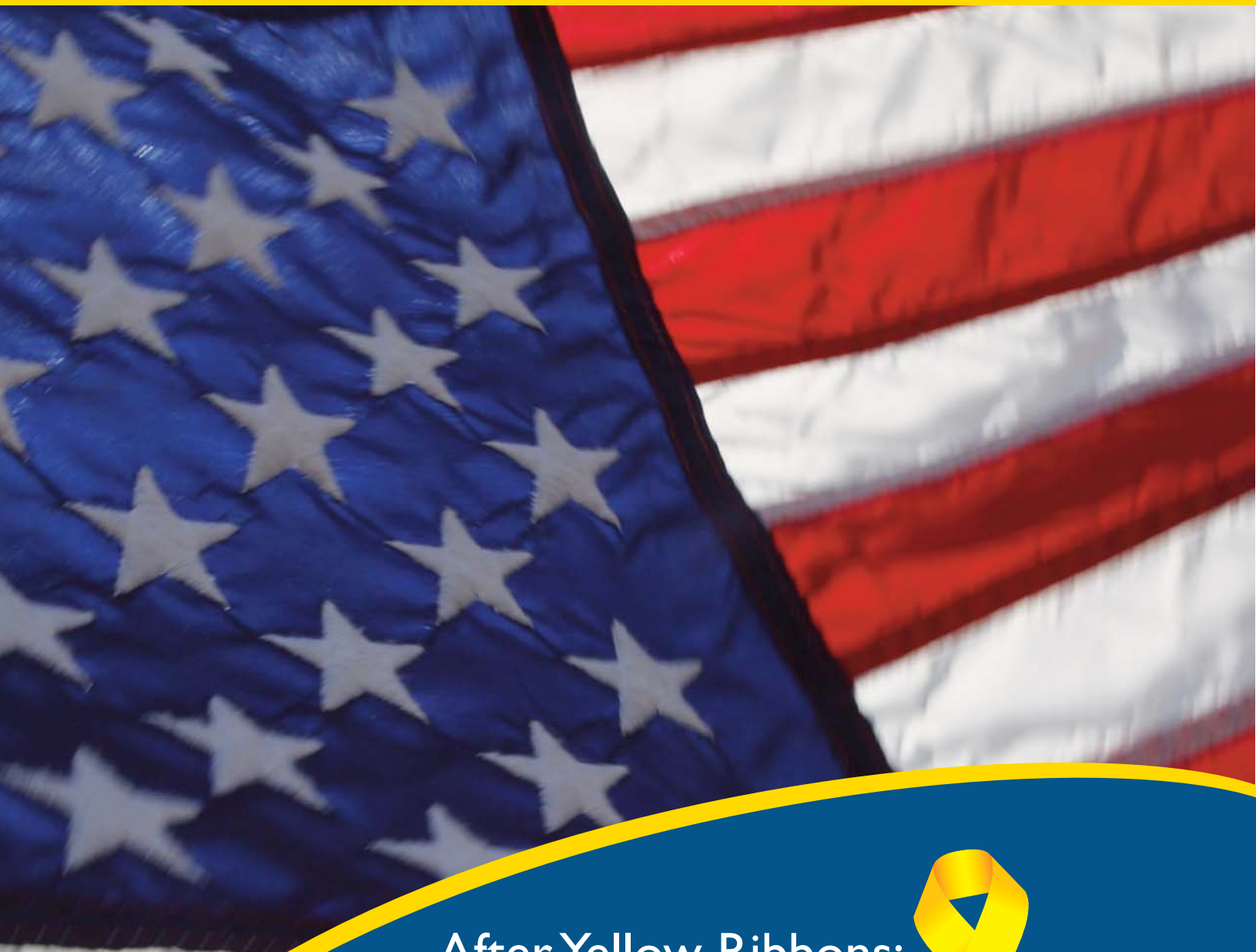


A Report of a Panel of the

# NATIONAL ACADEMY OF PUBLIC ADMINISTRATION

For the U.S. Congress and the U.S. Department of Veterans Affairs



## After Yellow Ribbons: *Providing Veteran-Centered Services*



2008



National Academy of  
Public Administration®

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**October 2008**

# **After Yellow Ribbons: Providing Veteran-Centered Services**

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## FOREWORD

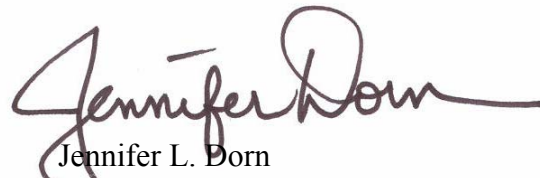
America has long recognized its obligation to those who have served our nation through military service. President Lincoln's expression of this commitment, "to care for him who shall have borne the battle, and for his widow and his orphan," is the founding principle of the Department of Veterans Affairs (VA). Today, of course, our nation continues to extend that commitment to men and women who have steadfastly served, and to the family members whose loved ones lost their lives in service on our behalf.

As the nature of battle changes and battlefield medical care improves, VA and its partners face new challenges. More than 837,000 service members have returned from Iraq and Afghanistan, and they, their families, and the families of those who did not return, have joined the millions of veterans and family members served by VA. Yet, numbers alone do not tell the story. This new group includes those suffering from or at risk for Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury, conditions that may be difficult to detect and slow to emerge.

As part of an effort to help VA improve its service to the new and earlier generation of veterans, Congress asked the National Academy of Public Administration to study the management and organizational challenges facing VA. Over the last several years, a number of distinguished panels, including a Presidential Commission led by former Senator Robert J. Dole and former Secretary of Health and Human Services Donna E. Shalala, have studied a variety of obstacles to prompt service and timely care for veterans and have made dozens of recommendations for improvement. In this report, the National Academy Panel provides practical administrative and management solutions to assist VA in implementing these recommendations and ensuring better outcomes for veterans.

The Report recommends actions to improve service to veterans and sustain a process of continuous improvement that will last beyond the term of any particular Secretary or Administration. They are directed to current VA officials, individuals who will assume responsibility for service to veterans in the next Administration, and members of Congress who must provide the required authority, resources, and oversight. It is the National Academy's intent that the true beneficiaries will be the veterans who have faithfully served their country.

The Academy was honored to undertake this study. I want to thank the Academy Fellows and other members of the Panel for their insights and guidance, as well as VA executives and staff, and many other stakeholders, for their cooperation. Finally, I extend my appreciation to the study team for its work to produce this important report.



Jennifer L. Dorn  
President and Chief Executive

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## EXECUTIVE SUMMARY

This study by a Panel of the National Academy of Public Administration addresses the practical questions of organizational capacity, management strategy, and implementation challenges related to improving the Department of Veterans Affairs (VA) service to veterans, including those returning from Iraq and Afghanistan.<sup>1</sup> The Panel's premise is that care and benefits to veterans can be improved if VA management, organization, coordination, and business practices are transformed with an eye to improving outcomes for veterans, rather than merely striving to improve operational processes within VA. The Panel is convinced that VA must reorient its services to focus on the veteran. To do so, it must sustain a long-term effort to transform the way it approaches and conducts its mission.

Successful achievement of this goal will require:

- I. VA Leadership Commitment to Creating and Maintaining Veteran-Centered Systems** to include, among other things, adoption of a “No Wrong Door” policy to ensure a veteran will receive appropriate and accurate guidance regardless of the point of contact with VA; Integrated Call Centers that are equipped to provide timely and correct responses to veteran queries; user-friendly web sites; and a customer service orientation on the part of VA personnel who deal with the public;
- II. Establishing a Congressionally-Chartered Permanent, Expert, External Advisory Board** to monitor the implementation of the steps necessary to create and maintain such a Veteran-Centered System, and with responsibility to provide regular reports concerning progress and problems to the Secretary of Veterans Affairs, Congress, and the American public;
- III. Developing and Applying Appropriate Performance Metrics** to guide and drive the VA change toward a Veteran-Centered System that provides clear and improved outcomes for veterans;

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<sup>1</sup> The disclosure in early 2007 of major inadequacies in facilities provided to wounded soldiers returning from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) at the Army's Walter Reed Medical Center, as distinguished from the excellent inpatient medical care that was provided there, heightened public and Congressional concern about management of care for the severely wounded. Although the DoD and the Army were responsible for these conditions, VA also accelerated its efforts to improve the system of care and benefits provided to this group and their transition from battlefield to medical facilities to home. Major reviews were undertaken by a series of panels, commissions, and task forces that made dozens of recommendations for changes in VA and DoD policies, practices, procedures, and programs. In May 2007, Congress mandated this independent study by the National Academy of Public Administration of the management and organization of VA, its interagency coordination processes, and its capacity to provide high quality health care and benefits to all veterans, including those of OEF/OIF. The *U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007* (H.R. 2206) authorized: “[a]n independent study [by the National Academy of Public Administration] of the organizational structure, management and coordination processes, including seamless transition, utilized by the Department of Veterans Affairs to provide health care and benefits to active duty personnel and veterans, including [OEF/OIF] veterans.” See also, H. Rep. 110-107, *Making Emergency Supplemental Appropriations for the Fiscal Year Ending September 30, 2007 and for Other Purposes*.

- IV. Improving Methods for Outreach and Improved Access to Care** for veterans, including using technology to provide veterans with personal records, enhancing efforts to coordinate with and assist organizations supporting veterans at state and local level, and greater collaboration in dealing with the existence and consequences of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) in the newest group of veterans; and
- V. Improving Information Technology and Internet Capabilities** to provide veterans with easy access to VA benefit and claims information, to further automate claims records, and to promote communications internally and externally. A central element will be strong Department-wide enterprise architecture with centralized control over the development of applications based on a sound system for identifying and satisfying customer requirements.

The Academy Panel makes numerous specific recommendations to VA. In addition, the Panel recommends actions for other federal agencies, such as the Department of Defense and the Department of Labor, that are instrumental to improving the transition from the military to civilian life. The Panel developed these recommendations on the basis of interviews with 165 individuals, including 98 from VA. (*See Appendix G for a complete listing of the individuals interviewed by organization.*) The study team also analyzed a wide variety of archival sources, professional literature, and congressional testimony. The study team did not conduct primary quantitative data collection. Implementation of the Panel's recommendations will require sustained leadership and an unwavering focus for VA to become a veteran-centered Department. The Secretary must make this veteran-centered approach the driving philosophy of VA, one that permeates every corner of its operations and that defines its interaction with every veteran. VA retains the challenge of serving the Nation's older veterans, but the new generation of veterans returning from the wars in Afghanistan and Iraq present special challenges that will require careful and sustained attention. The Nation owes them nothing less for their service.

The Panel's recommendations for achieving this goal are referred to in this summary, compiled following this summary, and explained in greater detail in the appropriate context in the chapters of this report that follow.

## **BECOMING VETERAN CENTERED**

For a decade, VA has made intermittent efforts to integrate the work of its disparate components, resolve their different ways of performing their functions, and ensure that their focus is on the best possible service to veterans. This goal has been identified as creating "OneVA," a goal that this Panel has adopted and referred to in this report as becoming "veteran-centered." Despite these efforts, and a variety of plans and initiatives, VA's structure and operations do not yet constitute an integrated veteran-centered system, but remain fragmented along administrative and program lines. This fragmentation not only results in inefficiency, but also hampers efforts to improve the lives of veterans and their families. For example:

- A veteran with multiple needs who approaches VA with a single query or need may not be identified as having other needs or entitlements, and thus may not be referred appropriately;
- Veterans with a pending claim do not have access to self-service applications that would allow them to determine a claim's status or the actions needed to move a claim through the system;
- Veterans may be confused regarding where in VA to call with a query or a complaint; and
- Veterans may be provided with incorrect or insufficient information or not be able to contact a call center easily to have their questions answered.

Such experiences unfortunately can lead some veterans to believe that VA is not concerned about their welfare. Several examples are provided in Chapter 2 of this report.

VA has been undergoing many changes in recent years. It now confronts a large and unexpected new mission—caring for the veterans returning from the wars in Afghanistan and Iraq, Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). There is a dual challenge. Some of these new veterans face long recovery from serious wounds that might well have proven fatal in previous wars. Other veterans face the challenges of mental illness associated with combat stress and Traumatic Brain Injury (TBI), brought on by improvised explosive devices, the signature weapon of the Iraqi insurgency. These injuries often emerge over time, present themselves in ways that can be hard to predict and diagnose, and create challenges for the veteran and the veteran's family. The host of new challenges will require VA to maintain a strong, sophisticated, and nimble system of care focused on recovery and reintegration. VA will have to continue to improve what it has been doing well, while at the same time learn new ways of dealing with the unique challenges that the OEF/OIF veterans present.

The Academy Panel recommends a more vigorous and sustained effort to make VA and its operations “veteran centered.” This report presents a vision, strategy, and recommendations for:

- A different way of organizing and delivering services to veterans, building on changes already planned or underway, including organizational and management changes to make VA fully veteran-centered;
- A three part strategy to strengthen the system of care by (1) identifying veterans who may need care, (2) improving access to care, particularly for veterans in remote areas, and (3) building on existing care management tools to increase the likelihood of recovery for all injured veterans; and
- Sustaining a process of continuous organizational improvement, driven by evidence of what works, that will be needed to transform VA's approach to serving veterans.

## **“No Wrong Door”**

Because VA offers so many different benefits and separate programs, there are many points in the organization where a veteran interacts with or enters the VA system. Depending on their specific needs at any given time, veterans may seek educational assistance, file a disability compensation claim, or seek medical care. These programs are managed independently by different VA components that maintain separate, often duplicative, data regarding the veteran and have only limited means for sharing information. A veteran should be able to enter VA at any location or electronic portal and obtain tailored and accurate information, appropriate referrals, and precise answers to queries.

VA should establish a “No Wrong Door” policy: an organization-level commitment to ensure that the veteran, and those acting on his or her behalf, are given accurate information about the issue at hand, informed of other benefits for which they may be eligible, and directed to the appropriate point of contact for more specific information.

Information Technology (IT) is critical to the success of VA’s strategy for becoming veteran-centered. A major precondition for implementing a veteran-centered approach is the automation of paper records and processes. A strong Department-wide enterprise architecture with centralized control over the development of applications is the optimal structure for efficiently building, deploying, and maintaining integrated capabilities that support the veteran-centered model, so long as it is based on a sound system for identifying and satisfying customer requirements.

## **Stronger Public Contacts and External Partnerships**

VA must do a better job of providing basic VA information to veterans who are not currently enrolled with VA and invite them to come learn more. Younger veterans entering the system can generally be presumed to be more comfortable with technology, and to prefer to interact with VA via the Internet. VA does not currently have a policy of collecting or retaining e-mail addresses of veterans who receive, or who are eligible to receive, benefits from the Department. Nor does it typically communicate with veterans by e-mail. The Department must use a variety of technologies and media to target and tailor outreach and public contacts to veterans who have particular needs. The Panel recommends several ways VA can improve its veteran/VA communications capabilities.

Other organizations may be more visible or accessible to some veterans, and veterans or their families may turn first to local or state programs, for example, before approaching a federal agency. Thus, to be truly veteran-centered in delivering service, VA must interact more effectively with many external organizations—including the Department of Defense (DoD) and the military services, other federal departments, state governments (especially their veterans affairs departments), Veteran Service Organizations, TRICARE providers<sup>2</sup>, private medical providers, and private health insurance carriers. VA must identify opportunities to contact

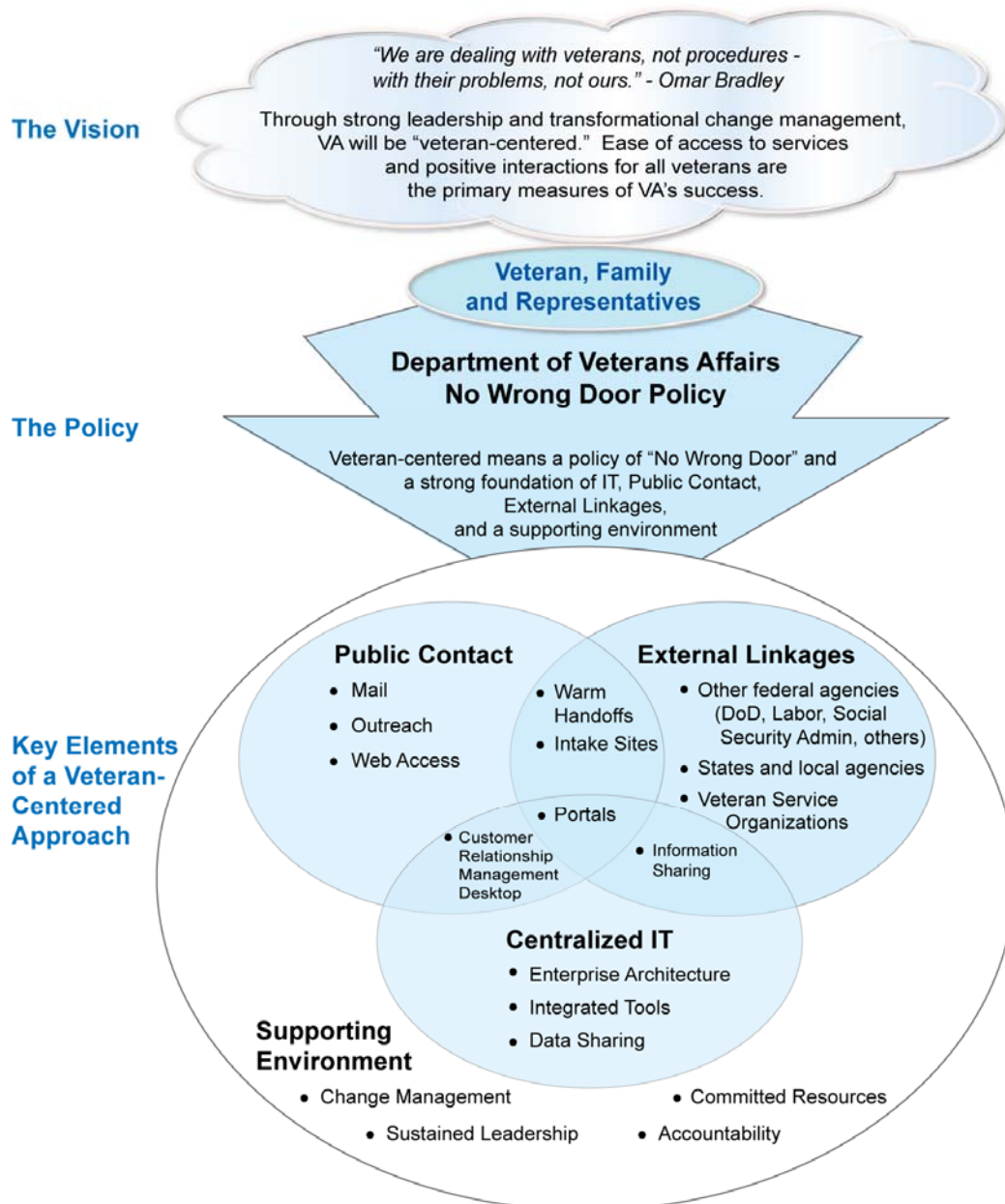
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<sup>2</sup> TRICARE is DoD’s health care program serving active duty service members and, under some circumstances National Guard and Reserve members, and their families.

veterans through all of the organizations with which they are engaged and to encourage these organizations to share basic information about VA benefits with veterans and their families.

In Chapter 2, the Panel recommends that VA undertake several actions to become veteran centered, including providing IT support and strengthening public contacts and partnerships for veteran-centered service. The following figure shows the various components of a veteran-centered approach.

**Figure ES-1. Components of a Veteran-Centered Approach**



Source: A Report of a Panel of the National Academy of Public Administration For the U.S. Congress and the U.S. Department of Veterans Affairs, *After Yellow Ribbons: Providing Veteran-Centered Services*, 2008.

## STRENGTHENING CARE FOR INJURED VETERANS

VA has provided health care to about 325,000 of the over 837,000 OEF/OIF veterans and about 15,000 injured veterans were offered a case manager to assist them in recovery.<sup>3</sup> About 1,200 service members have been classified as severely injured.<sup>4</sup> An undetermined number of OEF/OIF veterans who have not yet received care at VA may be suffering from (or at risk for suffering from) less severe physical injuries or mental illness, such as Post Traumatic Stress Disorder (PTSD)<sup>5</sup> arising from their military service and combat trauma. VA's success in serving all injured veterans will be judged by the extent of their recovery and reintegration into civilian life.

VA's goal should be to develop a continuum of care that has no gaps in service provision, whether in transition from DoD to VA's health care system or in subsequent linkages to care in the veteran's community. Strengthening the continuum of care for veterans who are at-risk of mental or cognitive disorders or are less severely injured, as well as those who are severely injured, will improve outcomes for other veterans who at some point will need VA care. VA can strengthen the system of care for returning veterans by: (1) identifying and contacting sooner those veterans who are at risk for physical or mental illness; (2) ensuring that those in need of care have access to and receive appropriate and high-quality care at the right time and place; and (3) building on existing care management tools to facilitate successful rehabilitation and reintegration of all injured veterans into society and family life.

### Reaching Those At Risk For Mental Illness

Many service members who may need health care now are not seeking care. The effect of deferring treatment, however, may be to require more aggressive treatment in the future. Various estimates suggest that anywhere from 12 to 20 percent of combat veterans may experience PTSD.<sup>6</sup> VA reports that it has provided care to about 134,000 OEF/OIF veterans (16 percent) who were diagnosed with mental disorders, including PTSD.<sup>7</sup> The process of identifying and treating veterans who are at risk for mental illness is challenging but extremely important in preventing the adverse consequences of untreated mental illness, including family violence, suicide, and loss of the ability to work.

Several gaps exist with respect to identifying service members who are at risk. For example, hundreds of thousands of service members were discharged before DoD implemented a Post-

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<sup>3</sup> Department of Veterans Affairs, *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008, p. 1.

<sup>4</sup> VA technical comments.

<sup>5</sup> PTSD symptoms include: (1) re-experiencing the traumatic event, (2) avoidance of anything associated with the trauma and numbing of emotions, (3) hyper-arousal, such as difficulty sleeping and concentrating and irritability. See Institute of Medicine, *PTSD Compensation and Military Service*, Washington, D.C., The National Academies Press, 2007.

<sup>6</sup> Department of Veterans Affairs, National Center for PTSD, *Fact Sheet: How Common is PTSD?*, February 27, 2008. p. 2.

<sup>7</sup> Department of Veterans Affairs, *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008, p. 15.



Deployment Health Reassessment (PDHRA), which is conducted 90 to 180 days after a service member returns from combat to identify health concerns—including mental health—that may arise after completing a combat tour. Other service members who received a PDHRA may have been referred to VA for treatment, but DoD is not sharing complete referral information with VA because of concerns about privacy. Finally, the PDHRA relies on service members to answer health-related questions and disparities exist in referral rates for care depending on the method DoD uses to evaluate service members' answers to these questions. Because of concerns about the stigma associated with mental illness, some veterans are not willing to report symptoms. VA has recognized that without a concerted effort to reduce the stigma associated with mental illness, service members and veterans will continue to underreport mental illness symptoms and choose not to seek care. As a result, VA has launched initiatives to address the stigma barrier.

However, the Academy Panel believes VA, working with DoD, must do more to identify those at risk, and the Panel recommends specific actions for accomplishing this in Chapter 3.

### **Improving Access to Mental Health Care**

Mental illness and cognitive disorders often go undiagnosed and untreated in the returning veteran population, with serious or fatal consequences. To improve access by those experiencing or at-risk of mental illness, VA has: (1) hired additional mental health staff and is expanding its use of contract providers; (2) increased the number of Vet Centers, which provide counseling for veterans' psychological and social readjustment issues, from 209 to 225;<sup>8</sup> (3) trained its providers as well as those in DoD on certain evidenced-based therapies for PTSD; and (4) used information and communications technology to deliver services. In July 2008, VA announced its plan to spend \$20 million to build 39 additional Vet Centers, 21 in counties that do not currently have one.<sup>9</sup> VA also continues to expand its web-based telehealth and telemental health programs.

It is unreasonable to expect that VA can be the single source of care for all OEF/OIF veterans, in part because many veterans do not live near a VA facility.<sup>10</sup> State and community mental health providers say they recognize their responsibility in serving veterans and would appreciate a more collaborative partnership with the VA in treating veterans.<sup>11</sup> VA can collaborate more closely with state and local providers in establishing effective referral and information sharing arrangements. New legislation and data sharing arrangements between VA and some states provide the rudimentary foundation for a broader set of referral systems. Achieving the goal of developing a nationwide sharing strategy is enormously complex.

As part of that effort, the Panel recommends, in Chapter 3, that VA take a series of actions to improve referral and access to care.

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<sup>8</sup> Vet Center data accessed at [www.vetcenter.va.gov](http://www.vetcenter.va.gov), updated September 10, 2008.

<sup>9</sup> Department of Veterans Affairs, Public and Intergovernmental Affairs, *VA Vet Centers Coming to 39 Communities*, July 9, 2008.

<sup>10</sup> RAND Corporation, *Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, CA, 2008, p. 302.

<sup>11</sup> Interviews with state mental health directors.

## **Veteran-Centered Care Management, Recovery, and Reintegration**

A fully developed veteran-centered strategy for effective, integrated care is one that focuses on the needs of the injured veteran; ensures access to and provision of timely, effective treatment; provides a means for identifying service or care providers in proximity to the veteran's community; and provides a tool for the veteran and his/her providers to monitor relative progress in treatment and recovery and reintegration into civilian life.<sup>12</sup>

VHA has created new positions that can support such a strategy for managing clinical and non-clinical care. In October 2007, VA established another new position, the Federal Recovery Coordinator with responsibility for coordinating care management for the severely injured. VA and its partners have developed two other key building blocks for a strategy to improve the management of care: (1) the Federal Individual Recovery Plan for the severely injured; and (2) MyHealtheVet, a web-based tool which enables veterans to create, view, and maintain a personal health record. These tools, with modifications, can be used to strengthen care management and aid recovery for a broader group of returning OEF/OIF veterans.

The Federal Individual Recovery Plan, a prototype of which is now being used by the Federal Recovery Coordinators, can be a patient-centered planning tool used to identify and track short- and long-term expected outcomes for recovery of health and for reintegration to civilian life. A Federal Individual Recovery Plan allows multiple care providers, the veteran, and the family to define objectives and goals, track current status, chart progress over time, and re-evaluate and modify the recovery plan as needed.

MyHealtheVet is an online portal that enables the veteran to create, view, and maintain a personal health record. The veteran can use it to access evidence-based health education information; visit 'healthy living centers' and other condition-specific centers of information; keep health journals and e-logs; track and graph metrics like weight, blood pressure, and blood glucose; and maintain a wellness calendar. The "My Recovery Plan" component of MyHealtheVet is in design, with implementation planned for 2009.<sup>13</sup> MyHealtheVet has great potential as a tool for establishing a more collaborative, veteran-centered system of care.

The Panel recommends, in Chapter 3, that VA build on existing care management tools to improve its system of care for less severely injured veterans.

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<sup>12</sup> This concept is similar to models for "patient-centered" care delivery, which have been under development for some time in the health care community. Patient-centeredness refers to "health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care." See Institute of Medicine, *Envisioning a National Health Care Quality Report*, 2001, as referenced in Center for Policy Studies in Family Medicine and Primary Care, Robert Graham Center, *The Patient Centered Medical Home, History, Seven Core Features, Evidence and Transformational Change*, November 2007, p. 3.

<sup>13</sup> Nazi, K.M., *My HealtheVet Personal Health Record Overview*, Department of Veterans Affairs, Veterans Health Administration, Office of Information, July 2008, p. 54.

## STRATEGY FOR CONTINUOUS IMPROVEMENT

VA and its partners face a very large and complex organizational and management challenge in improving care and benefits for veterans. To succeed in making the many related changes proposed in this report and other improvements, the Academy Panel believes VA and its partners must pursue a broader systematic organizational strategy of continuous improvement over a period of years. This will involve a series of successive and coordinated evidence-driven changes in the administration of services and benefits.

For the change to be sustained and successful, VA's top leadership must drive it, support it, and manage it centrally, with clear accountability by all for specific results under their control and a continuous focus on how their work contributes to better outcomes for returning veterans. In addition, a Congressionally chartered external Advisory Board of experts should be created to monitor VA's actions in establishing such a Veteran-Centered System and provide regular reports concerning progress and problems to the Secretary of Veterans Affairs, Congress, and the American public.

The change strategy must be guided by a clear vision, translated into specific performance goals and targets for achievement. At the highest level, the goal is to transform VA into a veteran-centered organization that produces better service to and outcomes for the current group of returning veterans and for other generations of veterans.

The Panel does not believe that addressing these challenges will require a major reorganization of roles and responsibilities within VA or between VA and DoD. It will require, however, creative leaders and managers, with sufficient authority and control over resources to manage the change process over an indefinite period. It will require generalizing the existing evidence-based learning capacity in the Veterans Health Administration, to enable the entire Department to learn continually from experience and adjust service strategies when, for example, evaluation identifies new, cost-effective means of targeted outreach or new scientific understanding emerges of how to diagnose and treat specific illnesses and injuries.

Fortunately, VA has in its own recent experience a model of successful change that includes the elements needed for sustained organizational improvement. The Veterans Health Administration reorganization of the last decade demonstrates that VA can manage large-scale change successfully.<sup>14</sup>

To be fully successful, the performance framework for improving service to veterans must encompass both benefits and health care. The framework that VA and its partners require in order to drive and manage successful change would:

- Establish goals for improved outcomes for each major category of veteran, including access to appropriate care and assistance, health and recovery, employment and earnings, and quality of life;

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<sup>14</sup> Phillip Longman, 2007. *Best Care Anywhere: Why VA Health Care is Better Than Yours*. PoliPoint Press.

- Provide VA and its partners with a common strategy for achieving improved outcomes by identifying actions that build on existing assets and deploy them more effectively;
- Design and apply new performance measures, supported by data collection, analysis, and reporting infrastructure, based on baseline performance levels and including interim and long-term improvement targets;
- Establish joint administrative responsibilities for performance measurement, including data quality and reliability, related to transitions from active service to veteran status;
- Develop new program measures for health and quality of life outcomes for veterans in recovery in order to assess program effectiveness and guide improvement;
- Establish baselines against which to judge progress and provide regular feedback on results to those working to improve outcomes;
- Support controlled trials of changes to critical treatment and services, including disability benefits, as they are introduced and use the results of these trials to guide decisions about program design; and
- Link information on results to program management, personnel ratings and rewards, program redesign, and policy and budget development.

Divided or disconnected management functions—between the Veterans Health Administration and Veterans Benefits Administration in VA, or between DoD and VA at different stages of the transition from active service to veteran status—create coordination problems that may impair effective service to the veteran. Where activities are managed by a cluster of people with overlapping roles and responsibilities to different organizations, as appears to be the case with care for the severely wounded, there is more potential for confusion and conflict. Sorting out proper roles and relationships for managing continuing improvement will require both coordination across congressional committees and close collaboration between DoD and VA and between the Veterans Health Administration and Veterans Benefits Administration within VA.

### **Actions to Support Continuous Improvement**

Effective transformation of VA to a veteran-centered department will require revision of the Department’s performance plans to focus on efforts which promote this objective and which measure veterans’ satisfaction with their encounters with VA. These measures must be valued as importantly as current “process goals.” A performance-driven management structure and philosophy can be supported by specific techniques that VA and its partners should use to drive continuous improvement in outcomes for veterans.

Successful change also will require sustaining and deepening the newly energized partnership between VA and DoD. It is too soon to judge how successful the recently increased level of cooperation between the two Departments will be in improving service member transitions to recovery and reintegration. Despite the high level of effort since Walter Reed, most initiatives are in the pilot stage. Specific steps must be taken by VA, DoD, and others to support this partnership as it evolves from high-level planning of pilot initiatives to broader sustained

operational cooperation that will ensure seamless transition and effective delivery of care and services to all veterans.

The Panel recommends VA take a series of actions in Chapter 4 to support actions to achieve a veteran-centered VA and strengthen VA's partnerships with DoD. Success in becoming veteran centered ultimately will be measured in terms of improved outcomes for veterans, including those returning from Iraq and Afghanistan. For the latter, VA and DoD have stated that their joint goal is to support the fullest possible recovery and reintegration of returning warriors. These outcomes must be measured in concrete terms, as described in this report. The first step by leadership to ensure success is to demand that all eyes, at all levels in the responsible organizations, are fixed on the goal of providing veteran-centered services.

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## COMPILATION OF RECOMMENDATIONS

All of the Panel's recommendations appearing in this report are included below and organized according to the five major components of change that are identified at the beginning of the Executive Summary.

The first number in each recommendation corresponds to the chapter in which the recommendation appears and where the context and further explanation can be found. The second number identifies the order in which the recommendations appear within the chapters.

### I. VA LEADERSHIP COMMITMENT TO CREATING AND MAINTAINING VETERAN-CENTERED SYSTEMS

**2-17. VA should update and implement OneVA plans and other documentation identifying requirements for tools and capabilities encompassed by the OneVA concept. The specific initiatives addressed in those plans should establish goals and timelines for the OneVA tools, outreach initiatives, building strong relationships with external organizations, and other emerging issues that support a veteran-centered approach. The plans should clearly articulate performance goals and metrics at all levels of the organization and demonstrate the commitment of senior leadership by:**

- **Emphasizing that this change is necessary and needed *now*, particularly given the anticipated surge of new OEF/OIF veterans in the coming years;**
- **Sponsoring the change at the Secretary's level and creating a cross-Administration team of change agents;**
- **Communicating the need for change to all sectors of VA, making the compelling case personal and relevant;**
- **Developing and implementing transformational change plans with timelines and goals;**
- **Creating accountability for demonstrating results by using incentives and penalties; and**
- **Sustaining the effort for the long term by continuing to commit resources, leadership, and require accountability until the change becomes the new status quo.**

**3-9. VA should pilot the use of recovery and reintegration plans for the less severely injured and those OEF/OIF veterans who are receiving case management services. In doing so, VA should:**

- **Identify which of the 20 elements currently included in the federal individualized recovery plans for the severely injured may be appropriate to use for the less**

severely injured, and whether other elements, for example those related to recovery from PTSD, are appropriate.

- **Pilot and evaluate the use of these elements in a recovery and reintegration plans for the less severely injured and/or those OEF/OIF veterans who are receiving case management services. The evaluation should also include an assessment of the types of services provided by different case managers within VA and DoD.**
- **Assign OEF/OIF program managers to serve as focal points for overseeing the recovery and reintegration plans.**

**4-1. VA should create a new performance-driven culture and management style to transform VA into a veteran-centered organization.**

**4-2. VA, the President, and Congress should provide leadership and a continuing commitment to achieving a veteran-centered department.**

- **the Secretary of VA should be held accountable for sustaining a commitment to achieving a veteran-centered department.**

Examples of actions to demonstrate commitment by the Secretary include:

- Creation of joint project teams across the VA Administrations;
- Identification of business leaders to direct the teams;
- Commitment of resources;
- Setting timelines with milestones and goals;
- Clear performance metrics and targets at all levels of the organization; and
- Accountability for goal achievement, including penalties for non-performance and rewards for progress.

- **OMB should require that VA's budget submission and performance reports document its progress toward achieving a veteran-centered department; and**
- **Congress should hold oversight hearings to examine the department's progress in achieving objectives designed to accomplish a veteran-centered VA.**

**4-3. The Secretary should establish a new Office for Veteran-Centered Change Leadership for coordinating change leadership. The new office should include a small analytical and monitoring staff and be led by a new senior executive officer who shall report directly to the Secretary.**

The Office for Veteran-Centered Change would be responsible for advising the Secretary on how to implement and sustain an overall strategy and specific changes to transform the VA into a veteran-centered service organization and to ensure timely, appropriate, effective treatment and benefits for veterans in need. The office would monitor progress and report to the Secretary, Congress, and the public on measures of effectiveness, including improved outcomes. It would advise the VA Undersecretaries for Health and Benefits and the Chief Information Officer on how they should prioritize and coordinate their efforts to ensure these improvements. The head of the office would continuously



advise the Secretary on how to improve service to veterans based on rigorous evaluation of elements of the change strategy and demonstrating what works and is cost-effective.

**4-8. VA should promote continuous learning for improving services to veterans that is research-driven and evidence-based.**

As previously noted, a model for this exists in Veterans Health Administration's Quality Enhancement Research Initiative process and performance metrics, and in its Performance Measurement Development and Life Cycle process. Using a similar research and testing approach, the Department's strategy for improving services to returning veterans would be modified as new evidence becomes available on more cost-effective ways to achieve better outcomes for veterans. As the organization learns from systematic evaluation of what works and is cost-effective, the more detailed versions of a Strategy Map like that shown in Figure 4-1, used to model and guide the change, would be revised to reflect this learning.

**4-9. Congress, DoD, and VA should take steps to strengthen DoD/VA collaboration using the lessons learned from the Senior Oversight Committee (SOC) process.**

Congress' role is to ensure that interdepartmental collaboration continues to be productive, even as senior level involvement becomes less frequent. Without waiting for Congress, however, it is important that VA formalize policy level agreements between DoD and VA and further institutionalize joint collaborative mechanisms. Lessons learned in the SOC process form the focus for institutionalization of a permanent productive partnership on issues of transition. Critical steps for VA include working collaboratively with DoD to:

- Explicitly integrate the mission and work of the SOC into the plans and structure of the Joint Executive Council (JEC) by designating a separate subgroup with a charter to improve transitions and service to returning veterans and reorganizing the JEC process to eliminate overlap in the jurisdiction of the Health Executive Council and Benefits Executive Council; and
- Pursue means for endorsing and monitoring specific objectives for DoD/VA collaboration at the most senior levels of the Executive Branch, possibly in the form of a new Executive Order that provides a framework for joint responsibility for certain outcomes.

**II. ESTABLISHING A CONGRESSIONALLY-CHARTERED PERMANENT, EXPERT, EXTERNAL ADVISORY BOARD**

**4-4. Congress should establish a new permanent, expert, external advisory board on veteran-centered change and require periodic reports on the progress in achieving veteran-centered service.**

This board would advise the Secretary and report to the public and Congress on administrative changes that would support veteran-centered service and improved care and benefits for veterans. It would include members with expertise in: (1) service delivery, especially those services using the internet creatively; (2) marketing (how to reach and spark the interest of new veterans); (3) healthcare delivery (especially those in integrated systems and mental health care systems); and (4) needs of veterans and Veteran Service Organizations. This Advisory Board would have access to VA staff with expertise in veterans' benefits and programs.

### III. DEVELOPING AND APPLYING APPROPRIATE PERFORMANCE METRICS

**2-18. VA should develop annual and long-term targets and associated service measures and intermediate outcomes to track VA's success in improving services to veterans. The measurement system should encompass: (1) building integrated information systems to facilitate service delivery and information; (2) improving public contact and outreach to veterans; and (3) forming linkages with non-VA partners. VA should also develop measures to assess progress in implementing organizational change.**

Examples of specific metrics that could be developed in each category are:

#### *Build Integrated Information Technology System*

- **Develop process measures and targets for:**
  - Percentage of claims processed electronically,
  - Percentage completion against timeline for update of Veterans On-Line Application, (VONAPP), Contact Management (CM), and Registration and Eligibility (RE) projects
  - Percentage of IT business planning documents that explicitly link to OneVA goals

#### *Public contact and outreach*

- **Develop process measures and targets for:**
  - Percentage of inquiries handled through e-mail
  - Number of new communication channels, including e-mail, web 2.0, partnering with other agencies
  - Number of contact lists by characteristics of interest (e.g., female, amputees, rural)
- **Develop service-related measures and targets for:**
  - Percent of veterans with electronic access to determine the status of their disability claim
  - Number of contacts needed to resolve a claim/issue

- Number of days to respond to inquiries/resolve claim
- Accuracy rate for inquiries and disability claims

*External linkages with non-VA partners*

- **Develop measures and targets for:**

- Number of outreach Memorandum of Agreements (MOAs) with other agencies (e.g., Department of Labor (DoL), Small Business Administration (SBA) and organizations
- Number of joint outreach opportunities identified
- Number of joint outreach efforts engaged in (e.g., job fairs)

**3-11. VA should revise the evaluation strategy for the new Federal Recovery Coordinator Program for the severely injured to include an element regarding the nature of Federal Recovery Coordinators' contacts with other case managers.**

**3-12. VA should develop an evaluation strategy, before implementing “best practices” in care management, to measure the impacts of care management on care quality and on recovery outcomes for veterans.**

**3-13. VA should develop new annual and long-term targets and associated service and intermediate outcome-based performance metrics to track VA's success in developing a continuum of care. This includes identifying and treating at-risk veterans, increasing access to services, improving the care management system, and ultimately improving the quality of life of veterans through rehabilitation and reintegration into society. In implementing this recommendation, VA should:**

- **Develop a set of service-related measures and targets.**

Examples of such measures are:

- Numbers of veterans who have been screened for Post Traumatic Stress Disorder, mental illness, and mild Traumatic Brain Injury (TBI), compared to estimates of at-risk population;
- Number of Post-Deployment Health Reassessment (PDHRA) referrals to VA care facilities, including Vet Centers;
- Outcomes that result from PDHRA referrals;
- Percentage of referred patients seeking mental health care from VA facilities or Vet Centers (rate of follow up);
- Percentage of those who opt to auto-enroll with VA at the time of the PDHRA;
- Percentage of PDHRA referrals provided to VA within 15 days of screening;
- Percent of veterans who report not seeking care due to stigma-related reasons;
- Proportion of wounded OEF/OIF veterans with an online reintegration plan;
- Number of state and community health providers trained on best practices in care for veteran-specific issues;

- Number of state and community health providers who report they are qualified to treat combat-related depression, mental illness and mild TBI; and
  - Number of referrals to VA health care from state and community services.
- **Develop intermediate outcome measures and targets that focus on the veteran’s rehabilitation and reintegration into society.**

Examples of intermediate outcome measures include:

- Proportion of at-risk veterans who receive appropriate, timely treatment;
- Proportion of at-risk veterans who report high levels of customer satisfaction with the care they have received;
- Percentage of injured veterans in need of community-based rehabilitation and support services receiving such services;
- Proportion of veterans and their families using the online web portal for benefits and health care tracking;
- Proportion of severely injured veterans who met Federal Individualized Recovery Plan short- and long-term goals.

**4-5. VA should develop and use new performance metrics to monitor progress and drive change. These measures should reflect a balance of perspectives consistent with an overall strategy to improve outcomes for veterans. They also should include direct measures of the extent of recovery and reintegration by returning veterans, consistent with the goals of the joint VA/DoD effort to improve these outcomes.**

Specific proposed metrics are included in the illustrative Balanced Scorecard in Figure 4-2. A scorecard similar to this can be used by senior managers of the change to assess in the short term whether it is on track and whether it is likely to produce long-term outcomes consistent with the aims of the transformation, such as those listed in the Strategy Map (Figure 4-1).

Such instruments are “balanced” in the sense that they look at the process of change from differing perspectives, including that of an internal manager; of the customer, i.e., veteran; of those responsible for promoting organizational learning and employee growth; and of the financial manager. As with the Strategy Map, VA leadership will determine how best to measure progress and what targets to set for change in a given year, consistent with resource levels and other environmental factors.

**4-6. VA should link new performance metrics to employee rewards and recognition for both individual and team performance in achievement of organizational results.** These results would include progress on the metrics identified in the Balanced Scorecard and other measures of improved service appropriate to each program and level of responsibility.

Some of the federal government’s merit system processes do not effectively support excellence, flexibility, urgency, and clarity of mission. VA is conducting a limited pay-

for-performance pilot, and its experience may help to inform a broader application of modern merit principles to its system for rating and rewards.

**4-10. DoD and VA should adopt a joint VA/DoD scorecard and revise targets in the Joint Executive Council (JEC) Strategic Plan. The two Departments should cement their joint responsibility for the results of the VA/DoD partnership to improve service member to veteran transitions by jointly adopting a set of goals and performance targets to guide the change.** One such instrument is the illustrative balanced scorecard for VA discussed earlier. Another approach is to incorporate goals and performance targets in the JEC Strategic Plan. Specific steps for VA to pursue with DoD include:

- Adopting a joint balanced scorecard with specific short-term and long-term performance targets for improved service to transitioning injured and non-injured service members and veterans; and
- Incorporating quantitative targets for improved short-term and long-term outcomes related to the goals of recovery and reintegration of returning veterans in the JEC Strategic Plan, in place of or in addition to the current activity milestones.

#### **IV. IMPROVING METHODS FOR OUTREACH AND IMPROVED ACCESS TO CARE**

**2-11. VA should develop, expand, and employ e-mail communication channels with veterans as quickly as possible. E-mail addresses should be routinely collected and centrally maintained.** The VA is missing this critical link with veterans by not using e-mail as an outreach mechanism. E-mail is considerably more cost-effective than traditional mail as a distribution medium. It is also faster and more reliable for reaching particularly mobile groups in the veteran population.

**2-12. VA should develop a VA-wide outreach strategy and action plan.** This outreach plan would:

- Describe the placement of coordinated outreach within the Department, including lines of communications to VA program offices;
- Identify the relevant target audiences and challenges involved in reaching each audience;
- Specify the methods and procedures that will be adopted to overcome those challenges;
- Use a multi-method approach to sharing information, including such channels as e-mail and Web 2.0 technologies for two-way communication, and television, radio, and print media for one-way outreach; and
- Set forth the timing and sequencing of routine and general information communications.

**2-13. VA should develop targeted outreach efforts to groups of veterans that are at greater risk of not receiving thorough, timely information about their benefits.**

These groups include:

- National Guard and Reserve members, who often miss information about programs to assist them during their intensive demobilization process;
- Those with PTSD, TBI, amputees, burn survivors;
- Female veterans;
- Family members;
- Caregivers;
- Surviving spouses and parents;
- Those at risk for PTSD, mental disorders, or experiencing TBI; and
- Others who may need specialized information.

**To better serve these groups, VA should develop:**

- 1. Mechanisms, especially IT tools, for maintaining accurate contact information for group members; and**
- 2. Specific messaging, tailored to the potential needs of each group, conveying information about whom to contact within the VA to learn more about accessing services.**

**2-14. VA should expand partnership opportunities with federal and state agencies and the media to provide outreach mechanisms. VA should employ multiple outreach mechanisms to increase both the depth and breadth of its network for providing service to veterans. This would include:**

- Increasing its participation with other federal and state agencies in state job fairs;
- Coordinating efforts with Department of Labor (DoL) to leverage its existing network of CareerOneStop opportunities as a mechanism to reach out to veterans in local communities and assist with a range of benefits, including employment assistance and filing claims; and
- Making better use of the media to convey basic information and invite veterans to contact the VA.

**2-15. VA should develop and implement an outreach plan for the Post-9/11 Veterans Education Assistance Act of 2008.**

When the educational benefits in this Act become effective in August 2009, VA will have to act aggressively to improve outreach and coordination with educational institutions

utilizing call centers, computer technology and the deployment of a cadre of trained staff specialists. The expanded educational benefit differs from the existing program in that it would pay variable tuition expenses and subsistence allowances based upon individual state public state school charges and regional cost of living indexes. In addition, the amount of assistance to be paid would vary depending on status, length, and type of service. There are also provisions allowing the Secretary to enter into certain arrangements with private institutions of higher learning. Obtaining and verifying necessary information to permit correct payments to veterans and to schools will be a complex and difficult task exacerbated by time constraints and the estimated 600,000 veterans who are expected to enroll. Expectations with respect to the benefits provided by the new GI Bill will be high and delays in responding to enrollment requests or errors in adjudicating the correct amount of assistance could generate vocal and widespread dissatisfaction by veterans.

Increased use of technology together with trained staff specialists will enable VA to:

- Identify, contact, and assist veterans in understanding and pursuing the new rules and provisions;
- Formulate, with inputs from educational institutions and associations, a coordinated approach to explaining and managing such benefits; and
- Maintain a capability to identify and address problems veterans may be experiencing, and continually take steps to improve service.

**2-16. VA should identify opportunities to contact veterans through other agencies, such as the Department of Labor (DoL) and the Small Business Administration (SBA), and provide sufficient training to representatives of those agencies to enable them to share basic information about VA benefits with veterans.** In addition to assisting veterans with job placement through the DoL's CareerOneStop, VA should ask DoL career center personnel to share basic information with veterans about how to contact VA. In addition, VA should give DoL, the SBA, and other agencies that work with veterans a brief set of scripted questions that can be used to direct the veteran to the appropriate door within VA.

**3-1. In collaboration with DoD, VA should develop a strategy for screening OEF/OIF veterans who have not received DoD's Post-Deployment Health Reassessment or an equivalent screening. This strategy should include:**

- Working with DoD to obtain a list of the over 400,000 veterans who were discharged before the PDHRA program was implemented;
- Identifying which of these veterans has not been seen by VA and their geographic location;
- Developing specific protocols for Veterans Integrated Service Network (VISN) directors to work with state Directors of Veterans Affairs and Mental Health Directors to identify cost-effective options for implementing screening programs

for these veterans. Priority should be given to geographic areas with large concentrations of veterans who have been discharged before January 2006, the implementation date for PDHRAs;

- Requiring VISN directors to develop actions plans and associated implementation timeframes for this screening; and
  - Holding VISN directors accountable for sufficient attempts at contacting those veterans who have not been screened.
- 3-2. VA should request that DoD provide an option for those service members, including National Guard and Reserve, who are demobilized after a combat tour, to enroll in VA health care as part of the PDHRA program.
- 3-3. VA should revise VA's health care enrollment form to include veteran-controlled authorization for VA to share appointment and medical information with specific family members or other persons.
- 3-4. VA should educate family members about the importance of such authorization so that they may play an active role in the veteran's recovery.
- 3-5. VA should pursue efforts to obtain PDHRA results from DoD for all referrals made to VA in a timely manner and in computable electronic format, so that they are available for review prior to the veteran visiting a VA facility. In the absence of progress by December 2008, VA should consider proposing a legislative remedy.
- 3-6. VA should apply the lessons learned from its delivery of evidence-based mental health training and coordinate with DoD's new Center for Psychological Health to:
- Develop a strategy for providing training to state and community providers to increase their capability to treat veterans effectively for combat-related mental illness, including PTSD, depression, and mild TBI. Providers trained through this program should be required to meet VA-specified quality standards for mental health care, and adhere to VA's performance standards; and
  - Use existing data to identify geographic concentrations of returning veterans and areas underserved by mental health providers, based on geographic locations of VA facilities and areas not included in Project Hero, and identify risk areas that should receive priority service. In these areas, VA should work closely with State Directors of Veterans Affairs and Directors of Mental Health to develop approaches and implementation plans for delivering training on evidence-based therapies for PTSD, depression, and TBI to state and community health care providers.
- 3-7. VA should identify best practices, pilot, and evaluate existing informal partnerships between VHA and community and state providers for health care referral and data sharing, consistent with Health Insurance Portability and Accountability Act requirements.



- 3-8. VA should pilot best practices and evaluate collaborative partnerships with state and local community providers to identify the most effective and efficient (1) treatment referral methods and (2) data exchanges for transferring relevant medical information needed for treatment, when authorized by the veteran.**
- 3-10. VA should initiate steps to strengthen the reach of VA’s MyHealtheVet web portal and:**
- **Increase access by developing an online authentication process. Until this on-line capability is available, VA should increase the number of sites at which in-person authentication process is provided, including Vet Centers and VBA Regional Offices.**
  - **Re-evaluate priorities for future information technology application releases, particularly the “Delegation” function, given its importance in facilitating sharing across non-VA providers and allowing family members to access a veteran’s Personal Health Record and reintegration and recovery plans.**
  - **Use MyHealtheVet to provide (1) easy-to-access evidence-based information on mental illness and conditions particular to returning veterans and their families; (2) actionable steps for users who access the anonymous screening capability, including direct links to VA and non-VA mental health care providers in close proximity to the veteran and the family; and (3) online capability for “web chat” support sessions with trained professionals and other veterans, available to both the veteran and family.**
  - **Incorporate the lessons learned from the recovery and reintegration plan pilot into the development of the “My Recovery Plan” component of the MyHealtheVet portal system.**
  - **Promote MyHealtheVet, particularly the mental health and substance use screening applications, to all veterans in multiple settings, including state and local community providers.**

## **V. IMPROVING INFORMATION TECHNOLOGY AND INTERNET CAPABILITIES**

- 2-1. VA should accelerate the migration to electronic records for claims processing and create a greater sense of urgency, specific target dates for migration, accountability mechanisms, and quantifiable performance measures.** VBA has begun a paperless processing initiative, moving from paper-based to electronic records for its business lines in Compensation & Pension, Education, Vocational Rehabilitation & Employment, Insurance and Loan Guaranty. As a Department, VA needs a more coordinated organizational approach, to and goals for, the migration.

- 2-2. VA should accelerate timelines for completing VA’s Contact Management (CM) and Registration and Eligibility (RE) projects. These OneVA, veteran-centered IT applications were originally scheduled for development and implementation years ago and should be initiated immediately, rather than postponed to FY 2010, as is currently planned.** VA IT officials have said that resolution of e-authentication issues to enable veteran based self-service while protecting privacy is essential to more rapid progress. A prompt resolution of these issues is necessary.
- 2-3. VA should update the Web-Based Veterans On-Line Application (VONAPP) process to allow the direct incorporation of claims information into benefit claims tracking applications (i.e., VETSNET MAP-D), which provide benefit payment and accounting functions.** Currently the *pdf* claim application form which the veteran submits has to be rekeyed into the VETSNET MAP-D application. Allowing direct import of claims information would expedite the process, as would developing a rules-based questionnaire with branching logic (in the manner of Turbo Tax). This would elicit more detailed information about the exact nature of the claim, as well as information that is relevant to the resolution of the issues presented.
- 2-4. VA should collect and maintain personal e-mail addresses of veterans in a manner consistent with protections for personal information.** Gathering e-mail addresses from veterans would enable more effective outreach by VA. This can be accomplished by adding an e-mail address field to all forms, applications, including the VONAPP and other documents that contain veteran contact information. (*See recommendation 3-11*). Veterans often change residence following discharge, but their e-mail address usually remains the same. A secure central file of veteran e-mail addresses should be created and maintained.
- 2-5. VA should align future Information Technology (IT) application development with OneVA goals by requiring that business plans and budget justification include an explicit statement regarding how the application promotes a veteran-centered Department.** This articulated linkage to Department-level goals should be a standard component within the business plans and justification developed for each new effort.
- 2-6. VA should adopt a single secure web portal to provide the initial “door” for veterans to have easy access to a variety of links to all VA benefits and services.** Adoption of a single portal will provide a consistent entry point to those accessing VA information, including veterans and others authorized to access information on their behalf, as well as links to different content areas based on the needs of the user. User groups could include:
- Veterans;
  - Family members (e.g., spouse, parent) and/or caregivers;
  - Survivors;
  - Those with power of attorney for a veteran (e.g., VSO representatives, County Service Officers);

- Private sector health care providers; and
- Employees of other state, local and federal programs assisting veterans.

**The site should provide “one-click” links to a variety of internal web environments and external links, such as My Health<sub>e</sub>Vet, eBenefits, and other current and future content areas, with secure access that is limited to those with appropriate authorization.** Examples of the accessible content and capabilities from this single portal could include:

- Benefits offered by each VA program;
- On-line enrollment capability;
- Specific benefits available to the veteran or survivor;
- Access to current claim status;
- Access to personal medical records;
- Health care management (e.g., appointment scheduling, request referrals, request prescription refills);
- Ability to ask about specific benefits; and
- Links to other federal, state, and local programs.

**2-7. VA should expand use of collaborative web technology as internal and external communication channels.** VA is currently working through the legal and contractual issues regarding use of popular public sites such as Facebook and MySpace. Veterans returning today are active users of social networking sites while they are deployed, as well as upon their return home. VA can leverage these existing communication channels, knowing that many veterans are current users of the technology. VA can launch a number of initiatives, such as the creation of Virtual Vet Centers to reach underserved populations of returning veterans, and blogs for sharing recent news, updates, general information, and collect comments and feedback from veterans.

**2-8. VA should deploy a Customer Relationship Management (CRM) desktop to further enhance performance of telephone call centers and capture caller satisfaction.** The call center consolidation is expected to increase the effectiveness of VBA public contact and provide greater opportunity for quality assurance actions by VBA management. The extensive training and quality control efforts provide new capabilities to capture data and pinpoint areas for continuous improvement. Addition of a CRM tool will provide VBA with further capabilities to access data from multiple VA databases in a more coordinated and rapid manner, as well as capture performance data. **VBA should build veteran satisfaction measures into the protocols for handling telephone inquiries.** Borrowing approaches used in private industry, each call might include a set of scripted questions asking the caller to rate his or her level of satisfaction with the outcome of the call, and to evaluate how thoroughly or appropriately the issue was resolved.

- 2-9. **VA should expand call center functionality to accommodate real-time live chat capabilities with veterans. Tools and business rules employed by the consolidated call centers should be leveraged to communicate with veterans on-line, in real time, in a similar manner to a telephone dialogue.** Online chat is a common communication channel used by organizations that provide customer service and technical support, and operates in a manner similar to a call center. Expanding the call centers to accommodate this additional communication channel would further support a veteran centered approach, and provide veterans with more flexibility in obtaining information from VA.
- 2-10. **VA should add communication channels used in VA’s general information outreach, such as providing separating service members with benefit information on DVD/CD or “memory stick”, a user-friendly web-site, podcasts, and other forms of easily accessible media.**
- 4-7. **VA should use collaborative web technology for internal and external collaboration and pursue a range of initiatives that would support veteran-centered service and would help implement and accelerate the necessary reorientation of the Department.** Implementation of this recommendation would include:
- ***Employee ‘Idea Factory’***—An internal collaborative site, similar to one used by the Transportation Security Administration should be established where any employee can (following ground rules and with attribution) propose any new practice or policy change (not requiring legislation) that would improve service to returning or all veterans, have these screened and presented for a vote of the collaborating employees, and then reviewed for possible adoption.
  - ***Partners Wiki***—A platform should be provided for any subgroup or existing network of non-VA service providers and other public or private agencies working on behalf of veterans to use to organize a collaboration regarding a particular problem related to improved service for veterans in a particular region, state, or with a particular need. Products would be proposals that could be formally endorsed or informally advanced for consideration by the VA in a fully transparent, open-ended process. Expected results would include a growing number of collaborative networks that could help disparate providers find each other, form constructive partnerships, and solve problems related to veteran service.
  - ***Veteran Feedback Site***—An interactive site should be built where a veteran could pose a query or post a complaint and receive both an initial automated response and, as needed, personalized follow-up and response or referral. A sampling of veterans would receive follow-up survey questions to assess their satisfaction with the response received and whether any problem identified had been corrected. Analysis of the resulting data would identify weaknesses in the existing services system and support remedial action.

# **CHAPTER 1**

## **SERVING THE VETERAN: VA AND ITS MANAGEMENT CHALLENGES**

A new generation of veterans is returning to the United States from the wars in Afghanistan and Iraq—Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). As has been true after every major war, providing for veterans’ needs and their reintegration into civilian society has raised anew the challenge of providing all veterans with a level of health care and benefits that honors their service to the Nation. (*See Appendix A for the historical context for the federal government’s repeated responses to the needs of returning war veterans.*) This is the mission of the Department of Veterans Affairs (hereafter referred to as “VA”), but is in many respects a joint responsibility of VA, the Department of Defense (DoD), and the uniformed military services.

This chapter is intended to illuminate the practical management challenges that VA and others face in improving care for the wounded and service to all veterans. It does so by describing: (1) the purpose of this study as contrasted with several that have preceded it; (2) the characteristics and needs of the current group of returning veterans; and (3) three of VA’s business lines and organizational factors that affect their performance. The chapter ends with a review of the management and organizational challenges to improve service to OEF/OIF veterans while sustaining and improving service to all veterans. These challenges fall broadly into two categories:

- the need to bridge organizational boundaries by coordinating policies and operations, and improving communications and systems that support coordinated action; and
- the need to organize and integrate outreach and care for individuals, especially the wounded and those who are at risk of illness or are having difficulty reintegrating to civilian life.

### **PURPOSE AND BACKGROUND**

The disclosure in 2007 of major inadequacies in the facilities housing OEF/OIF service members receiving outpatient care at Walter Reed Army Hospital—as distinguished from the excellent inpatient treatment being provided to the wounded there—heightened public and Congressional concern about management of care for the severely wounded. In the wake of those disclosures, efforts to improve the system of care and benefits to this group and ease their transition from battlefield to medical facilities to their homes were accelerated, and major reviews were undertaken by a series of panels, commissions, task forces, boards, and committees.<sup>15</sup> Another

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<sup>15</sup> The reviews were: (1) the President’s Commission on Care for America’s Returning Wounded Warriors; (2) Task Force on Returning Global War on Terror Heroes; and (3) Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center. A May 2003 report by the President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans addressed many of the same issues.

commission report addressed the need for broad structural changes in the disability compensation system for veterans.<sup>16</sup> Collectively, these reports included hundreds of recommendations for changes in a range of specific VA and DoD policies, practices, procedures, and programs. Viewed from this study's perspective, their recommendations raise or highlight a set of management and organization challenges facing VA and its partners, notably the DoD.

In May 2007, Congress mandated this independent review by the National Academy of Public Administration of the overall management and organization of VA and its capacity to provide high quality health care and benefits to all veterans, including those of OEF/OIF. Specifically, The *U.S. Troop Readiness Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007* (H.R. 2206) authorized: “[a]n independent study [by the National Academy of Public Administration] of the organizational structure, management and coordination processes, including seamless transition, utilized by the Department of Veterans Affairs to provide health care and benefits to active duty personnel and veterans, including [OEF/OIF] veterans. . . .” The accompanying Report of the Senate and House Conferees (H. Rep. 110-107) reinforced congressional concern “that effective management structures and interagency coordination processes must be in place to ensure that services of the Department of Veterans Affairs are provided in a timely and efficient manner, especially to returning OEF/OIF veterans.” This report is the product of that review.

This brief background statement raises several important questions:

- Why was this study needed in light of all those that have preceded it?
- What differentiates this study from the earlier studies?
- How can this study be expected to make a difference in the lives of those affected by VA services, the veterans and their families?

The focus of this study, as differentiated from those that have come before it, is on practical questions of organizational capacity, management strategy, and implementation. Unlike those prior reviews, it does not recommend significant changes related to health care policy and veterans' benefits or other changes that would require additional funding. Nor does it evaluate the substantive merits of the recommendations of those prior studies. Instead, it focuses on the administrative and management challenges that must be confronted in order to improve services to OEF/OIF veterans as well as other veterans, including efforts to implement the recommendations of the prior studies. It addresses candidly the capacity and performance of VA and its partners as they strive to meet those challenges—both what has been accomplished and where capacity falls short.

Based on this analysis and drawing on the expertise of the Panel members, this study offers advice and recommendations regarding practical strategies and specific actions to strengthen VA's capability to apply its resources most effectively to improve outcomes for veterans. In the few instances where the study recommends changes in authority or structure, the intention is to create conditions for more effective administration. A general strategy for continuous evidence-

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<sup>16</sup> Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability in the 21<sup>st</sup> Century*, October 2007.

driven organizational improvement is also recommended that, if adopted, will sustain the positive changes already underway at VA and produce better outcomes for OEF/OIF and other veterans and their families.

The premise of this study is that care and benefits to veterans can be improved if VA management and organization are reformed with an eye to improving outcomes for veterans, rather than merely improving processes. For years there has been an intuitive leaning within VA, sometimes promoted by policies and sometimes submerged, to pull the disparate components of VA together, resolve their different ways of performing their functions, and ensure that their focus is not on their preferred operational styles but on the best possible service to veterans. This objective has been referred to within the organization as “OneVA.” In this report, the goal is stated as making VA and its functions “veteran-centered.” Surprisingly, given the mission of VA and the substantial level of resources devoted to its programs, this orientation of the work toward the individual veteran is not always present.

## **WALTER REED AND ITS AFTERMATH**

In February 2007, The Washington Post reported that there were problems with the facilities housing wounded OEF/OIF service members who were receiving outpatient care at the Walter Reed Army Medical Center in Washington, D.C.<sup>17</sup> Although this was an Army and not a VA medical facility, the report and others that followed brought immediate responses not only from the Army and the DoD, but also from VA, the White House, Congress, and other organizations. A chronology of significant events that occurred following the Walter Reed disclosures is presented in Table 1-1 at the end of this chapter.

In the wake of the Walter Reed controversy, VA and DoD accelerated efforts that were underway, and introduced new approaches, to address the issues. In June 2007, for example, the Army began to organize its first Warrior Transition Units (WTUs) at Military Treatment Facilities (MTFs) in order to implement a new “triad” care approach featuring a single physician, a case manager, and a squad leader with responsibility for each wounded veteran. By February 2008, 35 Army WTUs were treating 9,000 wounded soldiers.<sup>18</sup> Also in early 2007, VA recognized that severely injured service members needed further assistance in completing the transition from the DoD to the VA health care system and hired 100 Transition Patient Advocates, many of whom are themselves OEF/OIF veterans.<sup>19</sup>

Other efforts to improve care for injured veterans were undertaken as well. For example, VA and DoD established a joint “Wounded, Ill, and Injured Senior Oversight Committee” (SOC) on May 3, 2007, to focus on the problems of care for returning veterans and to address recommendations of three studies completed in the immediate aftermath of the Walter Reed

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<sup>17</sup> See Priest, Dana, and Anne Hull. *Rotten Homecoming; This is No Way to Treat a Veteran*, The Washington Post, February 21, 2007.

<sup>18</sup> Lopez, C. Todd, *SecArmy: Soldiers Moved to Heaven, Earth to Fix Care*, Army Military News, February 8, 2008, p. 1.

<sup>19</sup> VA Public and Intergovernmental Affairs, *Nicholson Announces 100 New Patient Advocates for Wounded*, March 6, 2007.

reports. To ensure high-level attention to the issues, the SOC is co-chaired by the Deputy Secretary of Veterans Affairs and the Deputy Secretary of Defense and includes the Chairman or Vice Chairman of the Joint Chiefs of Staff, the Chiefs or Vice Chiefs of the four uniformed military services, the Under Secretaries of Defense for Personnel & Readiness and Comptroller, the Under Secretaries of Veterans Affairs for Benefits and Health, and other senior officials.

The SOC's original mandate was to spend 12 months ensuring that recommendations to remedy the issues presented by the situation at Walter Reed were properly reviewed, coordinated, implemented, and supported by appropriate resources. The SOC met for some time on a weekly basis; and focused most of its attention on the continuum of health care and benefits for wounded, ill, and injured service members. It organized its work around seven "lines of action" (LoAs), with an eighth LoA added in late 2007 for pay and financial support. Each of these LoAs was responsible for a specific type of issue and was led jointly by VA and DoD senior managers.

The SOC LoA for case/care management prepared an Interim Report to Congress in February 2008 to address the requirement of Section 1611 of the 2008 National Defense Authorization Act for development of a comprehensive policy on improvements to care, management, and transition of all wounded, ill, and injured service members/veterans and their families. That report stated that DoD and VA would complete the development and implementation of the comprehensive policy by July 1, 2008. However, as of this writing, DoD and VA were concurrently currently reviewing the policy.

## **SERVING THE NEWEST VETERANS**

Although there are similarities between veterans of the conflicts in Afghanistan and Iraq and veterans from previous wars, these groups differ in ways that have implications for how VA should interact with this new cohort of veterans. From FY 2002 through December 2007, 837,000 OEF/OIF service members separated from the military.<sup>20</sup> VA reports it has provided medical care to approximately 325,000 of these veterans.<sup>21</sup> This is about six percent of VA's total patient population.<sup>22</sup> It also, significantly, is less than 40 percent of all who have returned from Iraq and Afghanistan and separated from the military.<sup>23</sup>

One of most noticeable differences between OEF/OIF veterans and those from earlier wars is that many of the wounded are surviving injuries that would have been fatal in past wars.<sup>24</sup> Table 1-1 shows injury and death statistics for OEF/OIF veterans and veterans from previous wars. For

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<sup>20</sup> Separation data include former active duty military as well as members of the National Guard and Reserve who have been deactivated. Department of Veterans Affairs, *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008, p. 1.

<sup>21</sup> *Ibid.*, p. 1.

<sup>22</sup> Calculation using data from *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008, p. 1 and *VA Benefits & Health Care Utilization* Accessed at: [http://www1.va.gov/vetdata/docs/4X6\\_summer08\\_sharepoint.pdf](http://www1.va.gov/vetdata/docs/4X6_summer08_sharepoint.pdf), updated on July 22, 2008.

<sup>23</sup> Calculation using data from *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008, p. 1.

<sup>24</sup> Fischer, Hannah, Kim Klarman, and Mari-Jana Oboroceanu, CRS Report to Congress, *American War and Military Operations Casualties, Lists, and Statistics*, Washington D.C., Updated May 14, 2008, p. 9.



every seven injuries for OIF veterans, for example, there was one death, whereas in previous there was one death for one to three injuries. Several factors account for the higher survival rate, such as improvements in protective armor and access to more immediate and technologically-advanced medical care.

**Table 1-1. Comparison of the Number of Deployments, Deaths, and Wounded in American Wars**

American War	Deployments	Deaths <sup>c</sup>	Wounded	Ratio Deaths/Wounded
<b>Iraq</b>	1,697,308 <sup>a</sup>	4058	29,991	1:7.4
<b>Afghanistan</b>		490	1,937	1:4.0
<b>Persian Gulf War</b>	694,550 <sup>b</sup>	382	467	1:1.2
<b>Vietnam</b>	3,400,000 <sup>b</sup>	58,209	153,303	1:2.6
<b>Korea</b>	5,720,000 <sup>b</sup>	36,578	103,284	1:2.8
<b>World War II</b>	16,112,566 <sup>b</sup>	405,399	671,846	1:1.7
<b>World War I</b>	4,734,991 <sup>b</sup>	116,516	204,002	1:1.8

<sup>a</sup> As of October 2007. The number of deployments is larger than the total number of service members who served in Iraq and Afghanistan because some service members had multiple deployments.

<sup>b</sup> As of May 2008.

<sup>c</sup> As of April 2008.

Sources: Number of deployments for Iraq and Afghanistan from RAND Corporation, *Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, CA, 2008, p. 21; Number of deployments for other wars from Department of Veterans Affairs, Public and Intergovernmental Affairs, *Fact Sheet on America's Wars*, May 2008. Deaths, Wounded, and Ratio Deaths/Wounded from Congressional Research Service Report for Congress, *American War and Military Operations Casualties: Lists and Statistics*, Updated May 14, 2008, p. 9.

As a result of the improved survival rate, VA is faced with treating new types of injuries. Between December 2005 and December 2007, just over 1,700 severely injured OEF/OIF service members had been transferred from military treatment facilities (MTFs) to VA health care.<sup>25</sup> Unlike previous wars, rather than discharging injured service members quickly, the Army, for example, is attempting to retain them, and a small percentage have been reintegrated into their units. OEF/OIF service members are sustaining multiple severe injuries resulting from improvised explosive devices, blasts, landmines and fragments, which account for 65 percent of combat injuries.<sup>26</sup> Of these injured service members, about 60 percent have some degree of

<sup>25</sup> The category of “severely injured” includes those with spinal cord injury; burn; amputation; visual impairment; severe TBI; and severe mental illness. Number of severely injured obtained during interview with VHA official.

<sup>26</sup> Department of Veterans Affairs, Veterans Health Administration, *Polytrauma Rehabilitation Centers*, VHA Directive 2005-024, June 8, 2005, p. 1.

Traumatic Brain Injury (TBI).<sup>27</sup> TBI is frequently called the signature injury of the Iraq war. The Veterans Health Administration (VHA) has recognized that this new injury component will require specialized intensive rehabilitation processes, coordination of care throughout recovery, and, for some veterans, life-long case management.

The severity of TBI may range from “mild,” a brief change in mental status or consciousness, to “severe,” an extended period of unconsciousness or amnesia after the injury. TBI can cause a wide range of functional changes affecting thinking, sensation, movement, language, and emotions. Some symptoms may appear immediately after the injury, but other symptoms may not appear for days or weeks.<sup>28</sup> Estimates of the number of veterans who may be suffering from TBI are not precise but some experts have estimated the prevalence of TBI among wounded service members to be as high as 22 percent.<sup>29</sup> A recent study by the RAND Corporation, albeit one based on a small sampling, estimated that about 19.5 percent of troops returning from Iraq and Afghanistan suffered from TBI.<sup>30</sup>

In addition to suffering different types of injuries, OEF/OIF veterans are younger than the majority of those treated at VA facilities. In 2007, the median age of all living veterans was 60,<sup>31</sup> whereas about 52 percent of the OEF/OIF veterans are ages 20 to 29.<sup>32</sup> A 2008 RAND Corporation report stated that younger veterans feel “uncomfortable and out of place in VA facilities,” which disproportionately treat older and more chronically ill patients.<sup>33</sup> DoD officials and representatives of some Veterans Service Organizations corroborated this finding, and noted that such perceptions discouraged younger veterans from seeking needed care at VA facilities.<sup>34</sup>

The younger generation of veterans is on average more accustomed to utilizing computers, accessing customized services, and receiving immediate responses to queries or service requests via the Internet. This shift in expectations will influence older generations of veterans also, and will have implications for how VA communicates with veterans about their care and benefits.

Another generational change is the increased number of veterans who are women. More than 100,000 women have served in Iraq<sup>35</sup> compared to 7,500 women who served in the Vietnam

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<sup>27</sup> Ibid.

<sup>28</sup> DoD Deployment Health Clinical Center. *Traumatic Brain Injury*. <http://www.pdhealth.mil/TBI.asp>, 2008

<sup>29</sup> Defense and Veterans Brain Injury Center, *Blast Injury FAQs*, Accessed at [http://www.dvbic.org/cms.php?p=Blast\\_injury](http://www.dvbic.org/cms.php?p=Blast_injury), 2006.

<sup>30</sup> RAND Corporation, *Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, CA, 2008, pp. 2, 95. RAND’s estimate is based on a sample of telephone interviews conducted between August 2007 and January 2008, with 1,965 service members who had been deployed to Iraq or Afghanistan. This sample included service members from all branches of service, rank, military occupational specialty, and geographic regions, regardless of service branch, component, or type. Approximately 22 percent were veterans.

<sup>31</sup> Department of Veterans Affairs. *OEF/OIF Fact Sheet*, February 2008.

<sup>32</sup> Ibid.

<sup>33</sup> RAND Corporation, *Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, CA, 2008, p. 301.

<sup>34</sup> See Appendix G for the list of 165 individuals who were interviewed during this Panel’s study, including those from DoD and Veterans Service Organizations.

<sup>35</sup> Department of Veterans Affairs Advisory Committee on Women Veterans, Meeting Minutes, October 31-November 2, 2006. p. 8.

War.<sup>36</sup> Women are expected to represent over 14 percent of the total veteran population by 2010, twice the percentage of women veterans in 2001.<sup>37</sup> Women have distinctive mental and physical health care needs, and VA has responded over the years with relevant programs and services, such as outreach and counseling for women experiencing sexual trauma. VA also has designated a Women Veterans Program Manager at each VA Medical Center to assist women veterans in receiving the medical and psychosocial care they need.<sup>38</sup> However, VA reported in June 2008 that women veterans are not receiving the same quality of outpatient care as men in about one-third of the 139 VA facilities that offer such care, and that more equipment and clinicians who specialize in women's care are needed.<sup>39</sup>

OEF/OIF veterans, unlike Vietnam War veterans, are receiving post-deployment health screenings upon their return from deployment to identify early symptoms of combat-induced psychological stress. In the post-Vietnam era, the response to concerns about the psychological impacts of combat stress was somewhat delayed. DoD and VA now have a heightened awareness regarding the psychological impacts of combat stress and the importance of early intervention in preventing the development of chronic conditions. The result has been an accelerated response and much greater awareness of the condition both among combat veterans and among military and VA personnel.<sup>40</sup> To help track the health progress of OEF/OIF service members as they return from service in theater, DoD implemented two major post-deployment health assessments, one of which occurs within 30 days of returning from combat, and another that takes place between 90 and 180 days after return.

Research shows that OEF/OIF service members who: (1) are members of the military Reserves; and/or (2) experience relatively longer deployments, multiple deployments, and combat intensity are at higher risk of experiencing symptoms of mental health illness.<sup>41</sup> About 50 percent of OEF/OIF veterans are members of the National Guard or Reserve<sup>42</sup>, and about 34 percent of OEF/OIF veterans have been deployed multiple times.<sup>43</sup> Estimates of the percent of OIF veterans who may experience Post Traumatic Stress Disorder (PTSD) symptoms have ranged from 12 to 20 percent.<sup>44</sup> The RAND report discussed earlier estimated that 18.5 percent of the

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<sup>36</sup> Women In Military Service For America Memorial Foundation, Inc, *Statistics on Women in the Military*, Revised July 17, 2006. Accessed at: <http://www.womensmemorial.org/PDFs/StatsonWIM.pdf>.

<sup>37</sup> Department of Veterans Affairs, Office of Public Health and Environmental Hazards (OPHEH), Women Veterans Health Strategic Health Care Group, *VA Programs for Women Veterans*, Updated April 5, 2007. Accessed at: <http://www1.va.gov/wvhp/page.cfm?pg=26>.

<sup>38</sup> Ibid.

<sup>39</sup> Department of Veterans Affairs, Veterans Health Administration, *Hospital Report Card to the House Appropriations Committee, In response to House Appropriations Report No. 110-186, accompanying Public Law 110-161, The Consolidated Appropriations Act, 2008*, June 3, 2008, pp. 22, 23.

<sup>40</sup> Interviews with VA and DoD personnel.

<sup>41</sup> Statement of Charles Hoge, U.S. Army Director, Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research, Department of the Army, before the House Committee on Veterans' Affairs, Subcommittee on Health, Hearing on *Post Traumatic Stress Disorder Treatment and Research: Moving Ahead Toward Recovery*, April 1, 2008.

<sup>42</sup> Department of Veterans Affairs, *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008, p. 1.

<sup>43</sup> Department of Veterans Affairs, *OEF/OIF Fact Sheet*, February 2008.

<sup>44</sup> Department of Veterans Affairs, National Center for PTSD, *Fact Sheet: How Common is PTSD?*, February 27, 2008.

service members and veterans in its survey sample had a mental health condition (11.2 percent had a mental health condition only, another 7.3 percent had both TBI and a mental illness condition).<sup>45</sup> VA has expressed concern with projecting the results of RAND's survey to the veteran population because veterans accounted for only 22 percent of RAND's sample.

As of December 2007, VA reported having treated about 134,000 OEF/OIF veterans for mental disorders, 67,500 of whom were either evaluated or treated for PTSD.<sup>46</sup> As of February 2008, more than 300,000 OEF/OIF veterans had filed a disability compensation claim, and more than 38,000 had been awarded a PTSD-related disability.<sup>47</sup> VA also reported that it had seen about 8,300 OEF/OIF veterans for "conditions possibly related to TBI."<sup>48</sup> Because some veterans obtain care outside the VA health care system, a definitive estimate of the number of veterans who suffer from mental or cognitive disorders and who have not obtained medical care cannot be made.

Recent studies have shown that a large percentage of those who report having symptoms of mental illness or depression are not seeking treatment. The RAND study estimates that only 53 percent of those who met the criteria for PTSD or major depression had sought care within the last year.<sup>49</sup> Also, a survey of members of four U.S. Army combat infantry units found that only 23 to 40 percent of service members who reported symptoms of a major depressive disorder, a generalized anxiety disorder, or PTSD, actually sought care.<sup>50</sup>

One of the most disastrous consequences of untreated mental illness is suicide. Since December 2007, questions have been raised in congressional hearings and media reports as to whether suicides among OEF/OIF veterans have reached epidemic proportions. Research suggests that certain veterans are at higher risk for suicide than non-veterans.<sup>51</sup> However, a Congressional Research Service report observed that there are difficulties in determining the incidence of suicide among veterans because: (1) no nationwide system exists for surveillance of suicide

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<sup>45</sup> RAND Corporation, *Research Highlights, Invisible Wounds, Mental Health and Cognitive Care Needs of America's Returning Veterans*, Santa Monica, CA, 2008, p. 3.

<sup>46</sup> Department of Veterans Affairs, *OEF/OIF Cumulative Data*, FY 2002 through 1<sup>st</sup> quarter FY 2008.

<sup>47</sup> Veterans Benefits Administration, Office of Performance Analysis and Integrity, *VA Benefits Activity, Veterans Deployed to the Global War on Terror* (Draft), June 30, 2008, p. 3. Overall, about 2.9 million veterans are receiving VA disability compensation. See *VA Benefits & Health Care Utilization* accessed at [http://www1.va.gov/vetdata/docs/4X6\\_summer08\\_sharepoint.pdf](http://www1.va.gov/vetdata/docs/4X6_summer08_sharepoint.pdf), updated on July 22, 2008.

<sup>48</sup> *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008, p. 9.

<sup>49</sup> RAND Corporation, *Research Highlights, Invisible Wounds, Mental Health and Cognitive Care Needs of America's Returning Veterans*, Santa Monica, CA, 2008, p. 4.

<sup>50</sup> Hoge, Charles W., Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting, and Robert L. Koffman, *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, *New England Journal of Medicine*, July 1, 2004, p. 1.

<sup>51</sup> Kaplan, Mark S., Natalie Huguet, Benston H. McFarland, Jason T. Newsom, *Suicide Among Male Veterans: A Prospective Population-Based Study*, *Journal of Epidemiology and Community Health*, 2007 61:619-624. Also, see description of the VA's analysis of the Center for Disease Control's National Center for Health Statistics National Death Index and the Center for Disease Control's National Violent Death Reporting System that showed male veterans ages 18-29 had a suicide rate of 44.99 per 100,000 in 2005 compared with 20.36 for general population in that age group. Report of the Blue Ribbon Work Group on Suicide Prevention in the Veteran Population accessed at

[http://www.mentalhealth.va.gov/MENTALHEALTH/suicide\\_prevention/Blue\\_Ribbon\\_Report-FINAL\\_June-30-08.pdf](http://www.mentalhealth.va.gov/MENTALHEALTH/suicide_prevention/Blue_Ribbon_Report-FINAL_June-30-08.pdf)

specifically among veterans; and (2) suicide statistics for the general population include data on veterans.<sup>52</sup>

In May 2008, a panel of experts testified before the House Committee on Veterans' Affairs shortly after the media reported that VA had withheld data showing that 1,000 suicide attempts a month were occurring at VA medical facilities during a three-month period beginning in November 2007.<sup>53</sup> The VA Secretary indicated that VA decided not to report this data because it was based on reports from newly hired suicide coordinators who had been on the job for only a few months.<sup>54</sup> Hiring these new coordinators was one of several initiatives VA had implemented to address concerns regarding veteran suicide. Other initiatives included sponsoring suicide awareness days for all 200,000 health care employees, establishing a suicide prevention hotline for veterans, and adding 23 new Vet Centers. During the same hearing, a physician from VA's Office of Inspector General acknowledged VA's progress in implementing suicide prevention efforts in its mental health strategic plan, but offered some additional actions VA could take to improve care.<sup>55</sup>

## **VA TODAY**

Today there are almost 24 million veterans. (See *Figure 1-1*.) About 7 million of the 24 million are enrolled in VA health care, and about 5.6 million of these enrollees received VA medical care in FY 2007. About 2.8 million disabled veterans and 333,000 survivors received \$33.6 billion in disability compensation payments in FY 2007.<sup>56</sup>

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<sup>52</sup> Sundararaman, Ramya, Sidath Viranga Panangala, and Sarah A. Lister, CRS Report to the Congress, *Suicide Prevention Among Veterans*, Washington, D.C., May 5, 2008, pp. 2, 3.

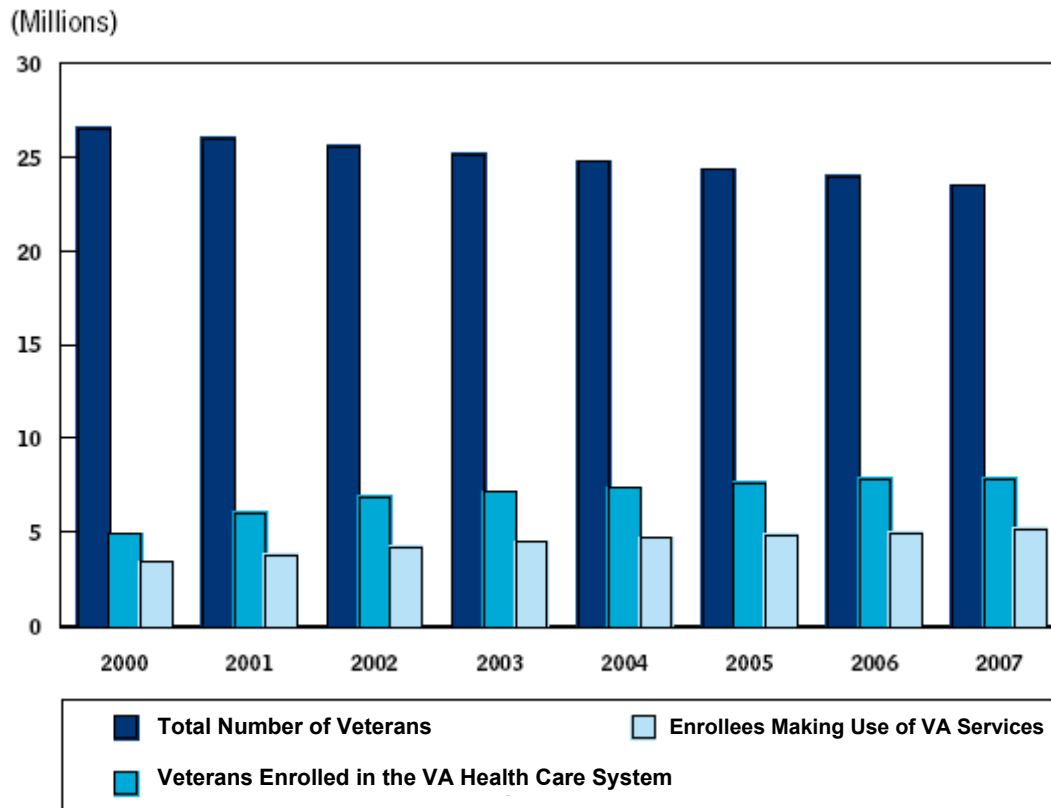
<sup>53</sup> CBS News, *VA Hid Suicide Risk, Internal E-Mails Show*, April 21, 2008 and Opening Statement by Honorable Bob Filner, Chairman, House Committee on Veterans' Affairs, *Truth About Veteran Suicides*, May 6, 2008, p. 1.

<sup>54</sup> Statement of James B. Peake, Secretary, U.S. Department of Veterans Affairs, before the House Veterans' Affairs Committee, *Hearing on The Truth About Veteran Suicides*, May 6, 2008, pp. 1, 2.

<sup>55</sup> Statement of Michael Shepherd, Physician, Office of Healthcare Inspections Office of the Inspector General, U.S. Department of Veterans Affairs, before the House Veterans' Affairs Committee, *Hearing on The Truth About Veteran Suicides*, May 6, 2008. These actions are discussed in Chapter 3 of this report.

<sup>56</sup> Davis, Carol, Sidath Viranga Panagala, Christine Scott, CRS Report to the Congress, *Veterans Benefits: An Overview*, June 25, 2008, p. 2.

**Figure 1-1. The Total Population of Veterans; Those Enrolled in VHA; and Those Using VHA services, 2000 to 2007**



Source: Statement of Allison Percy, Principal Analyst, Congressional Budget Office on *Future Medical Spending by the Department of Veterans Affairs*, before the House Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, February 15, 2007, p. 4.

VA has been a leader in advancing many aspects of the health care system in the United States, and has been described as providing “the best care anywhere.”<sup>57</sup> VHA’s electronic medical records system has been widely praised as a model for the health care sector generally. VA’s customer satisfaction levels and measures on various quality indicators support the view that VA’s health care system is arguably one of the best in nation.

Nevertheless, various aspects of VA’s services have been criticized. For example, VA’s performance with respect to processing disability claims has been the subject of much criticism, despite repeated attempts to reengineer the administration of disability exams and ratings. VA also has been criticized by some veterans and Veterans’ Service Organizations as bureaucratic and unresponsive to their needs.<sup>58</sup>

<sup>57</sup> See, e.g., Longman, Phillip, *Best Care Anywhere: Why VA Health Care is Better Than Yours*, Sausalito, CA, PoliPoint Press, 2007.

<sup>58</sup> Veterans For Common Sense, et al versus Department of Veterans Affairs, C 07 3758 (USD Ct. ND Ca. 2007); Testimony of Gunnery Sergeant Tai Cleveland, USMC, ret. before the House Committee on Veterans’ Affairs,

VA faces new challenges related to treating and compensating veterans for injuries resulting from OEF and OIF, but VA must do so without compromising service to other veterans. Some of these challenges were unexpected, in the sense that no one could have fully anticipated either the duration of the conflicts and resulting number of injuries and their distinct nature. The military services and VA must be prepared to deal not only with traumatic injuries that might not have been survived in previous wars but also with a larger number of veterans with emotional or cognitive disorders that are often hard to diagnose and may be identified long after service.

This section describes some of the organizational factors that affect VA's ability to address both new and ongoing challenges to improve service: touching on key business lines for delivering health care, providing vocational rehabilitation and employment services, and processing disability claims.

### **VA Health Care Delivery**

VA has the Nation's largest health network, with 155 hospitals, 881 outpatient clinics, 135 nursing homes, 46 residential rehabilitation treatment programs, and 225 readjustment counseling Vet Centers.<sup>59</sup> Notwithstanding recent concerns regarding access to timely mental health care, VA has been praised for the quality of its care. Customer satisfaction with VA's health care system in 2007 was higher than the private sector for the eighth consecutive year. Specifically, patients at VA medical centers recorded a satisfaction level of 83 out of possible 100 points, or 6 points higher than the private-sector health care industry.<sup>60</sup>

A major transformation initiative within the Veterans Health Administration (VHA) in the 1990s is often cited as one of the key factors contributing to VA's success in improving health care quality. This initiative began in response to mounting budget constraints and numerous calls for reform in its health care delivery system. From 1995-2000, VHA transitioned from a specialty and inpatient-based care system to a system focused on primary, outpatient-based care. As a result of this shift, the ratio of outpatient visits to inpatient admissions increased from 29:1 in 1995 to 100:1 in 2006.<sup>61</sup>

Critical elements of this transformation included:

- developing ongoing systems of measurement and reporting of key health care process and outcome indicators;
- creating linkages between these indicators and compensation decisions for VHA senior management;
- establishing a centralized, system-wide computerized patient record system; and

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January 29, 2008; and Testimony of Elizabeth O'Herrin, OIF Veteran and Former Wisconsin Air National Guard Member, before the House Committee on Veterans' Affairs, July 15, 2008.

<sup>59</sup> Department of Veterans Affairs, *2007 Organizational Briefing Book*, May 1, 2007; Vet Center data accessed at [www.vetcenter.va.gov](http://www.vetcenter.va.gov), updated September 10, 2008.

<sup>60</sup> Department of Veterans Affairs, Public and Intergovernmental Affairs, *FY '09 VA Budget Request Highlights*, February 4, 2008. Accessed at: <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1448>.

<sup>61</sup> U.S. Department of Veterans Affairs, *2007 Organizational Briefing Book*, May 2007, p. 8.

- developing evidence-based online clinical practice guidelines with automated tools to support their use, such as computerized reminders integrated into patient records.<sup>62</sup>

In 1996, Congress passed the Veterans Health Eligibility Reform Act, which simplified eligibility standards for hospital and outpatient care and allowed veterans without service-connected disabilities or low incomes to receive services. As required by Congress, VA began enrolling veterans in the VA health care system, initially establishing seven priority categories to help identify which veterans would be eligible for no-cost health care versus those who would be required to make co-payments. Later, an eighth category was established that includes veterans without service-connected disabilities and with incomes above a threshold amount that is based on geographic location.

VA's spending for health care increased by 54 percent from FY 2001 to FY 2007.<sup>63</sup> Total spending on veterans' programs increased by 62 percent over the same time period.<sup>64</sup> Nevertheless, budget constraints have and will continue to play a role in shaping the future of health care delivery for veterans. Pursuant to congressional authority, in January 2003, VA suspended enrollment of Priority 8 veterans in VA's health care system. VA's primary reason for this suspension was a concern that treating a large number of Priority 8 veterans could prevent it from focusing care on its core constituency of veterans with service-related disabilities, with low income, and with special health needs.<sup>65</sup> This suspension has remained in effect through FY 2008. As a result of this change, since 2003, about 400,000 veterans have been classified as ineligible for VA health care.<sup>66</sup>

VHA is continuing to take advantage of technology to improve access to care and provide veterans with information to help track their health progress. In fiscal year 2009, VA plans to expand its Telehealth program to provide access to care for veterans in rural areas. This program includes using: (1) real-time videoconferencing technologies that allow veterans to communicate with health providers and specialists from remote locations; and (2) new home Telehealth technologies that make it possible for patients to check on symptoms and measure vital signs from their home. VHA has also developed an award-winning web portal, My HealtheVet, which enables veterans and VA staff to create and maintain a robust personal health record.<sup>67</sup>

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<sup>62</sup> McQueen, Lynn, Brian S. Mittman, and John G. Demakis, *Overview of the Veterans Health Administration (VHA) Quality Enhancement Research Initiative (QUERI)*, The Journal of the American Medical Informatics Association, September/October 2004, p. 339.

<sup>63</sup> Budget of the United States Government, FY 2009, Historical tables, Table 3.2, pp. 66, 67.

<sup>64</sup> Ibid.

<sup>65</sup> Department of Veterans Affairs, Office of Public Affairs, *VA's 2003 Enrollment Decision Q & A*, January 2003, p. 1.

<sup>66</sup> Stiglitz, Joseph and Linda J. Bilmes, *The Three Trillion Dollar War: The True Cost of the Iraq Conflict*, New York, NY: W.W. Norton & Company, Inc., 2008, p. 82. The FY 2009 appropriations bill as passed by the Senate includes funding to increase the income eligibility threshold for Priority 8 veterans.

<sup>67</sup> Nazi, Kim M., *My HealtheVet Personal Health Record Overview*, Department of Veterans Affairs, Veterans Health Administration, Office of Information, July 9, 2008.



## Reengineering VA's Vocational Rehabilitation and Employment Services

Vocational Rehabilitation and Employment (VR&E) provides service-disabled veterans and service members awaiting medical discharge from active duty with a variety of services to assist them in preparing for, locating, and maintaining suitable employment or achieving independent living. These services include vocational planning counseling, case management, training, and job placement assistance. Veterans Benefit Administration (VBA) re-engineered the VR&E program in response to an internal task force that was established to address concerns regarding the disproportionate focus on education rather than employment, the amount of time it took for participants to be rehabilitated, and the program's poor performance in helping disabled veterans find suitable employment.<sup>68</sup>

In response to recommendations from this task force, VA implemented a Five-Track Employment Process to help veterans make informed choices through one of the following employment options: (1) reemployment from previous employers; (2) rapid access to employment through job readiness preparation and incidental training opportunities; (3) self employment; (4) employment through long-term services, including formal training or education; and (5) services to maximize independence in daily living for veterans who are unable to work.<sup>69</sup> As of February 2008, each VBA regional office had employment coordinators to provide veterans with employment services and to work closely with the Department of Labor's outreach and employment specialists.<sup>70</sup>

## Processing Disability Claims

As explained earlier, VHA has made major progress in improving the quality of VA health care and leveraging technology. VBA, however, has been unable to reduce processing times for disability claims substantially.

VBA implemented two different operating models, one in 1997 and another in 2001, in an effort to improve processing times, but the impact of each was limited.<sup>71</sup> In FY 2008, VBA plans to complete a two-year effort to hire 3,100 additional staff to help reduce the backlog of claims, and VA's FY 2009 budget request includes a request for 2,600 additional VBA staff.<sup>72</sup> VA

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<sup>68</sup> Statement of Cynthia A. Bascetta, Director, Education, Workforce, and Income Security, Government Accountability Office, before the Subcommittee on Economic Opportunity, Committee on Veterans' Affairs, House of Representatives, *Vocational Rehabilitation: VA Has Opportunities to Improve Services, but Faces Significant Challenges*, GAO-05-572T Washington, D.C., April 20, 2005, p. 1.

<sup>69</sup> Statement of Ruth A. Fanning, Director, Vocational Rehabilitation & Employment Service, Veterans Benefit Administration, Department of Veterans Affairs, before the Senate Committee on Veterans' Affairs, Washington D.C., February 5, 2008, p. 1.

<sup>70</sup> Ibid.

<sup>71</sup> IBM Global Business Services, U.S. Department of Veterans Affairs Veterans Benefits Administration, Claims Processing Improvement Study, Gap Analysis – FINAL, February 15, 2008, p. 15.

<sup>72</sup> Statement of Daniel Bertoni, Director, Education, Workforce, and Income Security, Government Accountability Office, before the Subcommittee on Disability Assistance and Memorial Affairs Committee on Veterans' Affairs, House of Representatives, *Veterans Disability Benefits, Claims Processing Challenges Persist, while VA Continues to Take Steps to Address Them*, GAO-08-433T Washington, D.C., February 14, 2008, p. 2. and Statement of the Honorable James Peake, Secretary of Veterans Affairs, before the House Committee on Veterans' Affairs, Washington, D.C., February 7, 2008, p. 7.

anticipates that the number of claims processed will grow to over 940,000, an increase of 14 percent from 2007.<sup>73</sup> VA asserts that with additional staff it could process claims within 145 days, a 21 percent improvement over the 182.5 days required to process claims in 2007.<sup>74</sup> Some progress already is being made; VA reported in July 2008 that it was processing more disability claims than it was receiving, despite a five percent increase in new claims over 2007, thereby reducing the claims backlog.<sup>75</sup>

Both internal and external factors affect VA's claims processing performance. These include increases in the number and complexity of claims being filed, reopening of existing claims, and the potential impacts of laws and court decisions. For example, the Veterans Claims Assistance Act of 2000 shifted the burden of collecting evidence to support claims from the veteran to VBA,<sup>76</sup> and VBA considers this change to be one of the key factors causing its backlog.<sup>77</sup> Other increases may be attributed to increased participation in benefits briefings that occur during DoD separation programs. While additional staffing may result in some improvement in processing times, additional restructuring, strengthening of raters' expertise in specific issues such as PTSD and TBI, and movement away from paper-based processing systems may be required to achieve dramatic improvement. The recommendations of the Disability Commission and others to change the legislative and regulatory framework for disability compensation are motivated in part by a desire to streamline the rating process.<sup>78</sup>

The Benefits Delivery at Discharge (BDD) Program represents one notable exception to VBA's inability to achieve significant improvements in processing times. The BDD program allows service members to file their disability claims from 60-180 days before they are discharged,<sup>79</sup> with the goal of providing benefits within 60 days following discharge.<sup>80</sup> Since March 2006, VA has been processing BDD claims electronically.<sup>81</sup>

In addition to lengthy processing times, the Government Accountability Office (GAO) and VA's Inspector General have also expressed concerns about the consistency of decisions across VBA's

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<sup>73</sup> Department of Veterans Affairs, *FY '09 VA Budget Request Highlights*, February 4, 2008. Accessed at: <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1448>.

<sup>74</sup> Ibid. See also, IBM Global Business Services, U.S. Department of Veterans Affairs Veterans Benefits Administration, *Claims Processing Improvement Study, Gap Analysis – FINAL*, February 2008, p. 15.

<sup>75</sup> Statement of Rear Admiral Patrick W. Dunne, USN (Ret), Acting Under Secretary for Benefits, Veterans Benefits Administration, Department of Veterans Affairs, before the Senate Committee on Veterans' Affairs, *Examining the Claims Processing System*, July 9, 2008, p. 1.

<sup>76</sup> IBM Global Business Services, U.S. Department of Veterans Affairs Veterans Benefits Administration, *Claims Processing Improvement Study, Gap Analysis—FINAL*, February 2008, pp. 17, 18.

<sup>77</sup> Ibid.

<sup>78</sup> Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability in the 21<sup>st</sup> Century*. October 2007. See also, Institute of Medicine, *A 21<sup>st</sup> Century System for Evaluating Veterans for Disability Benefits*, The National Academies Press, 2007.

<sup>79</sup> Veterans Benefits Administration, Department of Veterans Affairs, *Fast Letter 07-09: Claims Filed by Service Members Prior to Discharge*, April 20, 2007, p. 2.

<sup>80</sup> Statement of Michael Walcoff, Associate Deputy Under Secretary for Field Operations, Veterans Benefits Administration, before the House Committee on Veterans Affairs, Subcommittee on Disability Assistance and Memorial Affairs, House of Representatives, *Personal Cost of the Claims Backlog*, October 9, 2007, p. 3.

<sup>81</sup> VA technical review comments.

57 regional offices. VBA took steps in FY 2007 to improve consistency,<sup>82</sup> and in FY 2008 initiated quarterly monitoring of rating decisions by diagnostic code and increased the number of staff for quality assurance reviews.<sup>83</sup>

## **MANAGEMENT CHALLENGES OF IMPROVING SERVICE TO RETURNING VETERANS**

The recommendations of prior panels highlight several sets of management challenges that VA and its partners must meet if they are to succeed in their ongoing efforts to improve service to veterans. Some of these challenges are longstanding, while others relate to the particular characteristics of today's returning OEF/OIF veterans and to the unprecedented level of collaboration established in the last year between VA and DoD to address the transition of injured veterans from service to hospital to home.

While VA has done much to improve its service to veterans, the wave of veterans returning from the current conflicts presents even greater challenges. VA cannot succeed in meeting the needs of this new cohort of veterans either by shifting attention from older veterans or by increasing the services and benefits it provides within its existing service delivery systems. As described in detail in the following chapters, the Department can only meet the ever increasing and multiple demands of the veteran population if it takes specific actions necessary to be fully responsive to each veteran and learns to operate in a more coordinated manner. To be successful, VA must reorient itself to the needs of today's veteran in a manner that is more integrated, accurate, thorough, timely, responsive, and effective.

### **Developing a Veteran-Centered Approach**

For VA, the broadest set of management challenges is to reorient its operations from improving process to improving service to the individual veteran and meeting his or her needs. This will require much closer coordination between the operations and information systems of VHA and VBA, the two largest operating administrations within VA, thereby placing the veteran at the center of VA's focus and action at all levels. It will require integrating currently fragmented information and administrative systems so that veterans have easy access to information and help as needed regardless of which VA door they enter or which office or facility they approach.

To ensure accurate, efficient, and timely delivery of service to veterans, including those now returning from duty in Iraq and Afghanistan, VBA and VHA must work together to better share data and provide coordinated, effective outreach and service to veterans. These two major VA administrations are organized on different principles, have separate business and computer systems, are often physically separated, and have evolved distinct organizational cultures. VA

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<sup>82</sup> Some of these steps were: (1) conducting a pilot program to assess the consistency of rating-related claims, (2) completing a consistency review of PTSD claims from one of its regional offices that had rating decisions that were significantly different than other VBA offices, and (3) developing a plan to expand its quality assurance program. See Statement of Jon A. Wooditch, Deputy Inspector General, Department of Veterans Affairs, before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives, *Hearing on Disability Claims Ratings and Benefits*, Washington D.C., October 16, 2007, p. 3.

<sup>83</sup> VA technical review comments.

management's challenge is to establish mechanisms and information systems that provide comprehensive service to veterans, ideally one-stop service as opposed to fragmented service.

The Panel is proposing that VA adopt a veteran-centered approach to improve service delivery. This strategy and recommended actions to carry it out are discussed in Chapter 2. Specifically, this will require: (1) a unifying philosophy and approach to guide the work, including a commitment to a "no wrong door" policy for veteran access to information and help and a commitment to tying all actions to the veteran; (2) a centralized information technology (IT) function that develops a strong enterprise architecture across the VA's Administrations and emphasizes meeting component requirements while integrating tools and sharing data, including electronic claims information; (3) strong relationships with external stakeholders, such as DoD and state-level organizations, that also support veterans; (4) vigorous public contact/customer service; and (5) a supporting environment, which includes change management, resource commitments, sustained leadership, and accountability mechanisms.

### **Strengthening the System of Care**

A specific set of management challenges concerns organizing services for those who return from conflict with injuries or at risk for mental illness. The challenge is to ensure that these veterans receive appropriate help when needed, and that the delivery of services to injured service members and veterans during the recovery process is coordinated in a way that promotes rapid and full recovery and reintegration. Much attention has been given to improving care for those who return from service with severe injuries. Some of the lessons learned with this group can be applied to improve care for those with less severe injuries. Other veterans return with no apparent injury but can be identified as at risk for mental or cognitive disorders from exposure to battle trauma. This larger group of "at-risk" veterans warrants attention because the adverse consequences of untreated mental illness and cognitive disorders can be severe: family violence, suicide, or loss of the ability to work. To diagnose and treat these service members and veterans effectively and promptly, those needing treatment first must be identified. The challenge of serving this group of veterans requires VA to develop targeted outreach and prevention strategies to head off or minimize problems that affect recovery and adjustment to civilian life.

Chapter 3 discusses the Panel's proposed strategy to improve care and outcomes for all of those who are injured or at-risk, including how to address the challenge of identifying at-risk veterans and improving their access to timely, appropriate mental health care. Specifically, the Panel proposes a three-part strategy to strengthen the system of care for injured veterans, including steps to: (1) identify and contact those veterans at risk for physical or mental illness; (2) ensure that those in need of care have access to and receive appropriate and high-quality care at the right time and right place; and (3) build on existing care management tools to increase the likelihood of successful rehabilitation and reintegration into society for all injured veterans. Strengthening the continuum of care for OEF/OIF veterans who are at-risk or less severely injured, as well as those who are severely injured, will improve outcomes for many other veterans who will at some point need VA care.

## Organizing for Continuous Improvement

It is not easy for large organizations to sustain the process of continuous learning and improvement required to implement changes of the kind recommended in this report successfully. That is why the most successful organizations consciously design and build institutional support for strategic performance-driven management. Public organizations face special challenges given—among other factors—the complexity of their missions, the constant and often conflicting demands of various constituencies, and frequent changes in their top leadership. The net result of these pressures can be an organizational tendency to react to the latest crisis rather than planning to achieve long-term performance objectives. The prevailing environment can contribute to a defensive and overly cautious resistance to change. A conscious strategy for learning and improvement can help buffer and offset these inevitable, performance-eroding pressures.

VA has in its own recent experience a documented model of successful change that includes the elements needed for sustained organizational improvement.<sup>84</sup> The VHA reorganization during the last decade demonstrates that VA can manage large-scale change successfully. The success of that effort has been attributed to a combination of strong individual leadership with a well-defined vision of what the change was intended to accomplish and how to bring it about; a new management approach that combined delegation to strong regional administrators and accountability for specific results in line with the vision of improved health care; and a system of evidence-based evaluation research and testing of new clinical practices that has allowed the organization to learn and improve at a rapid pace.

One aspect of the challenge of sustaining continuous improvement is improve the ability of the two largest federal Departments—VA and DoD—to plan, manage, and operate jointly as required to improving services to returning veterans. Sustaining the intensity and degree of collaboration achieved by the SOC through the remainder of this year and through the next Administration into the future will challenge both VA and DoD. Furthermore, collaboration for improving care and benefits for OEF/OIF veterans should be institutionalized at the operational levels of VA and DoD as well as in those areas mandated by Congress.

The Panel is proposing a strategy of continuous improvement and learning that will help VA address the continuing challenge of improving service to returning veterans, as well as those of previous generations. This strategy and the associated recommendations are discussed in Chapter 4. Success will require a series of successive and coordinated evidence-driven alterations to the administration of services and benefits for veterans. For the change to be sustained and successful, it must be supported at the top and managed centrally, with clear accountability by all for specific results under their control and a continuous focus on how their work contributes to better outcomes for veterans.

More specifically, success at VA depends on: (1) leadership that is prepared to communicate a clear, consistent, and compelling vision—aligned with the organization’s statutory mission and reinforced by a steady focus on results, measurement, and reporting systems to track progress toward desired outcomes; (2) developing and using a balanced array of performance metrics to

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<sup>84</sup> Phillip Longman, *Best Care Anywhere: Why VA Health Care is Better Than Yours*, PoliPoint Press, 2007.

guide change and provide accountability for results internally and externally; (3) ensuring that personnel with the appropriate skills are employed and given sufficient authority, autonomy, and incentive to achieve the goals; (4) building internal and external relationships to ensure coordination among actors and units, and give each person a “line of sight” to the larger purposes; and (5) establishing regular processes for planning and managing strategically, enabling continual improvement by learning and then adapting to the new information.

## **CONCLUSION**

During the study team’s work, it was evident that at all levels within VA, thousands of talented and dedicated personnel are not only working hard at their jobs, but are finding creative ways to improve service to veterans. The same can be said of the people who work for other federal, state, and private organizations dedicated to serving veterans. Many of these individuals are at times frustrated by standard operating procedures, the information systems that are available to them, and other bureaucratic obstacles to serving veterans effectively. Others are in newly established roles based on earlier recommendations, and they are making an effort to learn quickly how to operate effectively and accomplish their appointed duties, while at the same time implementing new policies and programs and continuously responding to inquiries from study panels, government officials, and Congress regarding their positions, performance, and functions. The focus of their work is improving service to those who have served in the military. Their dedication, professionalism, and competencies offer ample raw material and energy with which to build a better system of service to current and future veterans.

One of the continuing challenges to the leadership of VA is to find better ways to mobilize the ideas and efforts of this talented, dedicated work force. By presenting a series of recommendations that are designed to make “OneVA” a reality, this report seeks to provide all of them with a vision and strategies for success in providing high quality outcomes for veterans of all ages. However, with frequent leadership turnover that occurs at the executive levels in federal departments, a permanent external advisory board is needed to provide continuity and sustained commitment to achieving the OneVA goal. Accordingly, the Panel is recommending that Congress establish such a board and require periodic reports on the progress in achieving veteran-centered service. This recommendation is discussed in Chapter 4.

## Table 1-2. Chronology of Events Since The Walter Reed Report

The following chronology highlights some of the most significant actions taken at the initiative of the Departments and the SOC in the wake of the Walter Reed stories:

### February 2007

Secretary of Defense Gates commissions an independent panel (the Independent Review Group) to review current rehabilitative care and administrative processes at Walter Reed and at National Naval Medical Center in Bethesda, Maryland. Togo West, former Secretary of VA, and John O. Marsh, former member of Congress and Secretary of the Army, are named co-chairs.

### March 2007

On March 6<sup>th</sup>, President Bush establishes the President's Commission for America's Returning Wounded Warriors, co-chaired by former Senator Bob Dole and former Secretary of Health and Human Services and current University of Miami President Donna Shalala.

Also on March 6<sup>th</sup>, President Bush creates the Task Force on Returning Global War on Terror Heroes, charged to improve the delivery of federal services and benefits to GWOT service members and veterans. VA Secretary Nicholson is named task force chair.

VA announces three major initiatives intended to improve health care services to military service personnel returning from Iraq and Afghanistan:

- To hire 100 new patient advocates to help severely injured veterans and their families navigate the VA system. The advocates are to be veterans of the Iraq and Afghanistan conflicts;
- To provide all VA health care professionals with training in diagnosing TBI; and
- To expand polytrauma care by designating 17 additional polytrauma sites at existing facilities.

### April 2007

On April 11<sup>th</sup>, the Independent Review Group's final report is issued. It contains 20 recommendations related to improving case management for returning soldiers, establishing guidelines and improving record keeping for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD), and, where possible, relocating patients to receive continuing treatment closer to their homes.

On April 19<sup>th</sup>, the President's Task Force on Returning Global War on Terror Heroes issues its final report, which includes 25 recommendations concerning health, benefits, jobs and education, and outreach.

### May 2007

VA and DoD establish the Wounded, Ill, and Injured Senior Oversight Committee (SOC).

On May 25, 2007, President Bush signed HR 2206, "emergency supplemental appropriations and additional supplemental appropriations for agricultural and other emergency assistance" for the fiscal years 2007 and 2008.

### June 2007

The Army establishes Warrior Transition Units to implement a new "triad" care approach consisting of a single physician, case manager, and squad leader.

### July 2007

The Commission for America's Returning Wounded Warriors issues its final report containing recommendations for: (1) implementing recovery plans; (2) restructuring disability and compensation systems; (3) improving care for PTSD and TBI (4) strengthening support for families; (5) transferring patient information across systems; and (6) supporting Walter Reed until closure.

### October 2007

The Veterans Disability Commission releases its final report, including 113 recommendations to help to ensure that VA benefits fairly compensate the service-disabled veterans and their families, as well as help them live with dignity.

An Institute of Medicine (IOM) committee, convened at VA's request, reports on its assessment of the evidence supporting the effectiveness of different treatment methods for PTSD. The IOM committee concludes that the evidence on treatment modalities for PTSD does not reach the desired level of certainty for such a common and serious condition among veterans.

The President proposes legislation to implement recommendations of the Commission for America's Returning Wounded Warriors. One goal of the legislation is to restructure the disability evaluation and compensation process.

#### November 2007

VA and DoD take steps to enhance care, management and transition of recovering service members:

- VA conducts joint training for DoD/VA Non-Medical Care Managers, including the Physical Evaluation Board Liaison Officers, VA Military Service Coordinators, and Multi-disciplinary Teams from the military treatment facilities;
- DoD opens a Center of Excellence for Psychological Health and Traumatic Brain Injury; and
- The VA Under Secretary for Health and the Under Secretary of Defense for Personnel and Readiness sign a Memorandum of Agreement establishing the concept of operations for Federal Recovery Coordinators positioned within military treatment facilities.

#### December 2007

DoD begins making inpatient discharge summary data from Landstuhl Regional Medical Center in Germany viewable to VA facilities; a series of additional patient records and reports are scheduled to be made viewable across the departmental boundary in 2008, beginning with inpatient consults and operative reports in March.

DoD introduces an interactive web portal, known as TurboTAP, to provide a single source for guidance for separating service members. TurboTAP provides pre-separation and transition guides, an employment hub, a VA benefits hub, and an individualized transition planning tool.

DoD and VA launch joint Disability Evaluation System pilot in the DC region, using a single comprehensive VA-conducted medical exam as the basis for military Medical Evaluation Board/Physical Evaluation Board determination of fitness to service and VA disability ratings.

#### January 2008

The first Federal Recovery Coordinators are hired.

VA contracts for analysis of the nature of specific injuries and diseases for which disability compensation is awarded in various disability programs in Federal, state, and foreign governments. The study is to be completed in August 2008.

#### February 2008

President signs the National Defense Authorization Act for Fiscal Year 2008. The Act mandates that, by July 2008, the two departments, "to the extent feasible, jointly develop and implement a comprehensive policy on improvements to the care, management, and transition of recovering service members," "develop a policy on improvements to the processes, procedures, and standards for the conduct of physical disability evaluations of recovering service members by the military departments and by the VA," and create a clear joint process for disability determinations of recovering service members.

The SOC LoA for case/care management issues Interim Report to Congress on Policy Improvements on the Care, Management and Transition of Recovering Service Members.

A February story on *National Public Radio* reports that Fort Drum Army representatives told VA officials last year to stop counseling wounded soldiers at Fort Drum on how to complete military disability paperwork. The two departments have since entered into an agreement governing coordination between VA benefits advisors and personnel at Army installations.

#### June 2008

President Bush signs into law the Emergency War supplemental appropriation, which includes the Post 9/11 Veterans Educational Assistance Act, also known as the "21st Century GI Bill." The bill includes provisions for establishing a new program of educational assistance for service members who have served on active duty since September 2001.



## CHAPTER 2 CREATING A VETERAN-CENTERED ORGANIZATION

More than 837,000 OEF/OIF veterans are expected to use one or more of the benefits and services available to them from VA or other federal and state agencies. Already, about 36 percent (300,000) filed a disability compensation claim<sup>85</sup> and this number is certain to increase. Beyond the needs for medical care and disability benefits, returning OEF/OIF veterans, like many of their predecessors, may encounter difficult economic circumstances and may look to the VA for additional education, job placement, and home purchase assistance. Nearly 600,000 veterans will be eligible for GI bill educational benefits that were enacted in 2008.<sup>86</sup>

Despite a variety of plans and initiatives over the past ten years, VA has not been able to shape its structure and operations into an integrated veteran-centered system, and it remains fragmented along administrative and program lines. This fragmentation results in many forms of inefficiency within the Department, and hampers efforts to improve the lives of veterans and their families.

This chapter discusses how VA should go about adopting a veteran-centered management approach. This discussion is focused strategically on business practices and the tools necessary to realize a veteran-centered approach. It does not recommend major reorganizations within VA, address human capital<sup>87</sup> or budget requirements, or offer detailed work plans for implementation. Instead, it identifies key elements and practices that support the strategy and fit within the existing organizational structure, and it offers recommendations for action in each of these areas.

Specifically, it discusses:

- The importance of creating a veteran-centered management approach;
- Past attempts to become more veteran-centered;
- Elements of a comprehensive veteran-centered management approach, including
  - a no wrong door policy;
  - centralized information technology function with up-to-date communication tools;
  - vigorous public contact and outreach,
  - strong relationships with external stakeholders, and
  - a supporting environment encompassing organizational change management and performance measurement.

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<sup>85</sup> Veterans Benefits Administration, Office of Performance Analysis and Integrity, *VA Benefits Activity, Veterans Deployed to the Global War on Terror* (Draft), June 30, 2008, p. 3.

<sup>86</sup> Overview of Post 9-11 Veterans Educational Assistance Act of 2008 (PL 110-252) Briefing by Keith Wilson, Director Education Service, Veterans Benefit Administration, July 8, 2008.

<sup>87</sup> A Report by a Panel of the National Academy of Public Administration for the U. S. Department of Veterans Affairs: *Recruiting and Retaining a Diverse High-Performing Workforce*, 2008.

## **THE IMPORTANCE OF A VETERAN-CENTERED MANAGEMENT APPROACH**

VA cannot achieve its mission simply by increasing the services and benefits it provides within its existing service delivery systems. To meet the ever increasing and multiple demands of the veteran population, the Department will have to focus on its mission in a more coordinated manner. To be successful, it must reorient itself to the needs of today's veteran in a manner that is more integrated, accurate, thorough, timely, and responsive.

Widely lauded for their sacrifices, veterans rightly expect that wherever they turn within VA for assistance, they will receive prompt, courteous, and accurate responses to their needs in a manner that truly demonstrates our nation's gratitude for their service. However, VA's interaction with veterans is often disjointed and results in inadequate service and failure to meet the veteran's needs. The structure of the Veterans Health and Veterans Benefits Administrations within VA, and the multiple programs within each Administration, result in complexity and isolated service activities. This inhibits VA's ability to satisfy veterans with multiple needs, creates redundancies and inefficiencies, and detracts from supporting the mission in a variety of ways:

- Veterans with multiple needs who approach the VA regarding a single query or need may not be identified as having other needs or entitlements, and thus may not be advised or referred appropriately;
- Veterans with a pending claim do not have access to self-service applications that would allow them to determine a claim's status or the actions needed to move a claim through the system;
- Veterans often do not know where to call in VA with a query or a complaint; and
- Veterans receive incorrect, insufficient or conflicting information, leading them to believe that the Department is incompetent or not concerned about their welfare.<sup>88</sup>

Fulfillment of veterans' expectations requires a new business philosophy, integrated information systems, better communication both within and outside the Department, and sustained leadership that will promote and manage the change. Focusing on the customer is a business philosophy that orients the organization to the needs and behaviors of its customers, rather than to internal priorities, such as increasing processing efficiency.<sup>89</sup> A "No Wrong Door" policy, for example, is a referral system that is designed to ensure that individuals who seek information from a public contact representative of a social services agency are provided accurate information and are directed or transferred to the appropriate program, including those that reside in other organizations. Public agencies at state and local levels are adopting this citizen-centered approach by establishing clear connections between mission, operations, and results for the

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<sup>88</sup> Testimony of Randal Omvig before the Senate Committee on Veterans' Affairs, April 15, 2007; Testimony of Gunnery Sergeant Tai Cleveland, USMC, ret. before the House Committee on Veterans' Affairs, January 29, 2008; Testimony of Elizabeth O'Herrin before the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, July 21, 2008.

<sup>89</sup> Customer Centricity is a trademarked term for a program at the University of Pennsylvania's Wharton School of Business.

citizen. “No Wrong Door” policies are one embodiment of a customer-centered approach to handling intake, inquiries, and referrals across programs, and are in place in a growing number of human services agencies at state and county levels.<sup>90</sup>

To ensure that it meets veterans’ expectations, VA must make a strong and enduring commitment to becoming veteran centered. This commitment requires a well-integrated foundation of information sharing across the Department. VA staff engaged in contact with veterans and their families must have the capability to access information across organizational and program lines and make appropriate referrals, and they must be rewarded and recognized for their efforts in providing service to veterans. A commitment by VA to become veteran centered would yield several important benefits. Such a unifying philosophy can provide a sense of common purpose within VA that is currently lacking between its major components. From an operational perspective, the tools associated with a veteran-centered approach will provide:

- A more integrated approach to accessing internal information;
- More comprehensive and informative interactions with veterans (i.e., discussing multiple issues in a single exchange);
- Fewer redundancies in collecting data and maintaining records;
- A more consistent VA response from the veteran’s perspective;
- Fewer errors of omission (e.g., failure to advise of other benefits), and commission (e.g., giving incorrect or conflicting information);
- Reduced number of call-backs, reworked cases, and other inefficiencies; and
- Faster response and processing time for claims.

These improvements will result in:

- Better outcomes for those now returning from Iraq and Afghanistan; and
- Increased overall veteran satisfaction with VA services.

Conversely, the costs of not adopting a veteran-centered focus are:

- Continued inefficiencies in handling inquiries, processing claims, coordinating care and services;

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<sup>90</sup> No Wrong Door citizen-centered models of human services delivery exist in Louisiana, Virginia, the District of Columbia, and Washington State. These citizen-centered policies also exist at the national level in Norway. Hubler, David *Accenture expands Norway’s citizen centric portal*, Washington Technology, July 14, 2008.

[http://www.washingtontechnology.com/online/1\\_1/33153-1.html?topic=&CMP=OTC-RSS](http://www.washingtontechnology.com/online/1_1/33153-1.html?topic=&CMP=OTC-RSS), 2007.

See No Wrong Door policy for the Virginia Department for the Aging at

<http://www.vda.virginia.gov/nowrongdoor.asp> 2007 and

Louisiana at [http://www.dss.state.la.us/departments/dss/No\\_Wrong\\_Door.html](http://www.dss.state.la.us/departments/dss/No_Wrong_Door.html), April 24, 2008.

See also, Ross, J.W., Weill, P., and Robertson, D.C., *Enterprise Architecture as Strategy*, Harvard Business School Press, August 8, 2006.

- More improper handling of veterans due to the isolation of VA components from one another;
- Difficulty in meeting the service needs of the large numbers of combat veterans projected to enter the VA system in the coming years;
- Growing negative perceptions of the VA, its inefficiencies, and inability to support its mission; and
- Increasing amounts of redundant, potentially inconsistent, hard-to-access data within the various programs.

## **PAST ATTEMPTS TO BECOME VETERAN CENTERED**

Despite commitment at the Department level to becoming veteran centered dating back to the 1990's,<sup>91</sup> a long-standing history of poor coordination of services and benefits for veterans within the Department continues to undermine full realization of the veteran-centered philosophy. Specific initiatives that reflect a veteran-centered approach have been planned at VA for years and referred to as becoming "OneVA."<sup>92</sup> The Department has, however, fallen short of full development and execution. The vision of a different kind of organization has, over the past decade, motivated a number of initiatives intended to better unify the Department's work. These initiatives have included specification of a set of software requirements that deal mainly with data sharing and/or integration between VHA and VBA. Full implementation of the OneVA concept has been prevented, however, by major organizational barriers, changes in business practices, and employee orientation, such as:

- Inconsistent responsibility for design and development of OneVA software applications, originally outlined in VA's 1999 OneVA IT Vision and set forth in the Department's 2003 Strategic Plan. Responsibility has shifted between Administrations and the Office of Information and Technology (OI&T) over the years. As a result there has been no effective champion for these initiatives, and they remain in the planning stages.

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<sup>91</sup> See, e.g., ONEVA IT VISION (Office of Information and Technology, March 1999); U.S. Department of Veterans Affairs Strategic Plan 2001-2006 (Office of the Secretary, July 2001); Department of Veterans Affairs Strategic Plan 2006-2010 (Office of the Secretary, October 2006).

<sup>92</sup> For example, the "VA May I Help You" campaign dating from the 1970s was an earlier attempt to unify VA's "voice" when the public called in, and to connect veterans with other programs and benefit offices. Secretary Jesse Brown was instrumental in initiating the OneVA concept in the mid-1990s. A series of OneVA conferences were held by the Department throughout the United States in 1999.

- Inconsistent and inadequate resources to develop OneVA applications. Previously approved or projected funding has shifted to other projects, with the result being that revised plans show a 2010 date to begin implementation.<sup>93 94</sup>
- Lack of continuity of leadership supporting the efforts. Application development proceeds at a slow pace without consistent leadership, and the assignment of oversight passes from manager to manager.
- Strong organizational barriers to becoming veteran centered, such as:
  - Distinctly different structures and cultures between VHA and VBA;
  - Varying degrees of connections with the veteran among the jobs and functions throughout the Department;
  - Poor understanding among many staff about programs other than their own, (especially those not in their Administration), how programs relate to each other, and in some cases how their own job affects the veteran; and
  - A reward structure based on meeting program management’s goals, but not on coordinating or collaborating with others, including those in other programs, to better serve the veteran.

Taken together, this has created the impression that realizing the OneVA vision is not a high priority. Leadership is not sufficiently or consistently involved in defining and achieving OneVA objectives. It has permitted insufficient cooperation between VHA and VBA in defining requirements and developing systems for their mutual benefit. Although the concept of OneVA has existed for over 10 years, no core team or consistent leader has been in place to ensure that development progresses from concept to implementation. Without strong, lasting, joint leadership, the individual champions assigned to the task lack the authority or strength of position to see efforts to fruition. These and other aspects of the working environment continue to challenge VA in focusing on veterans and creating lasting change to sustain that focus.

## **OVERVIEW OF VETERAN-CENTERED APPROACH AND NO WRONG DOOR**

For VA to become what it has termed “OneVA” or a “veteran centric” department, and what we term “veteran centered,” it must establish five foundational components:

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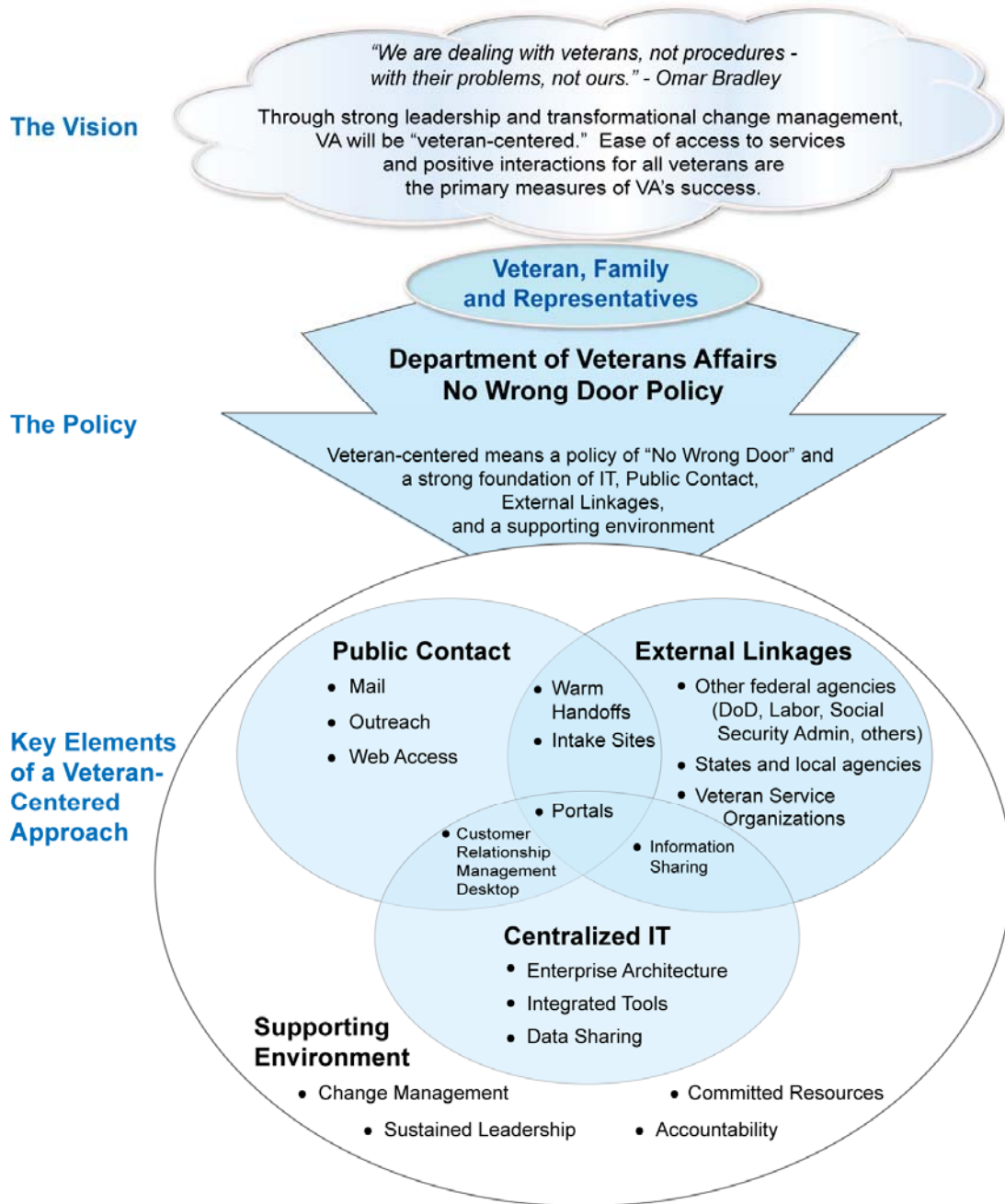
<sup>93</sup> See VA’s FY 2007, 2008 and 2009 budget submissions. Using the Contact Management (CM) application as an example, the FY 2007 budget to design and develop the application included no funds for the project. In the FY 2008 the budget for CM was \$6 million, but the funds were reallocated to other programs (e.g., meeting new badge requirements, addressing IT security issues). About \$7.3 million are budgeted for FY 2009, but, given the history of events surrounding OneVA and the competition among other programs for funds, funding may be in doubt. This is reflective of the resource challenges faced by all OneVA applications, which OneVA observer described as “orphans.”

<sup>94</sup> On the need for increased OMB guidance to agencies on re-baselining policies, see testimony of David A. Powner, Director of Information Technology Management Issues, Government Accountability Office, before the Senate Committee on Homeland Security and Government Affairs, July 31, 2008.

1. A unifying philosophy and approach to guide the work (e.g., No Wrong Door policy and commitment to tying all actions to the veteran);
2. A centralized information technology (IT) function that develops a strong enterprise architecture across the VA's Administrations, based on thorough understanding of customer requirements, and emphasizes the integration of tools, data sharing, and electronic claims information;
3. Vigorous public contact/customer service;
4. Strong relationships with external stakeholders, such as DoD and state-level organizations, that also support veterans; and
5. Supporting environment, change management, committed resources, sustained leadership, and accountability mechanisms.

The relationship among these components is shown in Figure 2-1, and each element is discussed in the text that follows.

**Figure 2-1. Components of a Veteran-Centered Approach**



Source: A Report of a Panel of the National Academy of Public Administration For the U.S. Congress and the U.S. Department of Veterans Affairs, *After Yellow Ribbons: Providing Veteran-Centered Services*, 2008.

Because VA offers so many different benefits and programs, there are many points in the organization where a veteran interacts with or enters the VA system. Depending on their specific needs at any given time, veterans may seek educational assistance, file a compensation claim, or seek medical care. All of these areas are managed independently and maintain separate,

sometimes unique, but often duplicative, data concerning the veteran, with limited mechanisms for sharing information.

There is insufficient operational coordination and integration in the work of VA's two separate major Administrations—Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA). The fact that VHA has dispersed authority through its Veterans Integrated Service Network (VISNs) and Medical Centers, and has adopted a case management model, while VBA is more centralized and claim file production oriented, is not an inherent flaw since VHA and VBA work processes intersect at only a few major points. Their distinct structures and limited connections have, however, hampered communication, information sharing, and referrals of veterans between Administrations, discouraged the adoption of a unified approach to dealing with veterans, and undermined development of information systems that are more capable of supporting mutual requirements.

A real commitment to being veteran centered will provide a strong unifying philosophy that all segments of VA can adhere to, promising better internal coordination and reducing many of the gaps in transition assistance and service delivery. VHA initiated significant efforts in this direction in the 1990s, when it reorganized and decentralized responsibility for achieving improved health care outcomes. This reorganization changed VHA's approach to health care delivery and supported the development of electronic health records.

As part of this veteran-centered approach, adoption of a “no wrong door” policy would represent an organization-level commitment to enabling the veteran, and those acting on his or her behalf, to enter the VA system at almost any point and be: (1) given accurate information about the issue at hand; (2) informed of other benefits for which they might be eligible; and (3) directed to the appropriate point of contact for more specific information. In addition to VA's leadership commitment to this policy and making it the new *status quo*, successful implementation of a “no wrong door” policy requires:

- Access to data across systems within the VA by those who interact with veterans;
- Improved public contact activities with adequate resources, tools, and training for personnel engaged in a public contact role;
- Coordination with external stakeholders who also serve veterans;
- A change management initiative to create and maintain the foundation for the veteran-centered approach and its associated practices; and
- The development of a performance management system to gauge the effectiveness of the change management initiative.

Each of these requirements is discussed in the following sections.



## **INTEGRATED IT CAPABILITIES**

Information Technology (IT) is absolutely critical to VA's success in becoming veteran centered. A strong department-wide enterprise architecture with centralized control over the development of applications is the optimal structure for efficiently building, deploying, and maintaining integrated capabilities that support the OneVA model, so long as it is rooted in the requirements of VA's patient and beneficiary service components.

One of the major preconditions for implementing a veteran-centered approach is the automation of paper records and processes. Continued movement from paper to electronic records, balanced with robust data security protections, will yield several benefits, including:

- Greater ease of data sharing within VA;
- Improved timeliness of claim decisions;
- Reduced risk of lost or misplaced records;
- Enabling the creation and use of specialized processing centers to rate complex or difficult-to-rate conditions (e.g., PTSD, TBI) by sharing records in real time;
- Enhanced ability to redistribute the claim workload among locations as needed; and
- Improved veteran access to their data and services.

### **IT Reorganization**

A major reorganization of IT activities, initiated in 2007, presents both major challenges and opportunities to achieve veteran-centered management of services. Prior to 2007, the overwhelming majority of IT dollars, personnel, infrastructure and application development resided with the VA's Administrations. In the reorganization, these functions were transferred to the Office of Information and Technology (OI&T). As the Deputy Chief Information Officer testified to Congress in September 2007, "the Secretary migrated all IT activities under single leadership authority, in part due to the need to drive standardization and interoperability of applications and infrastructure across VA."<sup>95</sup> His testimony further stated that achieving IT interoperability and compatibility requires that OI&T "collaborat[e] closely with the [VA's] Administrations in use of business modeling to provide a uniform basis of developing a shared understanding of new ways to serve veterans and the information required to do so."<sup>96</sup>

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<sup>95</sup> See Statement of Paul A. Tibbits, M.D., Deputy Chief Information Officer for the Office of Enterprise Development, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, U.S. House of Representatives, September 26, 2007.

<sup>96</sup> Ibid.

Short-term consequences of the OI&T reorganization include time delays in obtaining funds for business process development and in contracting for IT-related services. There is also controversy within VHA about the success of this reorganization, and dissatisfaction over VHA's loss of direct control over IT initiatives. While the ongoing reorganization has altered the established patterns of IT development, and added challenges to the rapid development of IT projects, centralization of IT management—so long as tied closely to customer requirements—will ultimately aid the Department in integrating systems and sharing information across Administrations and programs—a key foundation of a veteran centered, OneVA approach.

## **IT and Veterans Claims Processing**

Lengthy delay in disability claims processing is a long-standing issue that has received much attention and publicity.<sup>97</sup> At present, the claims processing system relies largely on paper records, which are cumbersome to compile and difficult to share among locations without risk of losing all or portions of a claim file. The Secretary and the Undersecretary for Benefits have endorsed the principal recommendation from a recent IBM study that VA should proceed towards paperless claims processing, much in the manner adopted by the Social Security Administration.<sup>98</sup>

VBA intends to move as quickly as possible toward this goal, recognizing that external constraints (e.g., a lengthy acquisition process to select a lead integrator and secure needed funding) will slow progress. Adopting a paperless claims process is critical to enabling improved timeliness in the disability rating process. Acting Undersecretary Dunne testified recently before the Senate Committee on Veterans' Affairs that, "[b]ecause our current claims process is heavily reliant on paper and the movement of paper claims folders, the greatest efficiencies will be gained as a result of IBM's longer-term recommendations to move to an electronic, paperless environment."<sup>99</sup> Senator Burr, the Ranking member of the Committee commented that "[s]imply drawing more money and more personnel to the problem clearly—clearly—has not been the solution. . . . It's time to seriously explore other options including conversion to paperless claims and overhauling VA's overly complex disability rating system."<sup>100</sup>

VBA has adopted other recommendations in the IBM study, including measuring and reporting work completed on discrete issues, in addition to completion of entire claims. Most claims filed by veterans seek determinations for multiple disabilities—an average of three issues, with many veterans filing for eight or more claimed conditions.<sup>101</sup> VBA officials believe that analyzing and reporting by issue will permit more accurate work performance measurement, increase the

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<sup>97</sup> See A Report by a Panel of National Academy of Public Administration report for Congress and the Department of Veterans Affairs, *Management of Compensation and Pension Benefits Claims Processes for Veterans*, August 1997; VA Claims Processing Task Force Report to the Secretary of Veterans Affairs, 2001.

<sup>98</sup> See IBM Global Business Services, *U.S. Department of Veterans Affairs, Veterans Benefits Administration: Claims Processing Improvement Study*, February 2008. See also Testimony by Acting Undersecretary Dunne before the Senate Veterans Affairs Committee, Oversight Hearing, Review of Veterans' Disability Compensation: Undue Delay in Claims Process, Senate Committee on Veterans' Affairs, July 9, 2008.

<sup>99</sup> *Ibid.*

<sup>100</sup> Senate Committee on Veterans' Affairs Hearing, July 9, 2008, *op cit.*

<sup>101</sup> Interviews with VBA officials.

number of partial awards, and permit earlier compensation payments to disabled veterans while awaiting final action on issues that take more time to evaluate.<sup>102</sup> Focusing on issues will allow an appropriate work credit structure to be implemented and will motivate VA claims personnel to adopt this approach.

VA has experienced some success with a paperless claims process. For example, through the Benefits Delivery at Discharge (BDD) program, VA has “electronically” processed about 22,000 claims through the third quarter of FY 2008.<sup>103</sup> The data are captured as scanned images of paper forms, however, and the result is non-computable data. While this approach supports the ability to share claim files among locations with less delay and risk, an end-to-end electronic capability would be more effective. Rules-based electronic claims allow the capture of fielded data at claim inception and augmentations to the file with additional electronic forms and documents throughout its processing lifecycle.

At present, VA is making strides in this area through improvements to its Veterans On-line Application (VONAPP) process. VONAPP is a Web-based system that allows veterans, survivors, and others to complete on-line applications for various VA benefits. Until recently, the process was only a quasi-online capability—after completing the form online the applicant was still required to print, sign, and send it through the U.S. mail. Upon receipt, VA then re-typed the claim information into its system. Recent resolution of e-authentication issues now allows VA to accept electronic submissions and process them without the claimant’s signature.<sup>104</sup> This decision should greatly improve the application process for the veteran and reduce the time involved in getting the application into the VA system.

### **Recommendations for IT Management and Access**

To ensure that VA is coordinated in the design and development of tools needed by multiple stakeholders across the Administrations, centralized development and management of IT is essential, with active involvement from the business lines in defining business requirements. VA’s recent centralization of IT planning should help facilitate the development and Department-wide deployment of appropriate tools in an efficient and coordinated manner. Each of the IT-related recommendations offered here relies on this centralized IT organizational structure to ensure that all tools and initiatives align with the vision of being veteran centered.

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<sup>102</sup> Certain types of partial payments have been official policy for some time, but there is evidence that it is underutilized because there is little incentive at Regional Offices to do so. Current policy allows for partial payments for veterans still in treatment for a condition, based on the assumption that they qualify for a certain percentage of disability in the interim, and the degree of disability is assumed to be at least as high or higher upon completion of their treatment. “Work credit,” a primary metric in determining individual and unit performance, is granted only for completed claims.

<sup>103</sup> Interview with VBA official. For comparison purposes, VA received a total of 838,000 rating-related claims in FY 2007. See Statement of Michael Walcoff, Deputy Under Secretary for Benefits, Veterans Benefit Administration, before the House Committee on Veterans’ Affairs, Subcommittee on Disability Assistance and Memorial Affairs, *Examining the VA Claims Processing System*, February 14, 2008. p. 1.

<sup>104</sup> Department of Veterans Affairs News Release. *VA Announces On-line Claims Applications*, July 16, 2008.

**The Panel recommends that VA:**

- 2-1. VA should accelerate the migration to electronic records for claims processing and create a greater sense of urgency, specific target dates for migration, accountability mechanisms, and quantifiable performance measures.** VBA has begun a paperless processing initiative, moving from paper-based to electronic records for its business lines in Compensation & Pension, Education, Vocational Rehabilitation & Employment, Insurance and Loan Guaranty. As a Department, VA needs a more coordinated organizational approach, to and goals for, the migration.
- 2-2. VA should accelerate timelines for completing VA's Contact Management (CM) and Registration and Eligibility (RE) projects.** These OneVA, veteran-centered IT applications were originally scheduled for development and implementation years ago and should be initiated immediately, rather than postponed to FY 2010, as is currently planned. VA IT officials have said that resolution of e-authentication issues to enable veteran based self-service while protecting privacy is essential to more rapid progress. A prompt resolution of these issues is necessary.
- 2-3. VA should update the Web-Based Veterans On-Line Application (VONAPP) process to allow the direct incorporation of claims information into benefit claims tracking applications (i.e., VETSNET MAP-D), which provide benefit payment and accounting functions.** Currently the *pdf* claim application form which the veteran submits has to be rekeyed into the VETSNET MAP-D application. Allowing direct import of claims information would expedite the process, as would developing a rules-based questionnaire with branching logic (in the manner of Turbo Tax). This would elicit more detailed information about the exact nature of the claim, as well as information that is relevant to the resolution of the issues presented. VA indicated that it has awarded a contract for the direct importing of claims information into benefit tracking applications.<sup>105</sup> However, the Panel was not provided a copy of the contract to verify its comprehensiveness.
- 2-4. VA should collect and maintain personal e-mail addresses of veterans in a manner consistent with privacy protections for personal information.** Gathering e-mail addresses from veterans would enable more effective outreach by VA. This can be accomplished by adding an e-mail address field to all forms, applications, including the VONAPP and other documents that contain veteran contact information.<sup>106</sup> Veterans often change residence following discharge, but their e-mail address usually remains the same.<sup>107</sup> A secure central file of veteran e-mail addresses should be created and maintained.

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<sup>105</sup> VA technical comments.

<sup>106</sup> Workflow analysis should also be performed to identify all the various places where veterans might interact with VA and provide this data.

<sup>107</sup> Testimony of Elizabeth O'Herrin before the House Committee on Veterans' Affairs, July 15, 2008.

- 2-5. VA should align future Information Technology application development with OneVA goals by requiring that business plans and budget justification include an explicit statement regarding how the application promotes a veteran-centered Department.** This articulated linkage to Department-level goals should be a standard component within the business plans and justification developed for each new effort.

## IMPROVED PUBLIC CONTACT

A strong customer support capability (public contact) is critical to a veteran-centered approach. VA recognizes that veterans interact with the VA through multiple mechanisms, and has begun efforts to improve its veteran/VA communications capabilities in several areas. As used here, public contact broadly encompasses communications initiated by those outside the VA (veteran initiated) and those initiated by the VA (outreach). Public contact mechanisms include:

- Call centers that handle telephone inquiries;
- Web portals that enable veterans to access a variety of VA information and engage in dialog utilizing the expanding possibilities of Web 2.0 technology discussed below;
- Mailings to communicate disability determinations and other benefit information; and
- Broader outreach to raise awareness about VA benefits and services among veterans not currently enrolled with the VA.

In the summer 2008, VA initiated a telephone outreach effort to contact over 500,000 OEF/OIF veterans who had not yet used VA's medical care system in order to inform them that they are entitled to treatment of their medical needs in VA's health care system for a minimum of five years.<sup>108</sup> While this was an important step to contact veterans who had not accessed VA's health care, opportunities exist for VA to strengthen its outreach to veterans, particularly in a more targeted manner.

### Call Centers

Call centers are an important component of VA's public contact efforts because, as one VA official stated, everyone who contacts VA ultimately wants to talk to someone. The number of telephone inquiries is high—23 to 25 million calls per year.<sup>109</sup> Many of these are from older veterans who are less likely than younger veterans to use the Internet.

VBA handles 90 percent of telephone inquiries that come into the VA system.<sup>110</sup> Calls concerning medical treatment issues are identified early in the process, and are transferred through VBA's automated system to the VHA Health Eligibility Center. About 50 percent of the calls handled by the Health Eligibility Center are received as "warm transfers" through this

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<sup>108</sup> Department of Veterans Affairs, Public and Intergovernmental Affairs, *VA Begins Next Phase of Combat Vet Outreach*. May 30, 2008.

<sup>109</sup> Interviews with VBA officials.

<sup>110</sup> Interviews with VBA officials.

process (i.e., the caller is transferred, rather than instructed to hang up and dial a different number).

VBA has already taken steps to improve its public contact program by initiating the consolidation of its call centers and development of a performance plan with quantitative measures of effectiveness. Efforts to obtain contractor support for systems integration, as well as for assistance in reviewing and revising its marketing approach, are further examples of the potential for VA to become a more integrated, coordinated, and veteran-centered organization. The call centers, which were located at each of VBA's 54 regional offices, are being consolidated to nine locations. VBA management believes this consolidation will increase the effectiveness of VBA public contact. In addition to customer satisfaction measures,<sup>111</sup> VBA has developed performance measures related to the quality of information provided to veterans during telephone inquiries. VBA will also continue to track "dropped" and "abandoned calls."<sup>112</sup> There remains, however, a pressing need for a Customer Relationship Management (CRM) desktop and better search capability to provide enhanced information availability to call agents.<sup>113</sup>

VA has already developed OneVA plans, concept papers, and requirements documents for several veteran-centered tools that provide the basis for new systems—Contact Management (CM), Registration & Eligibility (R&E) (both VA software development efforts), and Customer Relationship Management (CRM) (a commercial off-the-shelf application, modified to VBA's requirements)—could support better service to the veteran. CM and R&E will improve internal coordination and data sharing. CRM supports both access and delivery of the best information to the veteran by call agents. It also provides metrics for management to assess VA performance in public contact and resolution of issues.

In addition to handling live calls, VA can leverage the call agent systems and training by expanding its communication channels through addition of online chat capability. Offering veterans multiple mechanisms to query the VA and receive help—whether the query is for benefits and routed to VBA, or about health issues and routed to the Health Eligibility Center—is consistent with a veteran-centered approach. Chat sessions offer another communication option for those who prefer an online, real-time dialogue with knowledgeable VA personnel. Many of the resources exist within the call centers to accommodate this functionality, and the "chat agents" could access the same databases and follow the business rules currently used in telephone calls. Protocols for authentication must be employed, just as they are when handling calls, and developing this protocol should follow rules being used with the updated VONAPP.

### **Increased Use of Internet Technology**

As younger veterans enter the system, VA recognizes that many of them are comfortable with technology and actually prefer to interact with the VA via the Internet. At present, a number of web portals are available that support specific VA programs, in addition to the general VA

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<sup>111</sup> No customer satisfaction surveys were done in 2005 or 2006. Customer satisfaction survey results for 2007 are expected by the end of 2008. VA FY 2009 Budget Submission, Vol. 3, 4C-6.

<sup>112</sup> The dropped call and abandoned call rates for 2007 was 32 percent and 14 percent, respectively. Estimates for FY 2008 are 20 percent and 10 percent. VA FY 2009 Budget Submission, Vol. 3, 4B-20.

<sup>113</sup> Interviews with VBA officials.

website. As web portals proliferate, VA is faced with problems similar to its use of VA 1-800 lines, which at one point had expanded to hundreds of separate listings. A limited number of web portals with a consistent style and user interface and shared access to linked databases would enhance veterans' access to information and help create a more unified web presence for VA. This communicates to users that there is a single VA with multiple, coordinated programs and services.<sup>114</sup>

VA is working to link access from the portals to data residing in multiple databases. VA's current IT Strategic Plan states that the Department will implement a OneVA portal and interfaces to service applications by 2011, with ten percent completion by the end of September 2008. Eventually, this will allow veterans to access and manage all interactions with VA, such as address and beneficiary changes, check claim status, home loan applications, access to education benefits and medical records.

Continued maturation of My Health<sub>e</sub>Vet, together with VBA's recent commitment to developing paperless processing for all business lines, should facilitate a useful and robust VA web portal. It is unclear at this point what relationship the OneVA portal will have with the eBenefits site for veterans recommended by the Dole-Shalala Commission. Ultimately, the issues relating to consolidation of portals must be resolved at the Department level, because the portal must represent a unified VA persona, rather than individual programs or organizations.

Another avenue for exploiting new technology is using new collaborative environments (Web 2.0). Web 2.0 is an umbrella term, not a specific technology, which refers to two significant shifts in the Web technology—one focusing on users generating the actual content and the other on the user's method of access via a Web browser to Web-stored data and applications.<sup>115</sup> Examples of its use include blogs, podcasting, social networking sites, and webinars/ webcasts.<sup>116</sup>

The dynamic environment of information sharing and collaboration that embodies the Web 2.0 concept is rapidly expanding—even among federal agencies. (*See Appendix B for a matrix of Web 2.0 Technology and Government developed by the General Services Administration.*) Thirty-three federal agencies have public blogs. EPA and NASA participate in social networking sites, and agencies within the Intelligence Community are creating collaborative workspaces for analysts to share information between agencies.<sup>117</sup> Government sees Web 2.0 as an effective approach to collaborating and sharing information, both within and across agencies, and with the public.

VA is in the early stages of exploring Web 2.0 capabilities. In response to Congressional and other pressures, it is pursuing solutions to legal, security, and privacy issues regarding the use of

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<sup>114</sup> See also recent article describing OMB's efforts to reduce the proliferation of agency portals, with a target of 50 "connections" (down from 235) to access all federal agencies. Mosquera, Mary, *OMB Says Agencies Must Shed More Gateways*. Federal Computer Week, July 10, 2008.

<sup>115</sup> Adapted from <http://www.techweb.com/encyclopedia/defineterm.jhtml;jsessionid=VENRMYH2LN2D4QSNLPSKHSCJUNN2JVN?term=WEb+2.0&x=29&y=11>, 2008.

<sup>116</sup> Environmental Protection Agency, Web Workgroup, *Web 2.0 Whitepaper*, February 2008, p. v.

<sup>117</sup> See description of A-Space collaborative environment for intelligence analysts at [http://en.wikipedia.org/wiki/US\\_intelligence\\_community\\_A-Space](http://en.wikipedia.org/wiki/US_intelligence_community_A-Space). September 18, 2008.

public sites, such as Facebook and MySpace. VHA discussions are ongoing with GSA, vendors, and other stakeholders, about adopting these capabilities and using them to engage veterans.<sup>118</sup>

Assuming these issues are satisfactorily resolved in the near future, VA could adopt Web 2.0 technology as a way to establish “Virtual Vet Centers.” As discussed in chapter 3, returning veterans face many challenges in accessing care after they return to their local communities. Veterans who do not live near a VA health care facility or Vet Center may have limited access to care, which may make their transition and adjustment more difficult. Using Web 2.0 technologies, VA could host a social networking or other collaborative site and offer veterans a way to access information, and share ideas and experiences. This type of communication channel puts considerable control in the hands of veterans, allowing them to join communities of interest for support, as well as connecting them with relevant VA services.

### **Improving Outreach**

VA traditionally has used the mail as a means of outreach. VA is missing an opportunity to communicate faster and more effectively using e-mail, a communication channel many veterans prefer. On receipt of discharge information from DoD, VA sends a letter from the Secretary to the new veteran at the address listed in the discharge papers. This mailing includes a small pamphlet about various veteran benefits. Timing is critical in sending mail to new veterans because of their mobility, so even these mailings have presented a challenge to VA. Extended delays in receipt of some discharge papers from DoD result in a substantial amount of undeliverable mail. VBA is exploring the use of VA/DoD Identity Repository (VADIR) and alternative channels to obtain more accurate addresses in a timely manner and reduce the amount of undeliverable mail.

For veterans who file disability benefits claims, VBA communicates its disability decisions by letter. A package of material with information about other benefits to which the veteran may be entitled is included with this letter. Given the length and complexity of most claims decisions, and the detailed information on appeal rights that accompanies them, the veteran may overlook or give scant attention to this information about additional benefits.<sup>119</sup>

VBA, in conjunction with the Office of General Counsel, is working to rewrite these letters. Its goal is to provide clear, concise, and easily understandable information, while also furnishing more detailed information about due process and appeals required by law. VBA is also considering sending information about additional benefits in a separate mailing following the claims decision, to better capture veterans’ attention and make them aware of other possible benefit entitlements.

VA does not currently have a policy of collecting or retaining e-mail addresses of veterans who receive, or who are eligible to receive, VA benefits from the department. Nor does it typically communicate with veterans by e-mail when an e-mail address exists. VA is missing an

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<sup>118</sup> Testimony of Assistant Secretary Lisette Mondello, Assistant Secretary for Public and Intergovernmental Affairs, Department of Veterans Affairs, before the House Veterans’ Affairs Subcommittee on Oversight and Investigations, July 15, 2008.

<sup>119</sup> Interviews with VBA officials.



opportunity to communicate faster and more effectively using a communication channel many veterans prefer. For many members of the OEF/OIF generation, electronic mail is the preferred mode of communication, and e-mail addresses often are more reliable than physical addresses for this group. Requests for e-mail addresses can be made when a service member is separating from the service, during every communication with veterans (i.e., at every “door”), as well as in the standard forms used by VA (e.g., medical records, claims applications). This effort must, of course, be combined with the development of adequate and sound policies and procedures for protecting the names and other personally identifiable information acquired from veterans.

Veterans seeking information from VA, either on-line or through call centers, should routinely be asked for an e-mail address, and whether that veteran wants to receive information from VA electronically. Communications could be further enhanced if veterans who contact VA are asked what benefit or service areas they would like to receive information about in the future, and are added to a distribution list for that topic area. The use of distribution lists is widespread within VA for sharing information among the workforce, and a similar practice is widely used in other organizations to share targeted information with stakeholders quickly and easily.

If VA created an electronic enrollment form, veterans could sign up for specific updates regarding disability, health, education benefits, and other topics. This would permit targeting specific information to those with the highest interest or need.<sup>120</sup>

Obviously, whatever the form of communication used—mail, e-mail, telephone or personal contact—it is essential that the message is clear, comprehensible, and tailored to the maximum extent practicable to the individual needs of the recipient. Defining how e-mail will be used to achieve a more veteran-centered Department must be a priority matter in the VA’s revised strategic plan, and an element of its outreach plan.

### **Targeted Outreach/Communications**

VA has often been urged to do a better job of getting basic VA information to veterans who are not currently enrolled and inviting them to come and learn more. Opinions have been mixed about whether VA has the authority to advertise or market itself, with some citing OMB restrictions about soliciting business as a barrier.<sup>121</sup> Others have argued that VA is well within its legislative mandate to offer basic information about who might be eligible for benefits and what some of those benefits might include.

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<sup>120</sup> Many universities issue each student a permanent, life-time e-mail account where school and alumni information is sent. Some schools offer full e-mail capabilities for life (ensuring an alumnus always has an e-mail account), while others offer only permanent forwarding to a personal account of their choice. VA should consider the viability of a similar practice as part of its communications planning efforts. For examples of the practice see:

Pepperdine University <http://www.pepperdine.edu/alumni/onlineservices/email.htm>;

McComb’s School of Business at the University of Texas at Austin

<http://www.mcombs.utexas.edu/alumni/emailforwarding/>

Ball State University

<http://www.bsu.edu/alumni/iconnect>

<sup>121</sup> House floor debate on H.R. 3681, Congressional Record, May 20, 2008, and interviews with VBA officials.

The renewed emphasis on strengthening care for the severely injured and on responding to prior panel recommendations for improved service to returning war veterans has resulted in more attention to the issue of improving outreach. The U.S. House of Representatives on May 20, 2008, passed HR 3681, “The Veterans Benefits Awareness Act,” intended to clarify VA’s authority to engage in active outreach.<sup>122</sup> Committee members noted during debate on the bill that military services often run national advertising during the Super Bowl and other sporting events, while VA’s media use has been confined to “public service” spots usually run during off hours by local stations. Frequent commercials for *Militaryonesource.com* run during prime viewing hours, e.g., during daytime and children’s programming and during the evening news. The ads offer a simple message: visit the site or call the 800 number to learn more—a message similar to that which VA attempts to communicate when it engages in its more limited mass marketing. Secretary Peake decided on June 16, 2008, to lift restrictions on VA advertising in response to this congressional action.

VA is considering a marketing assessment that would inventory its current communications and develop recommendations for improving its outreach approach. This assessment could lead to development of a more extensive “marketing” campaign to reach those who are not currently in the system, and could perhaps include targeted “micro-marketing” to particular sub-groups with specific needs, such as those at risk for PTSD or those who have particular needs resulting from their disabilities.

VA has much to accomplish before it can communicate effectively with sub-groups of veterans. A recent attempt to secure a central list of OEF/OIF amputees revealed that VA headquarters could identify fewer than seven percent of that population. This suggests that, prior to launching new targeted marketing initiatives, VA should develop a robust and efficient capacity to classify veterans on the basis of their needs and eligibility for benefits. It also must coordinate and consolidate data across programs to ensure that it has correctly identified and tracked the size and makeup of various veteran subpopulations and can generate adequate registers of those with specific characteristics or needs. VA’s Assistant Secretary for Public and Intergovernmental Affairs testified before the House Committee on Veterans’ Affairs that the Secretary’s decision to use advertising resources will allow the VA to “modernize and reshape efforts to more effectively reach and educate veterans and their families about VA’s benefits and services.”<sup>123</sup> An “Outreach Strategic Plan” was promised by the end of 2008.<sup>124</sup>

### **Recommendations Related to Public Contact and Outreach**

Many of the recommendations concerning VA’s contacts with the public rely heavily on improved IT systems to support a veteran-centered focus.

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<sup>122</sup> Ibid.

<sup>123</sup> Testimony of Assistant Secretary Lisette Mondello before the House Veterans’ Affairs Subcommittee on Oversight and Investigations, July 15, 2008.

<sup>124</sup> Ibid.

**The Panel recommends:**

**2-6. VA should adopt a single secure web portal to provide the initial “door” for veterans to have easy access to a variety of links to all VA benefits and services.** Adoption of a single portal will provide a consistent entry point to those accessing VA information, including veterans and others authorized to access information on their behalf, as well as links to different content areas based on the needs of the user. User groups could include:

- Veterans;
- Family members (e.g., spouse, parent) and/or caregivers;
- Survivors;
- Those with power of attorney for a veteran (e.g., VSO representatives, County Service Officers);
- Private sector health care providers; and
- Employees of other state, local and federal programs assisting veterans.

**The site should provide “one-click” links to a variety of internal web environments and external links, such as My Health<sub>e</sub>Vet, eBenefits, and other current and future content areas, with secure access that is limited to those with appropriate authorization.** Examples of the accessible content and capabilities from this single portal could include:

- Benefits offered by each VA program;
- On-line enrollment capability;
- Specific benefits available to the veteran or survivor;
- Access to current claim status;
- Access to personal medical records;
- Health care management (e.g., appointment scheduling, request referrals, request prescription refills);
- Ability to ask about specific benefits; and
- Links to other federal, state, and local programs.

**2-7. VA should expand use of collaborative web technology as internal and external communication channels.** VA is currently working through the legal and contractual issues regarding use of popular public sites such as Facebook and MySpace. Veterans returning today are active users of social networking sites while they are deployed, as well as upon their return home. VA can leverage these existing communication channels,

knowing that many veterans are current users of the technology.<sup>125</sup> VA can launch a number of initiatives, such as the creation of Virtual Vet Centers to reach underserved populations of returning veterans, and blogs for sharing recent news, updates, general information, and collect comments and feedback from veterans.

- 2-8. VA should deploy a Customer Relationship Management (CRM) desktop to further enhance performance of telephone call centers and capture caller satisfaction.** The call center consolidation is expected to increase the effectiveness of VBA public contact and provide greater opportunity for quality assurance actions by VBA management. The extensive training and quality control efforts provide new capabilities to capture data and pinpoint areas for continuous improvement. Addition of a CRM tool will provide VBA with further capabilities to access data from multiple VA databases in a more coordinated and rapid manner, as well as capture performance data. **VBA should build veteran satisfaction measures into the protocols for handling telephone inquiries.** Borrowing approaches used in private industry, each call might include a set of scripted questions asking the caller to rate his or her level of satisfaction with the outcome of the call, and to evaluate how thoroughly or appropriately the issue was resolved.
- 2-9. VA should expand call center functionality to accommodate real-time live chat capabilities with veterans. Tools and business rules employed by the consolidated call centers should be leveraged to communicate with veterans on-line, in real time, in a similar manner to a telephone dialogue.** Online chat is a common communication channel used by organizations that provide customer service and technical support, and operates in a manner similar to a call center. Expanding the call centers to accommodate this additional communication channel would further support a veteran-centered approach, and provide veterans with more flexibility in obtaining information from VA.
- 2-10. VA should add communication channels used in VA’s general information outreach, such as providing separating service members with benefit information on DVD/CD or “memory stick”, a user-friendly web-site, podcasts, and other forms of easily accessible media.**

In addition to providing veterans easy access to learning about and filing for benefits and services, VA should increase and improve its proactive outreach efforts to veterans. At present, numerous offices within the Administrations are conducting *ad hoc* or uncoordinated outreach efforts, resulting in inefficiencies and potential risk of missed opportunities to reach key audiences. Outreach improvements should include developing appropriate methods for identifying and reaching specific groups of veterans with particular needs.

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<sup>125</sup> Many agencies first test a social networking capability with internal employees before creating capabilities with the public. Recommendations are offered in Chapter 4 for using these technologies to help facilitate internal change management efforts. However, implementation of this recommendation should not be delayed until after an internal capability is developed.

**2-11. VA should develop, expand, and employ e-mail communication channels with veterans as quickly as possible. E-mail addresses should be routinely collected and centrally maintained.** The VA is missing this critical link with veterans by not using e-mail as an outreach mechanism. E-mail is considerably more cost-effective than traditional mail as a distribution medium. It is also faster and more reliable for reaching particularly mobile groups in the veteran population.

**2-12. VA should develop a VA-wide outreach strategy and action plan.** This outreach plan would:

- Describe the placement of coordinated outreach within the Department, including lines of communications to VA program offices;
- Identify the relevant target audiences and challenges involved in reaching each audience;
- Specify the methods and procedures that will be adopted to overcome those challenges;
- Use a multi-method approach to sharing information, including such channels as e-mail and Web 2.0 technologies for two-way communication, and television, radio, and print media for one-way outreach; and
- Set forth the timing and sequencing of routine and general information communications.

**2-13. VA should develop targeted outreach efforts to groups of veterans that are at greater risk of not receiving thorough, timely information about their benefits.** These groups include:

- National Guard and Reserve members, who often miss information about programs to assist them during their intensive demobilization process;
- Those with PTSD, TBI, amputees, burn survivors;
- Female veterans;
- Family members;
- Caregivers;
- Surviving spouses and parents;
- Those at risk for PTSD, mental disorders, or experiencing TBI; and
- Others who may need specialized information.

**To better serve these groups, VA should develop:**

- 1. Mechanisms, especially IT tools, for maintaining accurate contact information for group members; and**

**2. Specific messaging, tailored to the potential needs of each group, conveying information about whom to contact within the VA to learn more about accessing services.**

**2-14. VA should expand partnership opportunities with federal and state agencies and the media to provide outreach mechanisms. VA should employ multiple outreach mechanisms to increase both the depth and breadth of its network for providing service to veterans.** This would include:

- Increasing its participation with other federal and state agencies in state job fairs;
- Coordinating efforts with DoL to leverage its existing network of CareerOneStop opportunities as a mechanism to reach out to veterans in local communities and assist with a range of benefits, including employment assistance and filing claims; and
- Making better use of the media to convey basic information and invite veterans to contact the VA.

**2-15. VA should develop and implement an outreach plan for the Post-9/11 Veterans Education Assistance Act of 2008.** When the educational benefits in this Act become effective in August 2009, VA will have to act aggressively to improve outreach and coordination with educational institutions utilizing call centers, computer technology and the deployment of a cadre of trained staff specialists. The expanded educational benefit differs from the existing program in that it would pay variable tuition expenses and subsistence allowances based upon individual state public state school charges and regional cost of living indexes. In addition, the amount of assistance to be paid would vary depending on status, length, and type of service. There are also provisions allowing the Secretary to enter into certain arrangements with private institutions of higher learning. Obtaining and verifying necessary information to permit correct payments to veterans and to schools will be a complex and difficult task exacerbated by time constraints and the estimated 600,000 veterans who are expected to enroll. Expectations with respect to the benefits provided by the new GI Bill will be high, and delays in responding to enrollment requests or errors in adjudicating the correct amount of assistance could generate vocal and widespread dissatisfaction by veterans.

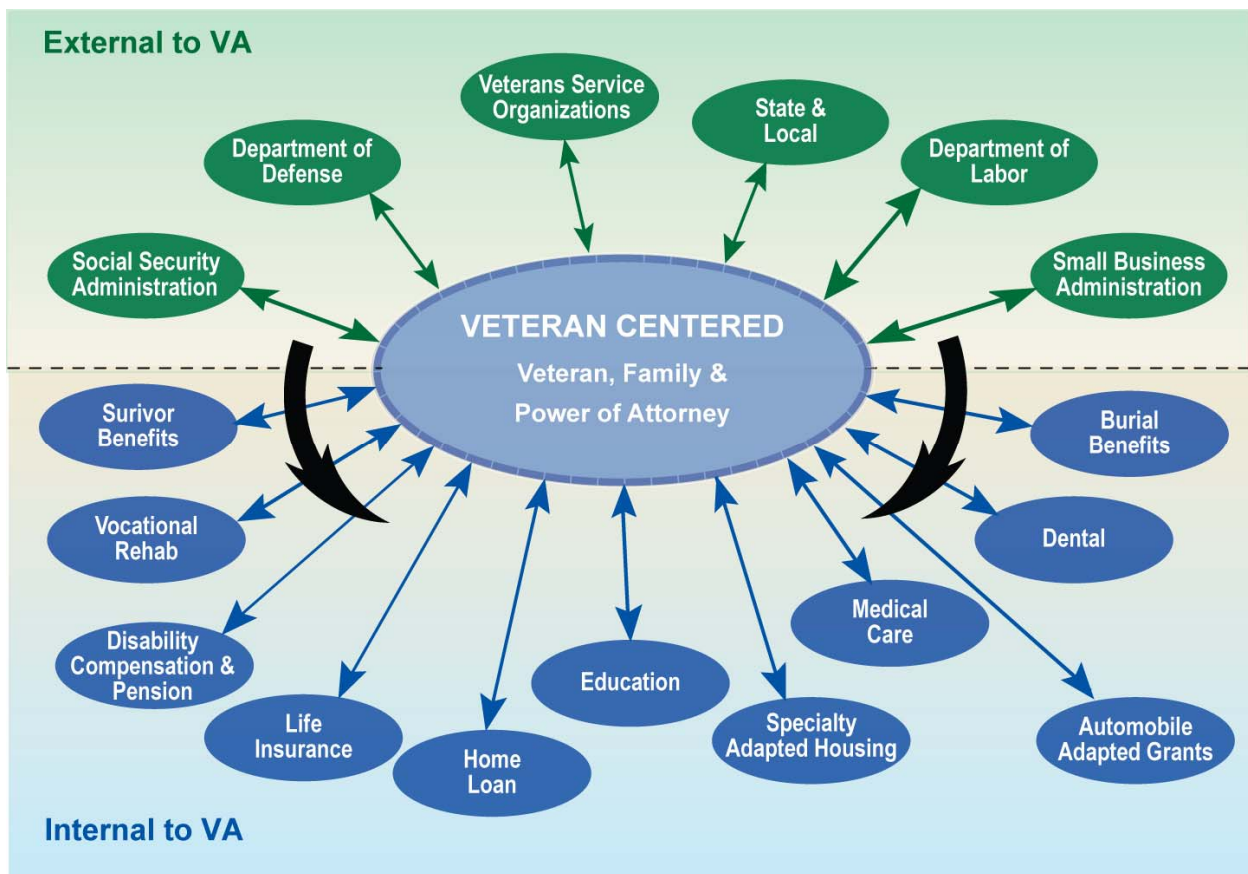
Increased use of technology together with trained staff specialists will enable VA to:

- Identify, contact, and assist veterans in understanding and pursuing the new rules and provisions;
- Formulate, with inputs from educational institutions and associations, a coordinated approach to explaining and managing such benefits; and
- Maintain a capability to identify and address problems veterans may be experiencing, and continually take steps to improve service.

## EXTERNAL LINKAGES

To be truly veteran-centered in delivering service, VA must interact with multiple external organizations—including DoD and the military services, other federal departments, state governments (especially their veterans affairs departments), Veteran Service Organizations (VSOs), private medical providers, and private health insurance carriers. Each of these organizations is a possible “door” of entry into the VA system, since veterans also interact with these external organizations directly, and can use any of them as an avenue to enter the VA system (See Figure 2-2). VA’s culture, however, does not consistently reflect the openness and interdependence of the system within which it operates. As a result, it sometimes fails to incorporate this interconnectedness in its routine program management.

Figure 2-2. Entry Points into VA



Source: A Report of a Panel of the National Academy of Public Administration For the U.S. Congress and the U.S. Department of Veterans Affairs, *After Yellow Ribbons: Providing Veteran-Centered Services*, 2008.

In becoming veteran-centered, VA must continually remind itself that:

- It is one among several agencies and support systems available to veterans;
- Other organizations in the community may be more visible or accessible to veterans—veterans may turn first to local or state programs before approaching a federal agency; and
- Good working relationships with external organizations are critical to a veteran-centered approach to service delivery.

VA has already established important external linkages with the Department of Labor (DoL) through its relationships with the VA's Federal Recovery Coordinators and employment assistance activities. For example, the DoL has several intersections with VA, and operates CareerOneStop centers. DoD and VA are working with these CareerOneStop centers in every state to integrate the HireVetsFirst campaign into over 120 private and public sector veterans job fairs, and to expand the number of employers actively involved in veteran recruitment. A careful examination of DoL's CareerOneStop efforts and their presence in the local community may suggest ways to leverage this relationship to the mutual benefit of veterans, VA, and DoL. In addition, the Small Business Administration (SBA) operates the Veterans Business Outreach Program, which provides entrepreneurial development services (e.g., business training, counseling and mentoring, and referrals) for eligible veterans who own or are considering starting a small business. While not affiliated with VA, this service offered through SBA may provide an additional door for veterans to enter the VA system by directing them to VA's programs and services

Other existing programs and veteran contact opportunities include:

- Job assistance coordinated with VBA's VR&E, and Transition Assistance Program/Disabled Transition Assistance Program (TAP/DTAP) briefings;
- Training and coordination with the Federal Recovery Coordinators (FRCs);
- CareerOneStop job fairs that include VA representation;
- REALines (Recovery and Employment Assistance Lifelines), a program aimed at providing assistance for the severely wounded and disabled; and
- DoD's Turbo TAP, an on-line automated web-based system for delivery of transition assistance and related information.

In addition, state and local services are primary contact points for the veteran, as they are often more visible and accessible to the veteran. State DVAs and county service officers are sometimes the one tangible, face-to-face connection a veteran has with the VA system. Some veterans, when interacting with the state DVA, do not distinguish the state VA system from the federal VA, despite their different mandates, services, benefits, and lack of systematized collaboration. State and community entry points are essential to a No Wrong Door approach and



are important mechanisms for referrals for needed services for veterans. Opportunities exist for VA to strengthen relationships with these partners.<sup>126</sup>

### **Recommendation Related to External Linkages**

Because VA is not the only service provider to veterans, and they may enter the system through multiple external “doors,” VA must develop stronger connections with external partners in service to veterans.

- 2-16. VA should identify opportunities to contact veterans through other agencies, such as the Department of Labor (DoL) and the Small Business Administration (SBA), and provide sufficient training to representatives of those agencies to enable them to share basic information about VA benefits with veterans.** In addition to assisting veterans with job placement through the DoL’s CareerOneStop, VA should ask DoL career center personnel to share basic information with veterans about how to contact VA. In addition, VA should give DoL, the SBA, and other agencies that work with veterans a brief set of scripted questions that can be used to direct the veteran to the appropriate door within VA.<sup>127</sup>

## **ORGANIZATIONAL CHANGE MANAGEMENT**

Managing the complex set of changes required to make VA fully veteran centered will be a major challenge. Chapter 4 discusses change management in more depth and more broadly, but the subject warrants mention here as it relates specifically to the process of moving the Department to a veteran-centered services orientation.

VA managers note that, historically, VA has not lacked for good plans to address a variety of issues that would move it toward becoming more veteran centered. Earlier versions of VA’s Strategic Plan assigned the OneVA concept high priority for development and implementation, and documents dating back to 1999 describe the OneVA vision and tools.<sup>128</sup> However, execution of those plans has fallen short because many of the components of successful change have been lacking.

VA has focused its change on the *content* of what is needed, and has identified many of the foundational tools and processes required to better serve veterans. The capabilities that VA considers veteran centered include:

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<sup>126</sup> Chapter 3 discusses that state mental health directors expressed an interest in improving collaboration with VA with respect to improving access to care.

<sup>127</sup> It is not recommended that non-VA personnel provide substantive content about VA benefits and eligibility, because previous efforts of this nature have resulted in misunderstandings and inaccuracies. To avoid this would require that VA provide training to non-VA employees about its benefits and services. Instead, it is preferable to ensure that non-VA organizations merely direct the veteran to one or more points of contact within VA to obtain more information.

<sup>128</sup> See ONEVA IT VISION (Office of Information and Technology), March 1999.

- Contact Management, Registration & Eligibility, a CRM desktop;
- Increased specialization among claims processing sites;<sup>129</sup>
- Performance accountability measured by issue determinations, as well as by claims resolved;
- Information-rich and user-friendly portals, such as My Health<sub>e</sub>Vet;
- Support of an IT integrator to coordinate various VBA applications;
- Consolidated call centers with well-trained call agents, access to multiple databases and sources of benefit information, and performance metrics to assess the benefit to the veteran from each call; and
- Metrics that focus on the degree to which the Department has met the legitimate expectations of veterans and their families.

VA has identified the need for each of these capabilities. As the number of returning veterans adds to VA's service challenge, new issues will emerge. The tools and processes needed to serve new and previous cohorts of veterans will change. A continued process of incremental change is not, however, the most effective method to ensure that each change is addressed in a manner that supports VA's operational integration, a central element of becoming veteran centered.

The biggest challenge to change at VA is managing the *process* of change. This includes establishing accountability through a reward system and performance measures. Strong, sustained leadership, committed to transformation, is critical to success. VA has lacked the sense of urgency and a clear leader at the Department level who is able to rally the organization across Administration lines and champion the change. Until this strong, committed and sustained leadership is present, VA will continue to struggle, adopting a series of piecemeal solutions that lack an overall framework and factors for long-term success.

### **Recommendation for Managing Change**

In addition to the recommendations offered in Chapter 4, the following change management steps would contribute to successful implementation of the specific foundation-building initiatives recommended in this chapter.

- 2-17. VA should update and implement OneVA plans and other documentation identifying requirements for tools and capabilities encompassed by the OneVA concept. The specific initiatives addressed in those plans should establish goals and timelines for the OneVA tools, outreach initiatives, building strong relationships with external organizations, and other emerging issues that support a veteran centered approach. The plans should clearly articulate performance goals and metrics at all levels of the organization and demonstrate the commitment of leadership by:**

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<sup>129</sup> See Undersecretary Dunne's testimony concerning the Development Centers in Togus, Maine and Lincoln, Nebraska before the Senate Veterans Affairs Committee on July 9, 2008.

- **Emphasizing that this change is necessary and needed *now*, particularly given the anticipated surge of new OEF/OIF veterans in the coming years;**
- **Sponsoring the change at the Secretary’s level and creating a cross-Administration team of change agents;**
- **Communicating the need for change to all sectors of VA, making the compelling case personal and relevant;**
- **Developing and implementing transformational change plans with timelines and goals;**
- **Creating accountability for demonstrating results by using incentives and penalties; and**
- **Sustaining the effort for the long term by continuing to commit resources, leadership, and require accountability until the change becomes the new status quo.**

With these elements of organizational change management in place, development will progress toward the creation of OneVA tools, helping form a foundation for performing work in a veteran-centered manner.

## **ASSESSING PERFORMANCE**

The ultimate measure of success of a veteran-centered approach is the ability to demonstrate a positive impact on the veteran, measured at multiple levels. Chapter 4 discusses how to measure the results of the change in more detail. The importance of establishing accountability for improving service to veterans and providing a way to assess progress and results of the change cannot be overstressed. The development of a performance measurement plan, and the cultivation of a culture of performance management through making available tools such as automated dashboards, is a component of any strategy and must include measures for gauging the effectiveness of the change *process*, especially in improving outcomes for veterans.

### **Recommendations**

The Panel is recommending that VA significantly improve its performance measurement system to track its progress in improving the outcomes for veterans.

- 2-18. VA should develop annual and long-term targets and associated service measures and intermediate outcomes to track VA’s success in improving services to veterans. The measurement system should encompass: (1) building integrated information systems to facilitate service delivery and information; (2) improving public contact and outreach to veterans; and (3) forming linkages with non-VA partners. VA should also develop measures to assess progress in implementing organizational change.**

Examples of specific metrics that could be developed in each category are:

*Build Integrated Information Technology System*

- **Develop process measures and targets for:**
  - Percentage of claims processed electronically,
  - Percentage completion against timeline for update of VONAPP, CM, and RE projects
  - Percentage of IT business planning documents that explicitly link to OneVA goals

*Public contact and outreach*

- **Develop process measures and targets for:**
  - Percentage of inquiries handled through e-mail
  - Number of new communication channels, including e-mail, web 2.0, partnering with other agencies
  - Number of contact lists by characteristics of interest (e.g., female, amputees, rural)
- **Develop service-related measures and targets for:**
  - Percent of veterans with electronic access to determine the status of their disability claim
  - Number of contacts needed to resolve a claim/issue
  - Number of days to respond to inquiries/resolve claim
  - Accuracy rate for inquiries and disability claims

*External linkages with non-VA partners*

- **Develop measures and targets for:**
  - Number of outreach Memorandum of Agreements (MOAs) with other agencies (e.g., DoL, SBA) and organizations
  - Number of joint outreach opportunities identified
  - Number of joint outreach efforts engaged in (e.g., job fairs)

## CONCLUSION

The Department has recognized for some time that it must become veteran centered and coordinated as “OneVA” to fulfill its mission more effectively. Translating this vision into reality requires a shift in priorities, a sustained commitment of resources, and a modification of the current performance system. The elements that form a veteran-centered foundation are described throughout this chapter, and VA has already made incremental steps toward improving

its service to veterans (e.g., through call center consolidation, defining requirements for better customer-support oriented systems).

To fully achieve this vision, however, VA requires a solid leadership foundation and infrastructure to both manage the changes needed and sustain them over time. Commitment to a well-planned and implemented change management strategy is required to create OneVA, and appropriate leadership structures that transcend any individual leader are critical to sustainment of veteran-centered principles. Sustaining the commitment to achieve a veteran-centered Department requires the adoption of a strategy for continuous improvement. This strategy is described in chapter 4. Chapter 3 applies the veteran-centered approach to service to a key element of VA's mission: providing the best care possible to injured veterans.

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### CHAPTER 3

## BRIDGING GAPS: STRENGTHENING CARE FOR INJURED VETERANS

This chapter describes the transitional system of care and presents a three-part strategy to strengthen it. To serve injured veterans successfully, VA must—in addition to making the broader reorientation required to be veteran-centered—establish an easy-to-access care continuum and a well-integrated system of care management. Such a system of care is not confined to the walls of a treatment facility, medical center, or clinic, but includes: (1) identifying and contacting those veterans at risk for physical or mental illness, including addictive disorders; (2) ensuring that those in need of care have access to and receive appropriate and high-quality care at the right time and right place; and (3) improving the administration and management of care to facilitate the successful rehabilitation and reintegration of veterans into society and family life. Strengthening the continuum of care for veterans who are less severely injured as well as those who are severely injured<sup>130</sup> will also improve outcomes for other veterans who will at some point need VA care.

VA defines the concept of a “continuum of care” as follows:

*The provision of comprehensive care throughout treatment, including from hospital to home, which advocates the pooling together of medical and social services within the community and the creation of linkages between community care initiatives at all levels of the health care system. The goal of the continuum is to prevent gaps or breaks in treatment by means of a comprehensive set of services ranging from preventive and ambulatory services, to acute care, to long term and rehabilitative services.*<sup>131</sup>

VA and DoD currently are focusing an unprecedented degree of attention on treating the severely injured: allocating new resources and applying new case management tools that are designed to improve transitions between the DoD and VA systems of care. Yet, an undetermined number of veterans who are at risk for mental illness, PTSD, addictive disorders, depression, or mild TBI may not have entered the continuum of care.

This chapter discusses the range of reasons that account for this gap, including underreporting of symptoms due to stigma, and also: (1) provides an overview of the transition pathways between the DoD and VA health care systems for different types of returning OEF/OIF veterans; (2) discusses the challenges of identifying and contacting veterans who are at risk for mental illnesses (hereafter the term mental illness includes addictive disorders); (3) discusses challenges in improving access to care for those at risk for mental illness; and (4) describes opportunities for applying some of the care management tools being used for the severely injured to veterans who are less severely injured.

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<sup>130</sup> The category of “severely injured” includes those with spinal cord injury; burn; amputation; visual impairment; severe TBI; and severe mental illness. Interview with VHA official.

<sup>131</sup> Definition provided by VHA.

## TRANSITION PATHWAYS

Since 2003, VA, in collaboration with DoD, has engaged in an intense effort to both ensure that service members are “transitioned seamlessly” from Military Treatment Facilities (MTFs) to VA facilities and back to their homes or units, and that the care provided is “coordinated, monitored, and tracked” with case managers assigned where needed.<sup>132</sup> Building on these efforts, the Dole/Shalala commission report identified the need for “integrated care management” to provide “the right care and benefits at the right place by leveraging all resources appropriate to the needs.”<sup>133</sup>

The concept of “integrated care management” is inherently veteran-centered, in that it is designed to engage patients in a collaborative process to manage their own medical, social, and mental health conditions more effectively:

*Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.*<sup>134</sup>

Such systems are intended to improve the quality and coordination of care while avoiding duplicative services and processes.<sup>135</sup> An effective care management system is critical to the development and maintenance of a continuum of care that has no gaps, both in transition from DoD to VA’s health care system and subsequent linkages between VA and care that is available in the veteran’s community.

VHA has created new positions in building a care management system to improve the transition of returning OEF/OIF veterans. For example, the OEF/OIF Program Manager oversees all transition activities and the coordination of care and services for OEF/OIF veterans, and supervises the Nurse and Social Work Case Managers as well as the Transition Patient Advocates (TPAs).<sup>136</sup> The approximately 100 TPAs, who have been in place since July 2007, support severely injured veterans in managing a vast array of non-clinical issues.<sup>137</sup> They assist the veterans and their families in securing all the support available to them, both within the VA system and in their local communities. They also assist them in navigating the benefits system by explaining the disability claims process; connecting veterans with Veterans Service

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<sup>132</sup> Department of Veterans Affairs, Veterans Health Administration, VHA Handbook 1010:01: *Transition Assistance and Case Management of Operation Iraqi Freedom and Operation Enduring Freedom*, May 2007, p. 1.

<sup>133</sup> President’s Commission on Care for America’s Returning Wounded Warriors, *Serve, Support, Simplify, Subcommittee Reports and Survey Findings*, July 2007, p. 20.

<sup>134</sup> Center for Health Care Strategies, Inc., *Care Management Definition and Framework*, 2007. Available at: [http://www.chcs.org/usr\\_doc/Care\\_Management\\_Framework.pdf](http://www.chcs.org/usr_doc/Care_Management_Framework.pdf). Adapted from Mechanic, R., *Will Care Management Improve the Value of U.S. Health Care?* Background Paper for the 11<sup>th</sup> Annual Princeton Conference, May 20, 2004.

<sup>135</sup> Ibid.

<sup>136</sup> The position descriptions of the care management positions are included in Appendix C.

<sup>137</sup> Interview with VHA official.

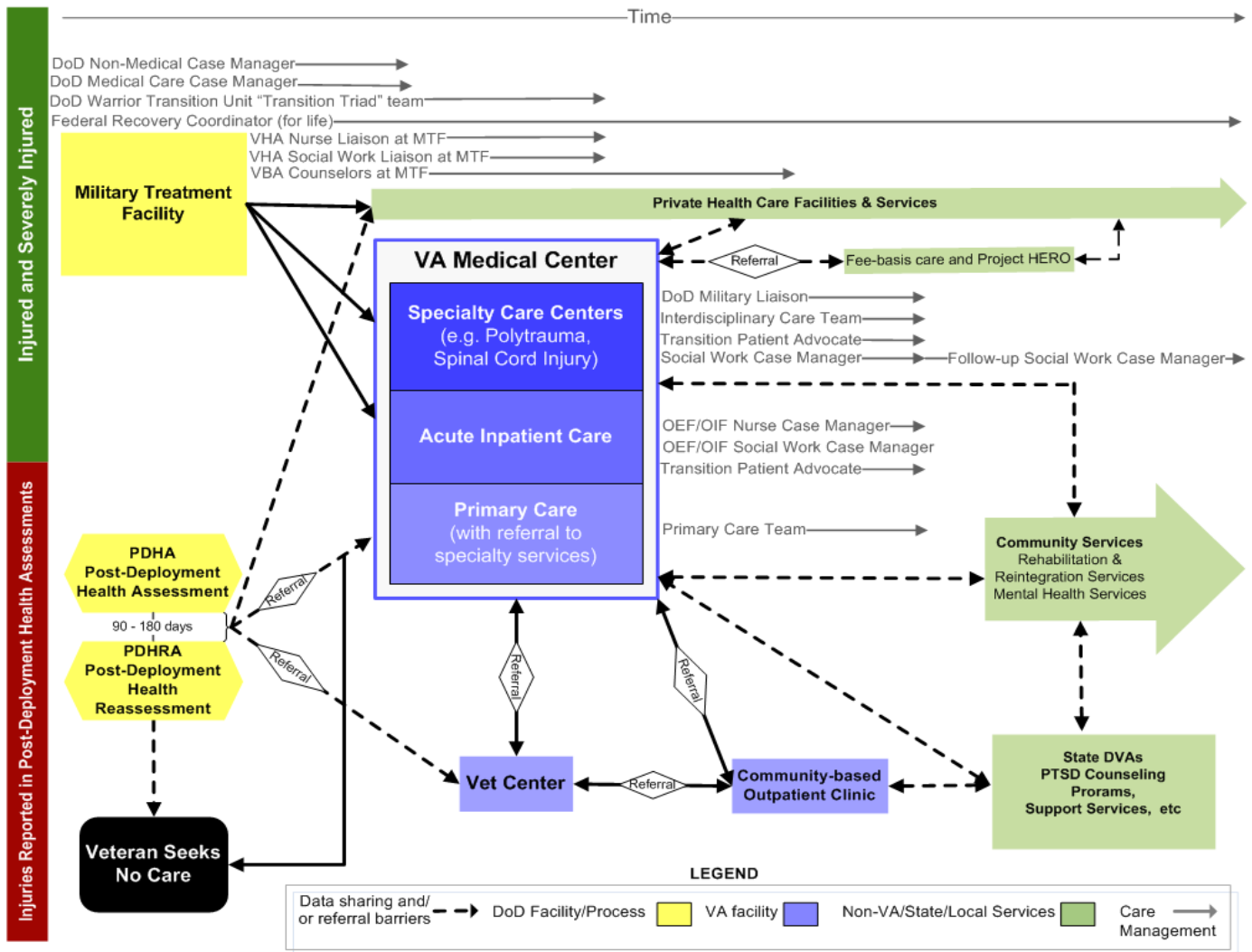


Organizations (VSOs) and other non-VA veteran advocates; arranging for transportation to examinations and therapy sessions; helping locate sources of community-based financial aid; assisting in employment searches; and addressing a host of other life needs that injured veterans face during their transition. In October 2007, VA established another new position, the Federal Recovery Coordinator (FRC), which is responsible for coordinating care management for the severely injured.

Beyond VA's health care system, VA's reintegration services are also available to veterans and include vocational rehabilitation and employment (VR&E) services for veterans who have a service connected disability rating of at least 10 percent. Veterans Benefit Administration (VBA) regional offices administer this program and employ vocational rehabilitation counselors who conduct assessments of a veteran's aptitudes and abilities. Depending on the needs of the veteran, a rehabilitation plan is developed, which focuses on one of the following five tracks of VR&E services: (1) reemployment with a former employer; (2) rapid employment for new employment; (3) self-employment; (4) employment through long-term services; and (5) independent living services

Injured veterans face many challenges in transitioning from DoD's to VA's health care system, and from these systems to care in their community. The pathway into and through the VA health care system for an individual depends on the nature and severity of their injury. This chapter distinguishes between those who: (1) are severely injured; (2) less severely injured; and (3) report cognitive deficit or mental health concerns during post-deployment health assessments. Figure 3-1 provides a basic overview of these pathways and transition points, including the various case managers who may follow a patient at a specific facility or point in time.

**Figure 3-1. Mapping Care Management: Transition Pathways for Care**



Note: This figure offers a general overview of pathways for care. Pathways may not always be linear. Also, the amount of time a service member or veteran spends at various points in the process and the degree of interaction with case managers will vary depending on individual needs and interests. Also, service members receiving medical care at VA facilities may not have been discharged from the military. Accordingly, they may continue to receive support from DoD case managers while they are receiving treatment at a VA facility.

Source: Analysis of interviews with VA and DoD officials and DoD and VA documents regarding case management. A Report of a Panel of the National Academy of Public Administration for the U.S. Congress and the U.S. Department of Veterans Affairs, *After Yellow Ribbons: Providing Veteran-Centered Services*, 2008.

## Care for the Severely Injured

Upon return to the United States, a severely injured service member is usually sent to an MTF where he or she is assigned a Medical Care Case Manager (MCCM)—most often a registered nurse or social worker—and receives acute inpatient care for injuries and illnesses. Recovering service members are sometimes assigned Non-Medical Case Managers, although currently there is no standardized system of assignment among DoD’s Wounded Warrior Programs.<sup>138</sup> The injured service member may also be assigned to a military Warrior Transition Unit (WTU) care team, which consists of a squad leader to help with “soldier issues,” a nurse case manager to help with appointments, medication and health care consultations, and a primary care manager to manage care plans and all medical needs. If service members require assistance in transition to a VA medical facility, VHA Nurse Liaisons, Social Work Liaisons, and VBA counselors at MTFs will facilitate the care and administrative aspects of the service member’s transition to the VA facility. A smaller subset of the severely injured may also become the responsibility of a Federal Recovery Coordinator (FRC), a new position in the care management system that is further described below.

When the medical team decides the service member is ready to be transferred from the MTF, the service member may, depending on the type of care needed and financial options: (1) choose to receive all further care from the private health care system; (2) be sent to one of VA’s four Polytrauma Centers (inpatient) or 17 Polytrauma Network sites (outpatient) for further care; or (3) be transferred to a VA Medical Center (VAMC) for inpatient or outpatient care (not associated with a Polytrauma Center).<sup>139</sup> Even after a severely injured service member or veteran is transferred from the initial care facility, the FRC may follow up with care managers at that facility to track and monitor progress.

The FRC is part of a new Federal Recovery Coordinator Program (FRCP)<sup>140</sup> that is designed to serve severely injured service members who have been admitted to MTFs.<sup>141</sup> The FRCP has three components:

1. an FRC who is to provide “close coordination of clinical and non-clinical care management for severely injured service members, veterans, and their families across the

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<sup>138</sup> DoD/VA Senior Oversight Committee Line of Action on Case/Care Management Reform, *Interim Report to Congress, Policy Improvements on the Care, Management and Transition of Recovering Service Members*, February 2008, p. 21.

<sup>139</sup> VA has designated four of the VAMCs as Polytrauma Centers and 17 as Polytrauma Network Sites. <http://www.polytrauma.va.gov/faq.asp#FAQ1>, April 9, 2007. Appendix C includes a description of the military and VHA case managers at MTFs, VA Polytrauma Centers, and VAMCs.

<sup>140</sup> VA and DoD began to implement this program for severely injured service members in October 2007 in response to a recommendation of the President’s Commission on Care for America’s Returning Wounded Warriors. See *Serve, Support, Simplify, Report of the President’s Commission on Care for America’s Returning Wounded Warriors*, July 2007.

<sup>141</sup> VA and DoD use the following enrollment criteria in deciding who should be enrolled in the FRC program: in acute care at a MTF; spinal cord injury; burn; amputation; visual impairment; TBI/PTSD; high severity/acuity level; at-risk on the basis of a psychosocial and family assessment; high potential for lifelong care needs; patient self referral or command referral based on ability to benefit; and willingness of either the service member or family. See *VA/DoD Joint Executive Council Strategic Plan*, November 2007, p. 23.

lifetime continuum of care.”<sup>142</sup> The term air traffic controller is frequently used to describe how the FRCs are expected to interact with other case managers.

2. a Federal Individualized Recovery Plan (FIRP) that is tailored to the service member’s specific treatment and rehabilitation needs, and identifies actions needed to meet short-term and long-term recovery and reintegration goals.
3. a web-based national resource directory of care providers that is searchable by diagnosis, geographic location, and service affiliation.

VA hired an FRCP Director and FRCP Supervisor at the end of 2007. The first FRCs were trained in early January 2008 and completed an orientation program at MTFs in late January. By May 2008, eight FRCs were at work in three MTFs—three at Walter Reed Army Medical Center, three at Bethesda Naval Hospital, and two at Brooke Army Medical Center. Six of the original eight, however, are no longer employed by VA.

As of July 30, 2008, 10 FRCs were at work and 94 service members were enrolled in the program.<sup>143</sup> VA estimates that about 1,200 OIF service members are severely injured.<sup>144</sup> To bring more top management attention to this program, VA has hired a former member of the Dole/Shalala Commission to oversee the program. VA officials report that no decisions have been made about the number of FRCs required or the average expected caseload for each FRC.<sup>145</sup>

### **Care for Less Severely Injured or Stabilized Severely Injured**

Veterans who are less severely injured may receive care initially at an MTF, VAMC, VA community based outpatient clinic, or private health care facility. Wounded service members receiving care on an outpatient basis at an MTF may be assigned an MCCM, depending on their care needs and the organizational structure of the Wounded Warrior Program.<sup>146</sup> When an OEF/OIF veteran receives care at a VA facility, they are screened for the need for case management services that are provided by an OEF/OIF Nurse and/or Social Work Case Manager. VHA’s policy requires that severely ill or injured OEF and OIF patients receive case management services.”<sup>147</sup> Each VAMC designates a Nurse or Social Work Case Manager to serve as the OEF/OIF Program Manager and coordinate the program.<sup>148</sup> VA reports that it has provided care to almost 325,000 of the 837,000 OEF/OIF veterans, and that 96 percent received

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<sup>142</sup> Statement of Mahdulika Agarwal, Chief Officer, Patient Care Services Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, March 13, 2008, pp. 2, 3.

<sup>143</sup> Interview with VHA officials.

<sup>144</sup> Ibid.

<sup>145</sup> Ibid.

<sup>146</sup> DoD/VA Senior Oversight Committee Line of Action on Case/Care Management Reform, *Interim Report to Congress, Policy Improvements on the Care, Management and Transition of Recovering Service Members*, February 2008, p. 20.

<sup>147</sup> Department of Veterans Affairs, Veterans Health Administration, *VHA Handbook 1010:01: Transition Assistance and Case Management of Operation Iraqi Freedom and Operation Enduring Freedom*, May 2007, p. 2.

<sup>148</sup> Additional information about the specific roles and responsibilities of the OEF/OIF Program Manager and the other VAMC case managers is included in Appendix C.

outpatient care.<sup>149</sup> In addition, VA says about 15,000 OEF/OIF veterans have been offered case management services.<sup>150</sup>

## Post-Deployment Health Concerns

As shown in Figure 3-1, the entry point into the care management process for veterans who may have post-deployment health concerns begins with DoD's post-deployment health screenings. The current DoD program to monitor the physical and mental health of service members consists of: (1) a mandatory pre-deployment assessment within 60 days prior to deployment overseas;<sup>151</sup> (2) a mandatory post-deployment health assessment (PDHA) between 30 days prior to leaving a deployment location and within 30 days after returning from deployment; and (3) a post-deployment health reassessment (PDHRA) conducted from 90 to 180 days after returning from deployment. According to DoD, the PDHRA is voluntary, but service members are strongly encouraged to participate.<sup>152</sup>

DoD issued its policy for conducting PDHAs on October 6, 1998.<sup>153</sup> Several years later, in March 2005, DoD announced its plan to implement PDHRAs because veterans experienced health problems, such as mental illness or cognitive deficiencies, several months after they return from combat. According to DoD's policy, service members who separate or retire before or during the reassessment period will be contacted by the military departments in which they served and offered the opportunity to participate. The policy did not require PDHRAs for service members who separated from the military before the policy was announced.<sup>154</sup>

PDHRAs are physical and mental health screenings and consist of two parts: (1) self-administered demographic-related questions, such as the total number of deployments, service branch, and contact information; and (2) specific health-related questions. A DoD contractor discusses the responses with the service member and makes referrals as needed to a MTF, VA Medical Center, a VA Vet Center, or a private health care facility.<sup>155</sup> If a service member receives a referral for medical care, his/her military unit commander is notified. Further, a DoD military benefits advisor follows up with the service member within 24 to 72 hours after a

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<sup>149</sup> Department of Veterans Affairs, *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter FY 2008, p. 1.

<sup>150</sup> VA's technical comments stated that VA's telephone outreach effort to OEF/OIF veterans assured that 15,000 OEF/OIF veterans were offered case management services, if they were not already receiving them.

<sup>151</sup> If appropriately structured, the pre-deployment health assessment could provide a baseline for later determinations regarding the impact of combat on a service member's physical, cognitive, and psychological health. This information could be useful to VA for evaluating disability claims. DoD has acknowledged the importance of cognitive baseline assessments and reports that it plans to include psychological and cognitive baseline measures to help identify health risks as individuals enter the military. It also reports it plans to pilot test cognitive assessment tools. See Department of Defense, *The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health*, Report to Congress, September 2007, p. 9.

<sup>152</sup> Interview with DoD official.

<sup>153</sup> Memorandum from Assistant Secretary of Defense Health Affairs regarding Pre and Post-Deployment Health Assessments and Blood Samples, October 1998.

<sup>154</sup> Interview with DoD official.

<sup>155</sup> Referrals are made to health care facilities or support organizations: (1) MTFs, (2) division/line based medical resource, (3) VAMC or Community Clinic, (4) Vet Center, (5) TRICARE provider, (6) contract support, or (7) community service, or (8) other facility or organization. See DD Form 2900.

referral to determine if he/she has made an appointment with a health care provider and again at 30 days to see if he/she followed through with the appointment.<sup>156</sup>

The PDHRAs are implemented in three different settings: (1) a DoD contract health care provider meets face-to-face with the service member at the military installation during an “on site” drill activity, generally when at least 30 service members are expected to attend; (2) service members may respond to questions via a scheduled DoD “call center” event at military installations; or (3) a service member who is not part of a unit event may telephone the DoD call center and speak with a health care practitioner on an individual basis from his/her home.

The Navy and Marines began PDHRA programs in the summer of 2005.<sup>157</sup> The Army began pilots in 2005 and announced plans for full implementation in January 2006. The Army extended the program to members of the Army National Guard and Reserve in April 2006.<sup>158</sup> In March 2007, DoD added additional screening questions related to TBI to the PDHA and PDHRA programs.<sup>159</sup>

Service members, either consciously or subconsciously, are likely to pass through several decision points before undergoing the PDHRA (See Figure 3-2). These decisions have a direct impact on whether they will or will not enter the system of care management.

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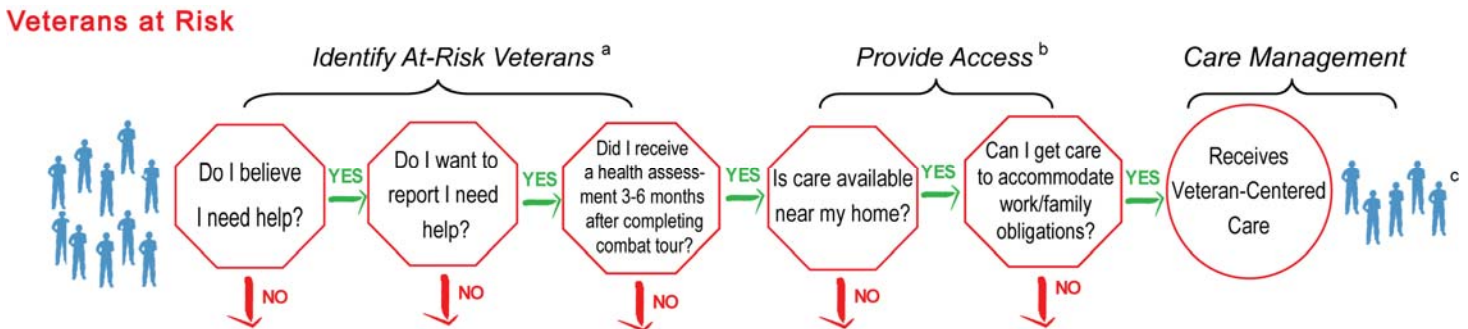
<sup>156</sup> VA/DoD PDHRA Partnership Overview: *Serving Citizen Warriors* (Presentation), January 31, 2008, p. 3.

<sup>157</sup> Morales, Mauricio Cmdr., Bureau of Medicine and Surgery, *NOSC Baltimore Hosts Navy Reserve’s First PDHRA Site Visit*, February 1, 2007.

<sup>158</sup> *Montana PDHRA Task Force, PDHRA Task Force Report: Assessment and Recommendations*, June 2007, p. 18.

<sup>159</sup> DoD Memorandum, Assistant Secretary of Defense for Health Affairs, *Traumatic Brain Injury Questions for the Post-Deployment Health Assessment*, March 8, 2007, p. 1.

**Figure 3-2. Possible Decision Points that May Lead Veterans to Fall Out of the Mental Health Continuum of Care**



Note<sup>a</sup> Studies have highlighted the role that stigma (both public and self-inflicted) plays as a barrier to seeking treatment for mental illness, both in the general population and the military. RAND reported that only 53 percent of its study sample of active duty military and veterans who appeared to meet criteria for mental illness or depression sought care. Army researchers reported that a survey of members of four U.S. Army combat infantry units found that only 23 to 40 percent of service members who reported symptoms of a major depressive disorder, a generalized anxiety disorder, or PTSD, actually sought care. (See Corrigan, Patrick, *How Stigma Interferes with Mental Health Care*, American Psychologist, Volume 59, No. 7, 614-625, The President’s New Freedom, Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003 p. 5 Executive Summary; RAND corporation, Research Highlights, *Invisible Wounds, Mental Health and Cognitive Care Needs of America’s Returning Veterans*, Santa Monica, CA, 2008, p. 4; Hoge, Charles W., Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting, and Robert L. Koffman, *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, New England Journal of Medicine, July 1, 2004, p.1 ) As discussed later in this chapter, gaps exist with respect to DoD’s post deployment health reassessments.

Note<sup>b</sup> Congressional hearings have focused on access to mental health care for veterans. (See for example Committee on Veterans’ Affairs, April 25, 2007 hearing on veterans’ mental health concerns, which included concerns regarding access to mental health care.) Concerns regarding access and VA’s actions to address them are discussed later in this chapter.

Note<sup>c</sup> The number of veterans falling out of the continuum of care is unknown. The numbers in the figure are illustrative but consider estimates referred to in note “a” above.

Source: Analysis conducted by a Panel of the National Academy of Public Administration. A Report of a Panel of the National Academy of Public Administration For the U.S Congress and the U.S. Department of Veterans Affairs, *After Yellow Ribbons: Providing Veteran-Centered Services*, October 2008.

The remainder of this chapter discusses the challenges faced in each of three areas shown in Figure 3-2: (1) identifying and contacting veterans at risk for post-deployment health issues, particularly mental illness (referred to as at-risk veterans); (2) providing access to those who need care; and (3) extending veteran-centered care management tools to veterans who are less severely injured. The identification and access sections focus on veterans who are at risk for mental illness, while the veteran-centered care section applies to a broader group of veterans who are injured, albeit not severely. Each section presents recommendations to address these challenges.

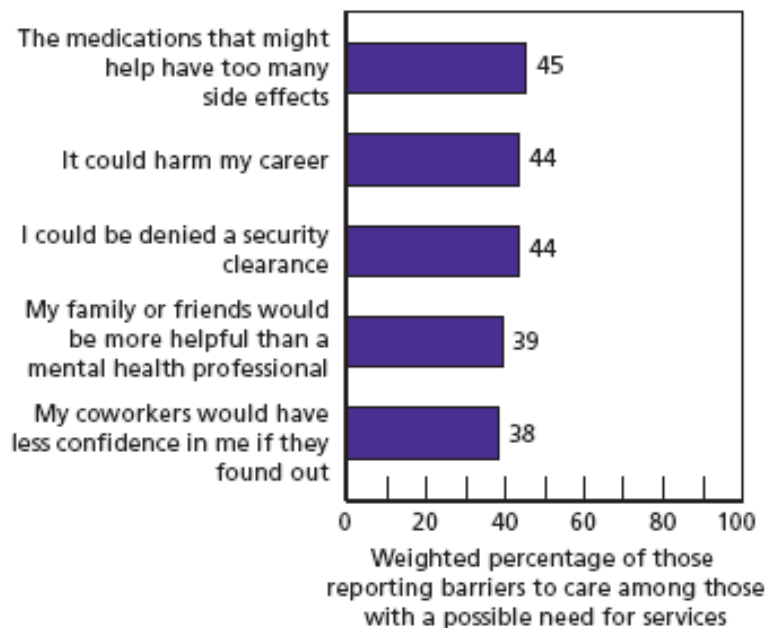
## IDENTIFYING AND CONTACTING AT-RISK VETERANS

Identifying and treating veterans at risk for mental illness is extremely important in preventing the adverse consequences of untreated mental illness, such as family violence, suicide, and loss of the ability to work. The process of doing so is a major challenge for VA.

To diagnose and treat the psychological impacts of combat exposure effectively and promptly, service members needing treatment must first be identified. DoD and VA have implemented several measures to identify those in need of care, but significant gaps in the identification and treatment process remain. Some gaps exist because of the perceived or real stigma associated with treatment for mental illness. Other gaps stem from the design and implementation of the PDHRA program, including the degree and timeliness with which PDHRA results are transferred from DoD to VA. Barriers to sharing health information, such as PDHRA screenings, impair VA's ability to contact veterans who may be at risk for mental or physical illness.

A 2008 RAND Corporation report identified the following five barriers that individuals say cause them not to seek treatment for mental health: medication, career impact, loss of clearance, reliance on non-medical help, and stigma (*See Figure 3-3*).

**Figure 3-3. Top-Five Barriers to Seeking Mental Health Care**



Source: RAND Corporation. Research Highlights, *Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans*, 2008, p. 3.



## Stigma Barriers

Research indicates that significant numbers of service members who may need mental health care now are not seeking care.<sup>160</sup> The adverse personal consequences that some service members and veterans believe could follow from reporting mental-health related symptoms (e.g., impact on career, delays in returning home) and the stigma associated in our society with having a mental health condition may lead service members not to report mental health symptoms during the PDHRA.

Estimates for the percent of veterans who may experience mental illness vary. For example, VA reports that anywhere from 12 to 20 percent of Iraq veterans may experience PTSD.<sup>161</sup> Also, the RAND Corporation concluded that 18.5 percent of OEF/OIF service members/veterans may suffer from PTSD and depression.<sup>162</sup> VA has expressed concern about applying this percentage to the 837,000 OEF/OIF veterans for several reasons, notably that only 22 percent of the RAND study sample included veterans. In terms of the prevalence of mental illness in the general population, by way of reference, a 2005 National Institute of Mental Health Survey of 9,282 English speaking respondents found that 26 percent had symptoms of mental illness within the last 12 months.<sup>163</sup> The study also found that half of all lifetime cases of mental illness begin at the age of 14, and 75 percent begin by the age of 24. In addition, the survey results show “there are long delays”—sometime decades—between the first onset of symptoms and when people seek treatment, but eventually approximately 80 percent seek treatment.<sup>164</sup>

VA reports that it has treated or evaluated about 16 percent (134,000) of OEF/OIF veterans for mental illness, including PTSD.<sup>165</sup> It is unclear how OEF/OIF veterans who VA has not treated are coping with the psychological stress associated with combat. Developing a reliable estimate of the number of veterans in this group is problematic for several reasons. For example, some veterans who needed care may have already received it outside the VA health care system. Also, as previously discussed, concerns about stigma present a significant barrier to reporting and seeking treatment. Importantly, in May 2008 VA initiated a telephone outreach effort to contact over 500,000 OEF/OIF veterans who had not yet used VA’s health care system.<sup>166</sup> The purpose of the outreach effort was to inform these veterans that their eligibility for no-cost health care at VA was extended to five years. The outreach effort also inquired about whether they were receiving the medical care they needed. While this was an important step, continuing efforts to

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<sup>160</sup> See note “a” to Figure 3-2.

<sup>161</sup> Department of Veterans Affairs, National Center for PTSD, *Fact Sheet: How Common is PTSD?*, February 27, 2008, p. 2.

<sup>162</sup> RAND Corporation, Research Highlights, *Invisible Wounds: Mental Health and Cognitive Care Needs of America’s Returning Veterans*, 2008, p. 2. RAND’s estimate is based on telephone interviews with a sample of 1,965 service members who had been deployed to Iraq or Afghanistan, regardless of service branch, component, or type.

<sup>163</sup> National Institute of Mental Health Press Release, *Mental Illness Exact Heavy Toll, Beginning in Youth*, June 6, 2005, pp. 1, 2.

<sup>164</sup> Ibid.

<sup>165</sup> Department of Veterans Affairs, *OEF/OIF Cumulative Program Data*, FY 2002 through the 1<sup>st</sup> quarter of FY 2008.

<sup>166</sup> Department of Veterans Affairs, Public and Intergovernmental Affairs, *VA Begins Next Phase of Combat Vet Outreach*, May 30, 2008.

reach out to this population are important considering the research which indicates that long delays exist between the onset of symptoms and decisions to seek treatment.

Some of the same barriers RAND identified as affecting the willingness to pursue treatment also reduce the willingness of service members or veterans to report symptoms during PDHRAs. For example, a State of Montana PDHRA Task Force survey of 308 Montana National Guardsmen concluded in June 2007 that the PDHRA “does not provide for proper follow-up and treatment either upon a Guardsman’s return from deployment or in the aftermath when emotional or mental health issues begin to emerge.”<sup>167</sup> The Task Force found that Guardsmen were “concerned about the negative impacts on their employment and career, both in the military and civilian sectors.”<sup>168</sup> Also, the Task Force noted that Guard members find it difficult to admit something is wrong; and they do not want to be viewed as weak by family, friends, or work colleagues.<sup>169</sup>

Without a concerted effort to reduce the stigma associated with mental illness, service members and veterans may continue to underreport mental illness symptoms and choose not to seek care. In 2004, VA developed a Mental Health Strategic Plan that included 265 recommendations and established nine working groups, including one for mental health awareness and veteran- and family-centered care.<sup>170</sup> Similarly, in 2007, DoD developed a mental health plan, which includes an action item to work with DoD’s new Center of Excellence in Psychological Health and Traumatic Brain Injury to develop and execute an anti-stigma campaign.<sup>171</sup> VA is to serve in a supportive role to this new Center, which will provide the opportunity for VA to be fully engaged and aware of these anti-stigma campaigns and tailor them, as necessary, for veterans. Additionally, VA recently developed a “virtual office” on Second Life, an online three-dimensional virtual world that incorporates veterans’ adjustment issues. VA has also recently collaborated with MTV on a video presentation on readjustment issues, including stigma.

### **Inherent Gaps in the PDHRA**

In addition to gaps in the number and quality of responses resulting from stigma, there are three gaps within DoD’s PDHRA process as it relates to veterans:

1. **It is likely service members who separated from active duty prior to 2006 did not receive a PDHRA.** As of April 2008, DoD had completed 486,998 PDHRAs.<sup>172</sup> Considering the total universe of 837,000 OEF/OIF veterans, hundreds of thousands of returning veterans have not undergone a PDHRA. Importantly, for OEF/OIF veterans who receive care at a VA health care facility, VHA implemented “clinical reminders” to prompt health care providers who are evaluating OEF/OIF veterans to ask a series of

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<sup>167</sup> *Montana PDHRA Task Force Report: Assessment and Recommendations*. June 2007, p. 3.

<sup>168</sup> *Ibid.*, p. 7.

<sup>169</sup> *Ibid.*, p. 7.

<sup>170</sup> Substance Abuse and Mental Health Administration, Department of Health and Human Services, *Federal Partner in Spotlight: U.S. Department of Veterans Affairs, Mental Health Transformation Trends: A Periodic Briefing*, May/June 2005, p. 4.

<sup>171</sup> DoD Task Force on Mental Health, *The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health, Report to Congress*, September 2007, p. A-1.

<sup>172</sup> Department of Defense, Armed Forces Health Surveillance Center, *Medical Surveillance Monthly Report, Deployment Health Assessments, U.S. Armed Forces, April 2008*, May 2008, p. 18.

screening questions designed to identify PTSD, depression, alcohol use, and physical symptoms of new veterans. This screening system has likely captured a proportion of those veterans at-risk who did not undergo a PDHRA but have been seen by VA. In April 2007, VA issued policies and procedures for screening and evaluation of possible TBI for OEF/OIF service members.

2. **DoD data indicate that PDHRAs that are conducted in person with health care professionals are twice as likely to lead to health care referrals than those conducted by telephone.** A DoD contractor is currently conducting an assessment of the referral process, including this disparity in referral rates, and expects to issue a report in 2009.<sup>173</sup>
3. **The PDHRA is the final DoD health assessment for service members who are discharged after returning from deployment, whereas service members who remain on active duty continue to receive health screenings.** Screening for, and treating, combat-related mental illness can be complicated by the variable timeline of manifestation, progression, and cessation of symptoms.<sup>174</sup> According to a November 2007 study, OIF service members were much more likely to report PTSD symptoms in health screenings three to six months after their return from combat than the screening conducted within 30 days of their return, confirming that mental health issues may not emerge until many months after the veteran has returned from deployment. Yet, at the three to six month screening, 49-59 percent of those who had reported PTSD symptoms at the earlier screening, reported an improvement in their symptoms.<sup>175</sup> The evidence suggests that multiple screenings would more effectively identify those at-risk for mental illness, and that those identified and treated soon after the traumatic event or onset of symptoms are more likely to avoid chronic and debilitating consequences.<sup>176</sup> VA's National Center for PTSD reported that:

*The most troubling aspect of military-related PTSD is its chronic course. There is evidence that once veterans manifest chronic post-traumatic adaptation difficulties, these difficulties remain chronic across the life span and are resistant to treatments that have been shown to work for acute trauma patients and other forms of chronic PTSD. Thus, it is vitally important to provide early intervention to reduce the risk of chronic impairment in veterans.*<sup>177</sup>

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<sup>173</sup> Interview with DoD official.

<sup>174</sup> Stone, Andrew M., *Dual Agency for VA Clinicians: Defining an Evolving Ethical Question*, *Military Psychology*, Volume 20, Number 1, 2008, p. 37-48.

<sup>175</sup> Milliken, Charles S., Jennifer Auchterlonie, and Charles Hoge, *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War*, *Journal of the American Medical Association*, November 14, 2007, p.1.

<sup>176</sup> Institute of Medicine, *Treatment of PTSD: An Assessment of the Evidence*, October 2007; Shalev, Arieh Y., Director of Center for Traumatic Stress at Hadassah University Hospital, Presentation at American College of Neuropsychopharmacology: 46<sup>th</sup> Annual Meeting, December 2007; Stone, Andrew M., *Dual Agency for VA Clinicians: Defining an Evolving Ethical Question*, *Military Psychology*, 2008, p. 37-48.

<sup>177</sup> Department of Veterans Affairs, National Center for PTSD, Fact Sheet: *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq*, May 2007, p. 3.

Individual states are taking initiatives to implement screening and counseling programs to address concerns about veterans who may not have received a PDHRA and may need care for mental illness or TBI.<sup>178</sup>

### **Gaps in Sharing PDHRA Referral Information**

Although the PDHRA program is designed and administered by DoD, an important aspect of the program involves referring service members to health care providers, including VA. As recognized by the Task Force on Returning Global War on Terror Heroes,<sup>179</sup> VA's participation in the PDHRA screening program is central to the objectives of identifying those in need of VA services, enrolling them in the VA health care system, and familiarizing them with the services available and for which they are eligible. For the PDHRA process to work effectively, VA should, at minimum, receive from DoD timely PDHRA results, in an accessible and computable format, for service members who are referred to the VA. As described below, progress has been made but significant gaps in information sharing remain.

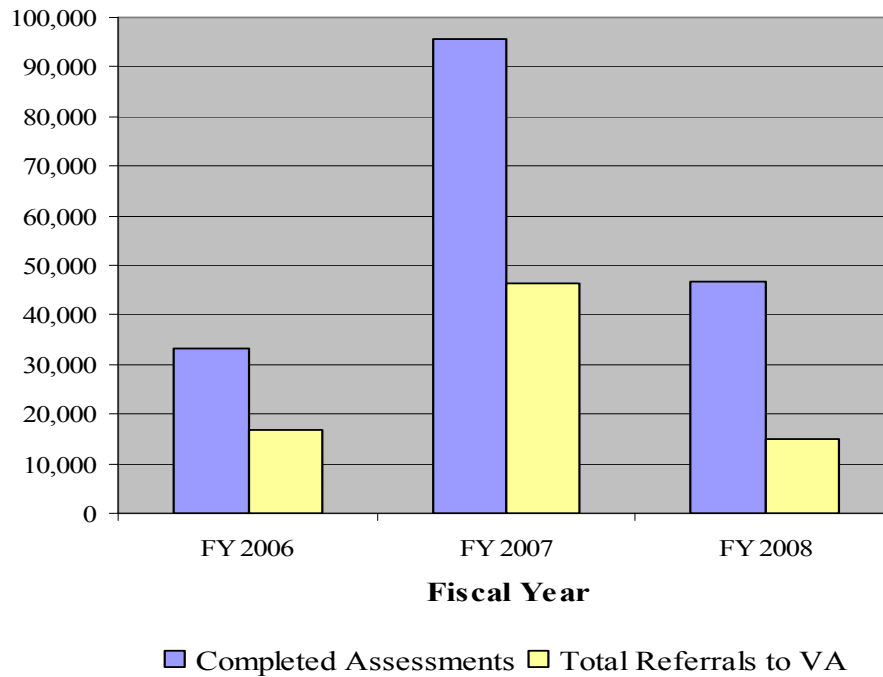
To date, VA participates in DoD's PDHRA program for the National Guard and Reserve, but does not participate in DoD's PDHRA program for active duty service members, some of whom may be separating from the military. Figure 3-4 shows the number of PDHRA assessments and resulting referrals to VA.

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<sup>178</sup> The Montana National Guard is conducting assessments every 6 months up to two years for Guard members who served in Iraq and Afghanistan. According to a Montana National Guard official, the Montana National Guard created two assessment tiers. The first tier included those who returned from deployment on or after March 10, 2005. The second tier includes those who returned from deployment from September 11, 2001 through March 9, 2005. In addition, the Montana National Guard partnered with the VA to compile a list of members of the Montana National Guard who had not yet enrolled in VA health care. The National Guard plans to use Montana as a pilot program to see how effective the second screenings are in detecting mental illness. (See *Senators: Military Personnel, Vets to Receive 2nd Mental Health Screening*, Press Release, Jon Tester, United States Senator for Montana., February 12, 2008. Accessed at [http://tester.senate.gov/Newsroom/pr\\_021208\\_vetsscreening.cfm](http://tester.senate.gov/Newsroom/pr_021208_vetsscreening.cfm)) Illinois has established a TBI screening program that is available to all Illinois veterans via a telephone helpline or through the State of Illinois Department of Veterans' Affairs Veteran Service Officers. This program makes TBI screenings mandatory for all returning members of the Illinois Army National Guard and Air National Guard. Other states, such as New Hampshire and Minnesota, have developed demobilization programs known as "Beyond the Yellow Ribbon." New Hampshire's program includes family briefings on readjustment issues and a health screening at a VA medical facility.

<sup>179</sup> Task Force on Returning Global War on Terror Heroes, *Task Force Report to the President: Returning Global War on Terror Heroes*, April 19, 2007, pp. 46-47.

**Figure 3-4. Total Reserve and National Guard PDHRAs Assessments and Referrals to VA for FY 2006-FY 2008 (as of February 29, 2008)**



Source: *VA/DoD PDHRA Partnership Overview: Serving Citizen Warriors (Presentation)*, February 29, 2008, p. 3.

In June 2006, VHA issued its policy regarding the nature of the support it provides to PDHRAs for members of the National Guard and Reserve.<sup>180</sup> This support includes:

- providing information on benefits for National Guard and Reserve;
- enrolling eligible veterans in VA health care;
- providing assistance in scheduling follow-up appointments at VA medical centers and Vet Centers; and
- developing on-going relationships with Reserve and Guard Commanders and their staffs.<sup>181</sup>

The VHA OEF/OIF outreach office is responsible for overseeing VA's involvement in DoD's PDHRA program, and is currently: (1) distributing the schedule of PDHRA events to field offices; (2) notifying VA medical staff and Vet Center staff of the need to attend all on-site PDHRA events and complete pre-event check sheets; and (3) requiring after-action reports to

<sup>180</sup> Department of Veterans Affairs, Veterans Health Administration, *Considerations for VA Support For the Department of Defense Post Deployment Health Reassessment (PDHRA) Program For Returning Deployed Service Members*, VHA Directive 2006-038, June 26, 2006.

<sup>181</sup> VA/DoD PDHRA Partnership Overview, *Serving Citizen Warriors*, January 31, 2008, p. 1.

document the numbers of service members screened by DoD contract staff, referrals made to either a VAMC or Vet Center, and service members enrolled in VA health care.

VA reports that it participated in all of the 944 on-site PDHRA events between November 2005 and February 2008. According to VA, these events are scheduled two weeks or more in advance of the event. Call center events, however, may be scheduled within 24 hours of the event; and the number of service members attending may range from as few as 5 to 100.<sup>182</sup> According to VA, medical center and Vet Center staff attend most of these events unless the number of expected participants is low (e.g., 5).<sup>183</sup> DoD indicated that 24-hour notice for events is an infrequent occurrence.<sup>184</sup> If VA does not attend, it develops a post-event referral assistance plan with the unit. Interviews with VA and Vet Center staff have revealed that the degree of participation of the VAMC and Vet Centers representatives at PDHRA events may depend upon factors such as staff availability on a particular weekend, distance from the VAMC and Vet Center, and number of service members attending the PDHRA. Without VA participation, under the current program design, an important opportunity for enrolling members of the National Guard and Reserve in VA health care is lost. DoD indicated that National Guard and Reserve members who participate in DoD call center events are sent information about VA health care benefits, but this information does not include the specific enrollment form for health care.<sup>185</sup>

During PDHRAs for members of the National Guard and Reserve, VA staff offer an option to enroll in the VA health care system to members who are demobilizing. This enrollment process at on-site events is sometimes automated, when the facility and technology allows, and sometimes recorded manually on hard-copy documents, with the information entered electronically after the event. The VHA enrollment process at a PDHRA is a primary point at which VA can gather important information about the veteran. For example, at the point of enrollment, VA may request that a veteran provide a copy of his/her PDHRA form. This represents VA's only opportunity to obtain this screening information for veterans who do not subsequently receive care at a VA medical care facility. Further, the VHA enrollment form gathers contact information about the veteran, as well as a family member, and an emergency contact. Currently, due to Health Insurance Portability and Accountability Act (HIPAA) restrictions, VA is not using this information to contact family members to ensure that veterans are aware of and receiving needed services. The PDHRA process presents an opportunity for the veteran to choose to sign an authorization that would allow the VA to communicate with specific family members regarding his/her health care, including scheduling appointments and discussing benefit options. A similar authorization, if signed by the veteran during the PDHRA process, could allow the sharing of PDHRA information between VA and State Departments of Veterans Affairs, including authorization for the state to contact the veteran to discuss what benefits the veteran may be eligible for, and better ensure that veterans are brought into the continuum of care.

Recognizing the importance of sharing valuable screening information on the mental and physical health of returning veterans, VA and DoD entered into a data sharing agreement in June

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<sup>182</sup> VA technical comments.

<sup>183</sup> VA technical comments.

<sup>184</sup> Interview with DoD official.

<sup>185</sup> Interview with DoD official.

2005 by which DoD transmits all completed PDHRA forms on separated service members to the Federal Health Information Exchange (FHIE). FHIE provides for the one-way exchange of patient information from DoD's legacy health information system to VA's VistA Computerized Patient Record System. According to VA officials, however, DoD's Privacy Office has limited VA's access, allowing it to view only the PDHRA forms of those veterans who have been seen at a VA medical facility and are subsequently listed on VA's Master Patient Index.

According to the Department of Health and Human Services, HIPAA privacy standards "set limits on how health plans and covered providers may use individually identifiable health information," and, in order to "promote the best quality of care for patients, the rule does not restrict the ability of doctors, nurses, and other providers to share information needed to treat their patients."<sup>186</sup> VA officials consider the DoD PDHRA referral information to be "treatment-related," and therefore believes it can be shared with VA as a provider under HIPAA.<sup>187</sup> Because VA does not receive information on all referrals made to it, a significant opportunity is missed for contacting and following-up with at-risk veterans. DoD officials acknowledge that DoD limits VA's access to viewing certain PDHRAs because of HIPAA-related privacy concerns.<sup>188</sup> Specifically, VA does not have access to PDHRAs for veterans who have not used VA's health care system. DoD responds, however, that VA restricts DoD's access to certain health encounter information for service members who receive care from VA due to privacy concerns. Specifically, DoD says VA does not share discharge summaries or outpatient notes for active duty military and members of the Reserve who are treated in VA's health care system. This includes health encounter information for members of the Reserve who are still performing military service and who receive a referral to VA as a result of a PDHRA. However, VA does share health encounter information with DoD for individuals who have been designated as "shared patients" between VA and DoD.<sup>189</sup>

## Recommendations

The Panel recognizes that a more thorough and reliable screening program for veterans would require legislation and that some veterans may choose not to participate in screening programs. In the absence of Congressional action, VA should, within its existing statutory authority and as a part of a broader strategy to improve collaboration with state and local community providers, leverage its partnerships to identify those veterans who have not undergone a PDHRA screening or been seen at a VA facility since the implementation of the OEF/OIF clinical reminders. Approaches may vary depending on the individual circumstances for each state.

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<sup>186</sup> Department of Health and Human Services Press Release, *Protecting the Privacy of Patients Health Information*. April 14, 2003, p. 2.

<sup>187</sup> Interview with VHA officials.

<sup>188</sup> Interview with DoD officials.

<sup>189</sup> Interview with DoD officials.

**The Panel recommends:**

- 3-1. In collaboration with DoD, VA should develop a strategy for screening OEF/OIF veterans who have not received DoD's PDHRA or an equivalent screening. This strategy should include:**
- **Working with DoD to obtain a list of the over 400,000 veterans who were discharged before the PDHRA program was implemented;**
  - **Identifying which of these veterans has not been seen by VA and their geographic location;**
  - **Developing specific protocols for Veterans Integrated Service Network (VISN) directors to work with state Directors of Veterans Affairs and Mental Health Directors to identify cost-effective options for implementing screening programs for these veterans. Priority should be given to geographic areas with large concentrations of veterans who have been discharged before January 2006, the implementation date for PDHRAs;**
  - **Requiring VISN directors to develop actions plans and associated implementation timeframes for this screening; and**
  - **Holding VISN directors accountable for sufficient attempts at contacting those veterans who have not been screened.**

While the PDHRA process has some inherent gaps, it nonetheless presents a good opportunity to offer enrollment in VA health care to service members separating from duty. Through this health care enrollment process, VA obtains contact information about the veteran, a member of the veteran's family, and an emergency contact that could be used for making future contacts and for follow-up. This option for enrollment should be extended to all separating service members who participate in PDHRAs regardless of whether VA is present at the PDHRA.

**The Panel recommends:**

- 3-2. VA should request that DoD provide an option for those service members, including National Guard and Reserve, who are demobilized after a combat tour, to enroll in VA health care as part of the PDHRA program.**
- 3-3. VA should revise VA's health care enrollment form to include veteran-controlled authorization for VA to share appointment and medical information with specific family members or other persons.**
- 3-4. VA should educate family members about the importance of such authorization so that they may play an active role in the veteran's recovery.**
- 3-5. VA should pursue efforts to obtain PDHRA results from DoD for all referrals made to VA in a timely manner and in computable electronic format, so that they are**



**available for review prior to the veteran visiting a VA facility. In the absence of progress by December 2008, VA should consider proposing a legislative remedy.**

## **IMPROVING ACCESS TO MENTAL HEALTH CARE**

In this decade, interest in improving access to mental health care returning veterans has grown substantially among members of Congress, state and local governments, and community providers. Addressing access barriers for mental health care is particularly critical, given that mental illness and cognitive disorders so often go undiagnosed and untreated in this population, with serious and sometimes fatal consequences. VA's Deputy Chief of Patient Care Services, Officer for Mental Health underscored this reality, stating:

*Moderate levels of the [mental] illness are strongly associated with problems at work and at home; severe manifestations can lead to devastating outcomes such as suicide. While relatively few people with mental illnesses die from suicide, the fact that it occurs is a constant reminder that these illnesses are real, and that they can be fatal.*<sup>190</sup>

In July 2007, VA, in partnership with the Substance Abuse and Mental Health Services Administration, began operation of a national suicide prevention hotline.<sup>191</sup> Recent statistics show that, of the more than 55,000 calls received between July 2007 and June 2008, just over 22,000 were identified as veterans,<sup>192</sup> and 621 were active duty service members.<sup>193</sup> Since the program's inception, VA reports that 1,221 veterans have been "rescued."<sup>194</sup>

The problem of increasing access to appropriate care has several dimensions, including: (1) cost; (2) availability of a sufficient number of qualified providers; (3) timeliness; and (4) availability of services in locations and during hours that make care accessible to veterans. Early in 2008, cost-related access barriers were addressed to some extent when Congress extended the eligibility for no-cost VA health care from two to five years after discharge for returning OEF/OIF combat veterans. VA has taken significant steps since 2007 to improve access, but additional actions are needed. These actions involve building more collaborative relationships with state and community providers to: (1) develop their expertise in treating combat-related

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<sup>190</sup> Statement of Ira Katz, Deputy Chief Patient Care Services Officer for Mental Health, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, December 12, 2007, p. 1.

<sup>191</sup> The hotline is available 24 hours a day, seven days a week, and is staffed by trained professionals. As necessary, hotline staff may take one of the following actions: (1) refer the veteran for an immediate evaluation at a VAMC or CBOC; (2) arrange for a veteran to be admitted as an inpatient to a hospital; (3) contact a local Suicide Prevention Counselor (SPC) who will arrange for appropriate care; (4) refer the veteran to other VA services such as the OEF/OIF case management, substance abuse, or homeless programs; (5) refer the veteran to community services if the veteran is ineligible for VA services; or (6) arrange for 911 emergency rescue. See Department of Veterans Affairs, *Press Release: VA's Suicide Hot Line Begins Operations*, July 30, 2007. Available at: <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1363>.

<sup>192</sup> The hotline is available to the civilian population as well as to veterans. Veterans may identify themselves as veterans when calling in.

<sup>193</sup> Department of Veterans Affairs, *VA National Suicide Prevention Hotline Call Report Totals YTD, FY 2007 through June 30<sup>th</sup> FY 2008*.

<sup>194</sup> *Ibid.*

mental illness; and (2) identify opportunities for more comprehensive referral systems to ensure veterans obtain timely access to mental health services.

### **VA's Actions to Improve Access**

In response to concerns about barriers to access, VA has taken numerous steps to facilitate access, such as: (1) hiring additional mental health staff and expanding its use of contract providers; (2) increasing the number of Vet Centers, which provide counseling for veterans' psychological and social readjustment issues, from 209 to 225;<sup>195</sup> (3) training its providers as well as those in DoD on certain evidenced-based therapies for PTSD; and (4) using information and communications technology to deliver services.

According to VA, it has steadily increased the number of mental health professionals over the last three years, hiring more than 3,800 staff, for a total mental health staff of over 16,500.<sup>196</sup> Yet, in 2007, there were indications that VA was having difficulty in meeting demand for its mental services. For example, in April 2007, the media reported on the results of a VA survey of Vet Centers in which approximately 55 percent of the centers reported they needed an additional psychologist or therapist to help meet demand for services. Vet Centers were established to address veterans' psychological and social readjustment problems in convenient, easy-to-access community-based locations. At the time of the survey, VA plans called for adding 61 new staff.<sup>197</sup>

Later, in June 2007, the Deputy Secretary for Health and Operations and Management advised network directors that they should allow medical centers and clinics to use VA's fee-basis program temporarily to provide mental health services until such time as VA has reached its recruiting targets for mental health professionals.<sup>198</sup> Through its fee-basis program, VA purchases care from non-VA facilities and providers when VA providers determine the necessary services are not available at a VA facility or the VA cannot provide care in a timely manner. According to VA officials, until 2007, the fee-basis program had not been used extensively for mental health services.<sup>199</sup> In another effort to increase access, the Deputy Secretary for Health and Operations and Management also required the Medical Centers to "enhance access and capacity for mental health services "by operating clinics beyond normal business hours", including one evening per week. This change was to have been implemented by August 2007.<sup>200</sup>

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<sup>195</sup> Vet Center data accessed at [www.vetcenter.va.gov](http://www.vetcenter.va.gov), updated September 10, 2008.

<sup>196</sup> Statement of Michael J. Kussman, Undersecretary for Health, Department of Veterans Affairs, before the Senate Committee on Veterans' Affairs, June 3, 2008, p.5.

<sup>197</sup> Zoraya, Gregg, *Staffing at Vet Centers Laggging*, USA Today; April 19, 2007.

<sup>198</sup> Department of Veterans Affairs, Memorandum from the Deputy Under Secretary for Health for Operations and Management (10N) to Network Directors, *Mental Health Initiatives*, June 1, 2007, p. 3.

<sup>199</sup> Data provided by VHA Chief Business Office showed that VA used fee basis care for about 580,000 veterans, including 17,000 OEF/OIF veterans from FY 2006 through May 2, 2008. However, the data was not sufficiently detailed to show the number of veterans who were provided mental health services through fee-basis care, and the associated costs.

<sup>200</sup> Department of Veteran's Affairs, Memorandum from Deputy Under Secretary for Health for Operations and Management (10N) to Network Directors, *Mental Health Initiatives*, June 1, 2007, pp. 3, 4.

In November 2005, Congress acted to increase veterans' access to specialty care by passing legislation requiring VA to implement a new contracting method.<sup>201</sup> VA responded by developing Project HERO, a pilot program in which VA contracts for health services in four VISNs, including specialty services for mental health. Service delivery began in January 2008. Project HERO was designed to address concerns that care under VA's fee-basis program was disjointed and variable across VISNs. It is expected to improve management of non-VA care through leveraging large-scale contracts with external providers, providing improved internal controls with respect to obtaining medical records from private providers, and holding contractors accountable for achieving performance standards. Benefits of Project HERO are expected to include:

- improved quality standards as contracted provider networks will be required to meet VA-specified quality standards and accreditation standards for inpatient and outpatient facilities;
- improved continuity of care for the veteran as provider networks will be required to submit clinical information to VA improved coordination of referral and appointment processes between VA and contracted provider networks; and
- improved access to specialty care services for veterans living in underserved locations.<sup>202</sup>

The evaluation strategy includes performance measures on access and timeliness of care; accreditation; clinical information sharing; patient safety; and patient satisfaction. For example, one access metric is whether the patient is seen within 30 days of the authorization for care.<sup>203</sup> The volume of cases and types of care provided also will be analyzed as well as patient safety and patient complaint data. Patients will participate in a patient satisfaction survey. Metrics for whether the patient achieved the goals of treatment and/or completed treatment are not included.<sup>204</sup>

Throughout the VHA system, performance measures have been implemented to gauge timeliness of, and access to, care. For example, one new target is that 90 percent of new mental health patients will have a mental health evaluation and care initiated in fewer than 15 days prior to or following a veteran's first encounter.<sup>205</sup> In February 2008 VA's data showed that only 6 of the 23 VISNs reported that they had either met or nearly met this goal.<sup>206</sup> Later, in June 2008, VA reported that 93.4 percent of all veterans seeking non-emergency mental health care received full

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<sup>201</sup> U.S. House of Representatives Conference Report, *Making Appropriations for Military Quality of Life Functions of the Department of Defense, Military Construction, the Department of Veterans Affairs, and Related Agencies for the Fiscal Year Ending September 30, 2006, and for Other Purposes*, 109<sup>th</sup> Congress (1<sup>st</sup> Session), House Report 109-305, November 18, 2005.

<sup>202</sup> Department of Veterans Affairs, *Project HERO General Overview Briefing (Presentation)*, January 23, 2008, p. 7.

<sup>203</sup> Department of Veterans Affairs, VHA Chief Business Office, *Project HERO, Performance Metrics (Presentation)*. May 2008, p. 7.

<sup>204</sup> *Ibid.* p. 6.

<sup>205</sup> Department of Veterans Affairs, *Mental Health: 14 Day Monitor by Facility Results for February 2008*.

<sup>206</sup> *Ibid.*

evaluations within the 14-day standard.<sup>207</sup> Project HERO may have the potential to improve performance on this measure, given its significant scope for expanding care to veterans. Considering Project HERO's proposed objectives and benefits, VA officials say that, if the project is successful, implementation in other VISNs could occur before the project completes the demonstration period.<sup>208</sup>

VA is continuing to identify new initiatives for FY 2009 to increase access to mental health care. For example, in July 2008, VA announced its plan to spend \$20 million to build 39 additional Vet Centers, 21 of which will be in counties that do not currently have one.<sup>209</sup> VA also continues to expand telehealth and telemental health programs. These programs use videoconferencing technologies to allow veterans to communicate remotely with providers and specialists, as well as facilitate the interaction between care teams, including establishing linkages between VA medical centers and community-based outpatient clinics so that care may be delivered closer to veterans' homes.<sup>210</sup>

Approximately 25,000 veterans, 1,521 of whom were OEF/OIF veterans, received telemental health services through this program in FY 2007.<sup>211</sup> By the end of third quarter FY 2008, the number of OEF/OIF veterans receiving telemental health services increased 40 percent.<sup>212</sup> VA is also considering the use of mobile health care vans, transportation grants, patient education through podcasts, and collaboration with non-VA facilities to increase veterans' access to care, particularly in rural and underserved areas.<sup>213</sup>

### **Partnerships with State and Local Providers**

The RAND report described earlier observed that it is unreasonable to expect that VA can be the single source for meeting the mental health care needs for all OEF/OIF veterans because: (1) VA operates on a fixed annual appropriation, and generally focuses on providing care to higher-priority disabled veterans; and (2) many veterans do not live near a VA facility.<sup>214</sup> According to a representative from the National Guard Association of America, "although perhaps most often associated with states west of Mississippi, geographical barriers to treatment can occur in states as small as Rhode Island and as far east as Maine."<sup>215</sup>

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<sup>207</sup> Statement of Michael J. Kussman, Undersecretary for Health, Department of Veterans Affairs, before the Senate Committee on Veterans' Affairs, June 3, 2008, p. 3.

<sup>208</sup> Interviews with VA's Chief Business Office.

<sup>209</sup> U.S. Department of Veterans Affairs, Office of Public Affairs, *News Release: VA Vet Centers Coming to 39 Communities*, July 2008.

<sup>210</sup> U.S. Department of Veterans Affairs, *What is Care Coordination Services: Telehealth Programs*, Updated July 8, 2008. Accessed at: <http://www.carecoordination.va.gov>.

<sup>211</sup> Department of Veterans Affairs, *VHA Telehealth Activity and VHA OEF/OIF Telehealth Activity*, FY 2007 through 3<sup>rd</sup> Quarter FY 2008.

<sup>212</sup> Ibid.

<sup>213</sup> Department of Veterans Affairs, Office of Public Affairs, *Press Release: VA Creating Advisory Panel on Rural Health*, February 20, 2008.

<sup>214</sup> RAND Corporation, *Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, CA, 2008, p. 302.

<sup>215</sup> Statement of Col (Ret) Peter Duffy, Deputy Director of Legislative Affairs, National Guard Association of the United States, before Senate Committee on Veterans' Affairs, October 17, 2007, p. 2.

Some state mental health directors say they expect to be overwhelmed with returning veterans' demands for services because they believe many veterans are more likely to seek care close to home. They are concerned that serving this population will divert resources from other needy populations and successful programs. To the extent that veterans' demands for mental health services overburden the state and community systems, state and local community providers have advocated a cost-sharing or fee-basis arrangement with VA to address this.<sup>216</sup> Directors say the states are not on equal footing with respect to their resources and capacity to meet new demands, as some states have been successful in obtaining additional state funds or receiving federal grants, while others have not. For states that have received additional resources, directors say that they are competing with the federal government for the same limited pool of qualified mental health professionals to fill vacancies.<sup>217</sup>

Accordingly, state directors would appreciate a more collaborative partnership with the VA in treating veterans, although they recognize that treating combat-induced mental illness requires special training and context they may not possess.<sup>218</sup> Some partnerships have been developed between federal VA, state Departments of Veterans Affairs, and state mental health commissions for such training purposes. For example, mental health providers in North Carolina have received training through collaboration with VA's Mental Illness Research, Education and Clinical Center for treatment of PTSD and exposure to battle mines, and will receive training for treatment of TBI in the coming year. Training in military-specific issues will also assist state and local providers in treating families affected by stress from prolonged deployments and in handling reintegration issues when the service member returns home.

RAND's April 2008 report recommended increasing "the cadre of providers who are trained and certified to deliver proven, evidence-based care, so that capacity is adequate for current and future needs."<sup>219</sup> VA is already well known for its delivery of training on evidence-based psychotherapies for PTSD, depression and anxiety and serious mental illness,<sup>220</sup> and has implemented national initiatives to train its staff as well as DoD's mental health staff.

An expanded network of qualified mental health care providers will benefit National Guard and Reservists, who are more likely than other separating service members to have limited access to services. The Department of Defense Task Force on Mental Health reported that 41 percent of Guard and Reservists who exclusively use civilian services say they do so because it is easier to access these services.<sup>221</sup> Further, the Task Force report noted that access to prevention and early intervention services, such as chaplains, family support programs, and other programs to support

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<sup>216</sup> The cost-sharing issue is presented here to provide a context for understanding the challenges faced by state and local community providers. It is not within the scope of this study to examine this issue in detail or to propose recommendations that would require policy changes or administrative changes requiring additional federal funding.

<sup>217</sup> Interviews with state mental health directors.

<sup>218</sup> Ibid.

<sup>219</sup> RAND Corporation, *Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, CA, 2008, p. 446.

<sup>220</sup> DoD/VA Senior Oversight Committee Line of Action on Case/Care Management Reform, *Interim Report to Congress, Policy Improvements on the Care, Management and Transition of Recovering Service Members*, February 2008, p.13.

<sup>221</sup> U.S. Department of Defense Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health*, Falls Church, VA, Defense Health Board, Task Force on Mental Health, 2007, p. 28.

psychological health, is limited among National Guard, Reservists, and their families. Guard and Reservists, and especially those who are Individual Augmentees assigned to a unit to fill shortages or offer specialized skill sets, lack the psychological support system and camaraderie that comes with being in or near an active duty military unit upon return from deployment, and are therefore believed to be at increased risk for mental health and reintegration issues when they return to homes that often are located in rural or isolated environments.<sup>222</sup>

Another possible area of collaboration with state and local providers is establishing effective referral and information sharing arrangements with state and local providers, as they are often the first point of entry for a veteran into any health care system. The National Defense Authorization Act (NDAA) of FY 2008 requires military departments to establish uniform policies and procedures “on the referral of recovering service members to the Department of Veterans Affairs and other private and public entities”<sup>223</sup> in order to provide the most appropriate care based on, but not limited to, criteria regarding medical needs of service members and the geographic location of available and necessary care services. NDAA also mandates procedures to ensure that, “with the consent of the recovering service member concerned, the address and contact information of the service member is transmitted to the department or agency for veterans affairs of the State in which the service member intends to reside after the retirement or separation of the service member from the Armed Forces.”<sup>224</sup> In the meantime, VA has established data sharing agreements with 43 State Departments of Veterans Affairs.<sup>225</sup> Under these agreements, VHA liaisons, upon receiving written consent from the veteran, provide State Departments of Veterans Affairs information about the injured veteran who transfers from a MTF to a VA facility. Thus far, VA has shared data for 350 veterans.

NDAA, along with data sharing arrangements between VA and states, provides the initial foundation for referral systems. These systems can fall along a continuum that ranges from informal collaboration to formalized information sharing. Some informal collaborative referral networks have already been established between VA and state and local community services and providers. For example, VAMCs in Philadelphia, New York City, and Los Angeles have established relationships with homeless organizations in the community to determine if a homeless person is a veteran. When city officials identify a shelter occupant as a veteran, they provide the VBA Regional Director with the first and last name of the veteran and shelter location. VA can then verify veteran status and eligibility and conduct outreach as needed.<sup>226</sup> Also, one county in New Mexico developed a pilot program to improve timely access to service by building a partnership between state agencies, VA, and DoD sites. Under this partnership pilot, if a returning soldier, veteran, or any family member requests help from any entity in the partnership, the requester is triaged and connected to the appropriate services either from the

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<sup>222</sup> Interviews with state directors of mental health.

<sup>223</sup> National Defense Authorization Act for FY 2008 (H.R. 4986), Title XVI – Wounded Warrior Matters, Sec. 1611 Comprehensive Policy on Improvements to Care, Management, and Transition of Recovering Service Members from Care and Treatment through DoD to Care, Treatment and Rehabilitation through the DVA, January 28, 2008.

<sup>224</sup> National Defense Authorization Act for FY 2008 (H.R. 4986), Title XVI – Wounded Warrior Matters, Sec. 1614 Transition of Recovering Service Members from Care and Treatment through DoD to Care, Treatment and Rehabilitation through the DVA, January 28, 2008.

<sup>225</sup> Veterans Health Administration State Benefits Seamless Transition Program Issue Brief, May 14, 2008 and supporting data.

<sup>226</sup> Interview with VHA officials.

state, VA, or DoD, to ensure he or she receives services on the basis of his or her individual needs. Psychiatrists are co-located at the project sites. It is not clear, however, that this pilot could be expanded statewide given limited resources.

General consensus exists, at a conceptual level, that more collaboration and improved referral systems would improve service to returning veterans. The challenges of sharing personal and medical information, as well as that of incompatible information systems, pose barriers to effective, systematic sharing. In August 2008, VA, DoD, the Department of Health and Human Service's Substance Abuse and Mental Health Services Administration (SAMHSA) hosted a conference to help federal, state, and local partners improve and enhance mental health and substance abuse services for returning veterans and their families.<sup>227</sup> One of the goals was to facilitate nationwide sharing of information on mental health and substance abuse services across multiple health care delivery systems. Key stakeholders include the National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse directors. Given the variability of programs within the different states, developing a nationwide sharing strategy would be complex. Clearly, referral systems should be a part of this effort at systems development.

## **Recommendations**

### **The Panel recommends:**

- 3-6. VA should apply the lessons learned from its delivery of evidence-based mental health training and coordinate with DoD's new Center for Psychological Health to:**
- **Develop a strategy for providing training to state and community providers to increase their capability to treat veterans effectively for combat-related mental illness, including PTSD, depression, and mild TBI. Providers trained through this program should be required to meet VA-specified quality standards for mental health care, and adhere to VA's performance standards; and**
  - **Use existing data to identify geographic concentrations of returning veterans and areas underserved by mental health providers, based on geographic locations of VA facilities and areas not included in Project Hero, and identify risk areas that should receive priority service. In these areas, VA should work closely with State Directors of Veterans Affairs and Directors of Mental Health to develop approaches and implementation plans for delivering training on evidence-based therapies for PTSD, depression, and TBI to state and community health care providers.**
- 3-7. VA should identify best practices, pilot, and evaluate existing informal partnerships between VHA and community and state providers for health care referral and data**

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<sup>227</sup> <http://www.returningveteransconference.com/2008>

sharing, consistent with Health Insurance Portability and Accountability Act requirements.

- 3-8. VA should pilot best practices and evaluate collaborative partnerships with state and local community providers to identify the most effective and efficient (1) treatment referral methods and (2) data exchanges for transferring relevant medical information needed for treatment, when authorized by the veteran.**

## **VETERAN-CENTERED CARE MANAGEMENT, RECOVERY, AND REINTEGRATION**

A fully developed veteran-centered strategy for effective, integrated care will focus on the needs of the injured veteran; ensure access to and provision of timely, effective treatment; provide a means for identifying providers in proximity to the veteran's community; and provide a tool for the veteran and his/her providers to monitor relative progress in treatment and recovery and reintegration into civilian life.<sup>228</sup> The VA and its partners have developed two key building blocks for achieving these objectives through different programs within VHA: (1) the FIRP for the severely injured; and (2) MyHealth<sub>e</sub>Vet, a web-based tool which enabled a veteran and care providers to create, view, and maintain a personal health record (PHR). Together, these two tools, with some modifications, offer a major opportunity to strengthen the system of care management and recovery for a broader group of returning OEF/OIF veterans beyond the severely injured. Furthermore, VHA's existing systematic evaluation and measurement program to assess progress in achieving effective care management, the Quality Enhancement Research Initiative (QUERI), could help improve and rationalize the current system.

### **Web-based Recovery Plans**

Synergy between an appropriately tailored FIRP and PHR can create a powerful tool for charting the success of reintegration into civilian life for the less severely injured. As discussed in the section on transition pathways for the severely injured, the VA has developed a patient-centered FIRP that provides a comprehensive mechanism for establishing and tracking short- and long-term outcomes on multiple clinical and non-clinical aspects of the transition and reintegration to civilian life. A FIRP allows multiple care providers, the veteran, and the family to define objectives and goals for a veteran's recovery and reintegration, track the veteran's progress over time, and re-evaluate and modify the recovery plan as needed. FRCs are currently using a FIRP prototype which is not yet entirely web-based. DoD and VA are developing technical requirements for this capability and, in the interim, are using software that does not provide a full range of reporting.

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<sup>228</sup> This concept is similar to models for "patient-centered" care delivery, which have been under development for some time in the health care community. Patient-centeredness refers to "health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care." See Institute of Medicine, *Envisioning a National Health Care Quality Report*, 2001, as referenced in Center for Policy Studies in Family Medicine and Primary Care, Robert Graham Center, *The Patient Centered Medical Home, History, Seven Core Features, Evidence and Transformational Change*, November 2007, p. 3.



The FIRP template is organized around short-term and long-term goals for 20 different subject areas, some of which focus exclusively on the veteran/service member (e.g., accommodations, education, vocational rehabilitation, career planning, VA benefits) and others which focus on the family and other key clinical and non-clinical case managers and state and local participants involved in the recovery and reintegration of the veteran. Table 3-1 contains an excerpt from the template.

**Table 3-1. Data Elements for One of 20 Subject Areas Included in a FIRP**

<b>Behavioral Health (Counseling, Assistance and Outreach)</b>		<b>Responsible Point of Contact</b>	<b>Action Timeline</b>	<b>Status (open/closed)</b>
Children	Short-term goal:			
	Long term goal:			
Family member	Short-term goal:			
	Long term goal:			
Service member	Short-term goal:			
	Long term goal:			

Source: Excerpt from FIRP Prototype Template

The importance of involving the family in an injured veteran’s recovery was emphasized by VA staff and external stakeholders in many interviews. Because the FIRP provides a systematic tool for involving the family and encompasses educational and employment elements, applying it, or an appropriately down-scaled version, presents an opportunity to strengthen the care, recovery, and reintegration for the less severely injured. This application would also be consistent with the requirements of the NDAA of 2008, which states that elements of best practices and policies on improvements to the care, management, and transition of recovering service members should be “extended, where applicable, to the care and management of other injured or ill members of the Armed Forces or veterans.”<sup>229</sup> Also, consistent use of a recovery and reintegration plan for less severely injured throughout all VA medical facilities could help facilitate smooth transitions as veterans move to new locations.

In a separate initiative, VHA has developed and implemented an online portal that allows the veteran to participate actively in managing his or her health, including creating a PHR. Current features that are operational include accessing evidence-based health education information; visiting “healthy living centers” and other condition-specific centers of information; maintaining health journals and e-logs; tracking and graphing metrics like weight, blood pressure, and blood glucose; and maintaining a wellness calendar. If the veteran chooses to undergo an “in-person

<sup>229</sup> National Defense Authorization Act for FY 2008 (H.R. 4986), *Title XVI – Wounded Warrior Matters, Sec. 1611*, January 28, 2008.

authentication (IPA)” process at either a VAMC or a Community-based Outpatient Clinic, he/she will be given access to view all prescribed medications and to order prescription refills online. In-person authentication is not currently offered at Vet Centers or VBA regional offices, which could be a barrier to expanding its use.

New features are being added over the next several years for authenticated users. Near-term enhancements include the ability to view VA appointments; view lab test results; send secure messages electronically to providers via the online system and receive reminders. Longer-term initiatives include building an online recovery plan; checking prescription drug interactions; and delegating access to others, including family members and other non-VA care providers, to view the veteran’s PHR. The program has more than 600,000 registered users, although just over 70,000 have been authenticated to access the full range of applications. VA expects the number of authenticated users to increase as these additional services are added over the next several years.<sup>230</sup>

The “My Recovery Plan” component of MyHealthVet is in the design process, and implementation is planned for 2009. VA is also designing a delegation feature that will allow the veteran to authorize various users to view and contribute to the PIR and Recovery Plan. However, implementation of this feature is not scheduled until post-2009 at the earliest. It is unclear to what extent the elements of “My Recovery Plan” are analogous to the FIRP, and whether the FIRP is intended to eventually be accessible for veterans through the MyHealthVet web portal. Obviously, the current implementation timeline for delegation poses a significant barrier to establishing a fully effective and automated recovery and reintegration plan for the less severely injured.

MyHealthVet has a feature allowing visitors, who are not required to register or log in, to respond to anonymous self-assessment surveys to help them determine if they are at risk for alcohol use, substance abuse, depression, and PTSD. Given the stigma associated with mental illness in some veterans’ minds, these private and confidential assessments may be attractive to at-risk veterans. A weakness of this feature, however, is that if the results of the survey indicate the possible need for treatment, MyHealthVet does not readily provide clear instructions to seek care, with accessible links to both VA and state and local providers in the veteran’s region. A tool such as the “Mental Health Services Locator,” which is a link of mental health service providers by location developed by SAMHSA may be useful to veterans using the VA site. On the SAMHSA site, information can be accessed by selecting a State or U.S. Territory from the map or drop-down menu and then searching by city/town name.<sup>231</sup>

Nonetheless, the MyHealthVet program has significant potential as a tool for establishing a more collaborative, veteran-centered system of care. It has a robust program evaluation process

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<sup>230</sup> Nazi, Kim M., *My HealthVet Personal Health Record Overview*, Department of Veterans Affairs, Veterans Health Administration, Office of Information, July 9, 2008, p. 7.

<sup>231</sup> Substance Abuse and Mental Health Service Administration, National Mental Health Information Center, *Mental Health Services Locator*. Accessed at: <http://mentalhealth.samhsa.gov/databases/>, 2008.

in place, and is aligned closely with VA's QUERI centers to pursue a research agenda that will inform the improvement of the MyHealthVet program.<sup>232</sup>

### **Rationalizing the Care Management System**

As discussed earlier in this chapter, VA and DoD have been actively building an integrated system of care management. These efforts have resulted in the creation of several new care management positions, which are intended to better coordinate and manage care, and streamline the staff resources and responsibilities. Analysis of Figure 3-1, which depicts the care managers who may be encountered by a veteran along the continuum of care, and of detailed descriptions of the roles and responsibilities of each position (*See Appendix C.*), suggests, however, that the result at times may be excessive or overlapping care management.

The new FRCP provides useful tools for improving and streamlining care management, although it is too early to tell whether the program will improve outcomes for the severely injured. From the study team's limited direct interactions with FRCs,<sup>233</sup> indications emerged that coordination was improving, but that further streamlining in VA and DoD case management will be needed.

The Dole/Shalala report noted the often excessive and confusing case management system that was in place for returning injured service members, particularly those transitioning between military and VA facilities.

*An injured service member hospitalized at one military treatment facility and discharged to outpatient status may have as many as 15 case managers—all at the same facility. Patients requiring more complex care get more case managers; patients going between DoD and VA facilities for care get even more. The individual's health needs may be met, but it appears that much of the time case managers are managing the patient through a set of services or episodes of care instead of coordinating service. The end result for the service member and his or her family is confusion and redundancy in a system that was intended to coordinate care.*<sup>234</sup>

With respect to care management for the severely injured, coordination between DoD and VA case managers appears to be improving, in part due to Warrior Transition Unit leadership. The improvement underscores the importance of interdepartmental working relationships between the two agencies.<sup>235</sup> For example, the Surgeon General for Warrior Care and Transition mandated that all WTUs be co-located with VHA and VBA liaisons at MTFs, effectively creating an environment that promotes communication and collaboration.<sup>236</sup>

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<sup>232</sup> Nazi, Kim M., *My HealthVet Personal Health Record Overview*, Department of Veterans Affairs, Veterans Health Administration, Office of Information, July 9, 2008, pp. 34-42.

<sup>233</sup> Interaction with Federal Recovery Coordinators was limited to one interview with two FRCs at one MTF.

<sup>234</sup> President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify, Subcommittee Reports and Survey Findings*, July 2007, p. 20.

<sup>235</sup> Interviews with case managers at MTFs.

<sup>236</sup> Interviews with case management staff at MTFs; See also Deputy Commander Clinical Operations, Western Regional Medical Command, *The Warrior Transition Unit: What Works (Presentation)*. Presented at TRICARE West Sub-Regional Conference on Warrior Care Coordination, Tacoma, WA, December 4-5, 2007.

VA was in the midst of evaluating the Phase I implementation of the FRCP at the time the study team was completing its work. During this phase, interviews revealed that there was the potential for some overlap between the roles and responsibilities of the various case managers at MTFs and VA facilities, including overlap among case managers at the same facility. Further, given the newness of the FRC position, few clinicians or care management staff could clearly explain how the FRC would integrate into the current system of care management. Some overlap and uncertainty exists because numerous changes to streamline care and provide additional support for patients and their families were implemented simultaneously, followed by the addition of a new FRC position.

Two separate initiatives are underway that could offer opportunities for rationalizing care management practices for both the severely injured and less severely injured. First, the NDAA of 2008 requires DoD and VA, by July 2008, to identify the most effective and patient-oriented approaches to care and management of service members who are “undergoing medical treatment, recuperation, or therapy on and are in an outpatient status while recovering from a serious injury or illness related to the member’s military service.”<sup>237</sup> When the study team finished its work, this initiative was not completed.

Second, VA and DoD recognize the importance of evaluating Phase I of the FRC program and have developed an evaluation strategy. However, the strategy omits an assessment of the frequency and nature of the FRC’s encounters with other DoD or VA case managers interacting with the patient. Such an assessment would help determine the degree to which FRCs and case managers are duplicating effort, something that integrated care management seeks to avoid. Reduction in overlap of responsibilities and duplication of services is critical to improving coordination of care and rationalization of limited resources.

The FRCP evaluation strategy has two additional gaps related to performance measurement that are discussed in the next section.

## **Performance Measurement**

VHA’s system of performance measurement has been developed with the assistance of the National Performance Measurement Workgroup (PMWG), the National Advisory Council for Clinical Guidelines, and clinicians and administrators from VHA. The measures and metrics chosen focus on the following six “Domains of Value” that represent both problem areas and opportunities for improvement: access to care; quality of care; patient functional status; cost of care; customer satisfaction; and building healthy communities.<sup>238</sup> Further, through its Quality Enhancement Research Initiative (QUERI), VA is making efforts to move beyond treatment and clinical metrics and measure quality of life, functional status, and patient satisfaction—all important measures in evaluating the successful reintegration of the veteran or service member into society. Extending this outcome-oriented approach more broadly to VA’s strategic planning

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<sup>237</sup> National Defense Authorization Act for FY 2008 (H.R. 4986), *Title XVI – Wounded Warrior Matters, Sec. 1602 and 1611*, January 28, 2008.

<sup>238</sup> Department of Veterans Affairs, *VHA Performance Measurement Development and Life Cycle*, Received from VA on July 25, 2008.

process and incorporating the outcome-oriented aspects to VA's evaluation of the FRCP program evaluation could strengthen VHA's overall performance measurement system.

In 1998, the Health Services and Research and Development Service, one of four research services within VHA's Office of Research and Development, launched QUERI.<sup>239</sup> It is "designed to improve the quality, outcomes, and efficiency of VHA health care through the identification and implementation of evidence-based practices in routine care settings."<sup>240</sup> Data sources such as VHA electronic data, surveys of patients, caregivers, and clinicians, and manual reviews of electronic records are measured and analyzed to produce an assessment of system-related outcomes and patient outcomes associated with improved health-related quality of life.<sup>241</sup>

VA's Strategic Plan FY 2006-2011 lays out an impressive performance plan that defines outcome-based goals, program-oriented objectives, strategies and initiatives to achieve those objectives, and performance measures to track progress, as exemplified in Table 3-2. VA also has added some new timeliness measures for which baselines will be developed in FY 2009. These include percent of new patient appointments completed within 30 days of desired date and percent of unique patients waiting more than 30 days beyond desired appointment date.<sup>242</sup> Although the goals, objectives, and strategies in VA's Strategic Plan are largely focused on outcomes, the performance measures VA has defined are generally process-oriented and insufficient to measure effectively success in reaching the intended goals and implementing strategic initiatives. For example, as shown in Table 3-2, although two measures are outcome oriented (i.e., the degree of patient satisfaction with health care services and percent of veterans with a serious employment handicap exiting the VR&E program who obtain and maintain suitable employment or achieve independent living goals), all others are process oriented.

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<sup>239</sup> <http://www.research.va.gov/about/default.cfm>, April 6, 2007 and <http://www.hsrd.research.va.gov/queri/program.cfm#org>, July 9, 2008.

<sup>240</sup> McQueen, Lynn, Brian Mittman, and John DeMakis, *Overview of the Veterans Health Administration (VHA) Quality Enhancement Research Initiative (QUERI)*, *Journal of the American Medical Informatics Association*, September/October, 2004, p. 339.

<sup>241</sup> Ibid.

<sup>242</sup> Department of Veterans Affairs, Volume II, Medical Programs & Information Technology Programs, Congressional Budget Submission FY 2009, Performance Summary Table: Veterans Health Administration, February 2008, p. 1G-7.

**Table 3-2. Examples of Goals, Objectives, Strategies and Metrics from VA's Strategic Plan, FY 2006-2011**

Goal	Objective	Strategies	Performance Metrics
Restore the capability of veterans with disabilities to the greatest extent possible, and improve the quality of their lives and that of their families.	Maximize the physical, mental, and social functioning of veterans with disabilities and be a leader in providing specialized health care services.	Improve outreach, collaboration, and data sharing to assist veterans in identifying and receiving appropriate healthcare, benefits and services	Percent of severely-injured or ill OEF/OIF service members/veterans who are contacted by their assigned VA case manager within 7 calendar days of notification of transfer to the VA system as an inpatient or outpatient.
		Improve the quality and expand the availability of comprehensive mental health services.	Percent of Community Based Outpatient Clinics (serving more than 1,500) that provide Mental Health specialty services for encounters in at least 10 percent of patient visits.
	Provide eligible service-connected disabled veterans with the opportunity to become employable and obtain and maintain employment, while delivering special support to veterans with serious employment handicaps.	Identify and address obstacles to the successful completion of vocational rehabilitation programs	Percent of veterans with a serious employment handicap exiting the VR&E program who obtain and maintain suitable employment or achieve their independent living goals.
Ensure a smooth transition for veterans from active military service to civilian life.	Ease the reentry of new veterans into civilian life by increasing awareness of access to, and use of VA health care, benefits, and services.	Partner with DoD to ensure that the transition from active duty to veteran status is seamless for service-members	Percent of separating, deactivating, and retiring service members who participate in VA benefits and TAP/DTAP briefings prior to separation, deactivation, or retirement.
		Improve access to VA health care through the use of technological advances.	Number of implementation guides developed for those Consolidated Health Informatics Standards adopted by VA and DoD.
Honor and serve veterans in life, and memorialize them in death for their sacrifices on behalf of the Nation.	Provide high quality, reliable, accessible, timely, and efficient health care that maximizes the health and functional status of enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the costs, and those statutorily eligible for care.	Ensure quality health care delivery and outcomes through care coordination, disease management, and prevention.	Percent of resident-associated inpatient admissions to medicine, psychiatry, or surgery bed service for which the supervising attending practitioner receives an independent progress note from the attending physician within one day of admission
		Improve access to health care through the use of advanced technologies for diagnosis, testing, data exchange, and scheduling.	Percent of patients rating VA health care service as very good or excellent.
			Percent of primary care appointments scheduled within 30 days of the desired date

Source: Excerpts from the Department of Veterans Affairs, Strategic Plan FY 2006-2011, Washington, D.C., Office of the Secretary of Veterans Affairs, October 2006, pp. 37-59.

As discussed in the previous section, VA and DoD have developed an evaluation strategy for the FRCP, but the strategy has gaps in coverage that limit its comprehensiveness and value. First, there are no measures regarding the degree of family involvement in the development of the FIRP. Second, the evaluation does not address the extent to which service members' short-term or long-term goals in the FIRP were achieved or even whether the treatment plan as originally conceived was followed or modified. The patient-centered attribute for clinical information systems includes the monitoring of adherence to treatment, which is crucial information needed to guide treatment planning for future patients.<sup>243</sup> Outcomes-based metrics used by QUERI could be applicable more broadly to the non-clinical short-term and long-term goals of the FIRPs, and to recovery and reintegration plans for the less severely injured, as well as to the success of initiatives to identify and treat at-risk veterans.

## **Recommendations**

The Panel recommends VA improve performance in four areas of care management and recovery: (1) web-based recovery and reintegration plans; (2) improvements to MyHealthVet; (3) rationalizing care management; and (4) performance measurement.

### *Recovery and Reintegration Plans for less severely injured*

**3-9. VA should pilot the use of recovery and reintegration plans for the less severely injured and those OEF/OIF veterans who are receiving case management services. In doing so, VA should:**

- **Identify which of the 20 elements currently included in the federal individualized recovery plans for the severely injured may be appropriate to use for the less severely injured, and whether other elements, for example those related to recovery from PTSD, are appropriate.**
- **Pilot and evaluate the use of these elements in recovery and reintegration plans for the less severely injured and or those OEF/OIF veterans who are receiving case management services. The evaluation should also include an assessment of the types of services provided by different case managers within VA and DoD.**
- **Assign OEF/OIF program managers to serve as focal points for overseeing the recovery and reintegration plans.**

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<sup>243</sup> One researcher has identified the following seven attributes of patient-centered care: “(1) superb access to care; (2) patient engagement in care; (3) clinical information systems that support high quality practice-based learning and quality improvement; (4) care coordination; (5) integrated and comprehensive team care, practice-based learning, and quality improvement; (6) routine patient feedback to doctors; and (7) publicly available information to help patients choose a practice that meets their needs.” See the Commonwealth Fund, *A 2020 Vision of Patient Centered Primary Care*, October 2005, p. 1.

## *MyHealthVet*

### **3-10. VA should initiate steps to strengthen the reach of VA's MyHealthVet web portal and:**

- **Increase access by developing an online authentication process. Until this on-line capability is available, VA should increase the number of sites at which in-person authentication process is provided, including Vet Centers and VBA Regional Offices.**
- **Re-evaluate priorities for future information technology application releases, particularly the "Delegation" function, given its importance in facilitating sharing across non-VA providers and allowing family members to access a veteran's Personal Health Record and recovery and reintegration plan.**
- **Use MyHealthVet to provide: (1) easy-to-access evidence-based information on mental illness and conditions particular to returning veterans and their families; (2) actionable steps for users who access the anonymous screening capability, including direct links to VA and non-VA mental health care providers in close proximity to the veteran and the family; and (3) online capability for "web chat" support sessions with trained professionals and other veterans, available to both the veteran and family.**
- **Incorporate the lessons learned from the recovery and reintegration plan pilot into the development of the "My Recovery Plan" component of the MyHealthVet portal system.**
- **Promote MyHealthVet, particularly the mental health and substance use screening applications, to all veterans in multiple settings, including state and local community providers.**

## *Care Management*

### **3-11. VA should revise the evaluation strategy for the new Federal Recovery Coordinator Program for the severely injured to include an element regarding the nature of Federal Recovery Coordinators' contacts with other case managers.**

### **3-12. VA should develop an evaluation strategy, before implementing "best practices" in care management, to measure the impacts of care management on care quality and on recovery outcomes for veterans.**

## *Performance measures*

### **3-13. VA should develop new annual and long-term targets and associated service and intermediate outcome-based performance metrics to track VA's success in developing a continuum of care. This includes identifying and treating at-risk veterans, increasing access to services, improving the care management system, and**



**ultimately improving the quality of life of veterans through rehabilitation and reintegration into society. In implementing this recommendation, VA should:**

- **Develop a set of service-related measures and targets.**

Examples of such measures are:

- Numbers of veterans who have been screened for Post Traumatic Stress Disorder (PTSD), mental illness, and mild Traumatic Brain Injury (TBI), compared to estimates of at-risk population;
- Number of Post-Deployment Health Reassessment (PDHRA) referrals to VA care facilities, including Vet Centers;
- Outcomes that result from PDHRA referrals;
- Percentage of referred patients seeking mental health care from VA facilities or Vet Centers (rate of follow up);
- Percentage of those who opt to auto-enroll with VA at the time of the PDHRA;
- Percentage of PDHRA referrals provided to VA within 15 days of screening;
- Percent of veterans who report not seeking care due to stigma-related reasons;
- Proportion of wounded OEF/OIF veterans with an online reintegration plan;
- Number of state and community health providers trained on best practices in care for veteran-specific issues;
- Number of state and community health providers who report they are qualified to treat combat-related depression, mental illness and mild TBI; and
- Number of referrals to VA health care from state and community services.

- **Develop intermediate outcome measures and targets that focus on the veteran's rehabilitation and reintegration into society.**

Examples of intermediate outcome measures include:

- Proportion of at-risk veterans who receive appropriate, timely treatment;
- Proportion of at-risk veterans who report high levels of customer satisfaction with the care they have received;
- Percentage of injured veterans in need of community-based rehabilitation and support services receiving such services;
- Proportion of veterans and their families using the online web portal for benefits and health care tracking;
- Proportion of severely injured veterans who met Federal Individualized Recovery Plan short- and long-term goals.

In the longer term, the ultimate gauge of success is whether VA is successful in improving the long term rehabilitation and recovery outcomes for veterans and reducing the incidence of negative outcomes that some veterans experience, such as homelessness and unemployment. These longer term measures and a broader organizational strategy of continuous improvement are discussed in Chapter 4.

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## **CHAPTER 4**

### **ORGANIZING FOR CONTINUOUS IMPROVEMENT**

An array of federal departments and agencies, including the VA and DoD, face a very large and complex organizational and management challenge in improving care and benefits for veterans, including those now returning from Iraq and Afghanistan. To succeed in executing the many changes recommended in this report, along with the changes recommended by other panels and commissions, VA and its partners must pursue a broader systematic organizational strategy of continuous improvement. This strategy will involve a series of successive and coordinated evidence-driven alterations to the administration of service and benefits for veterans. For the change to be sustained and successful, it must be supported at the top and managed centrally, with clear accountability by all for specific results under their control and a continuous focus on how their work contributes to better outcomes for veterans.

The change strategy must be guided by a clear vision, translated into specific performance goals and targets for achievement. At the highest level, the goal of the change is to transform VA into a veteran-centered organization that produces better service and outcomes for veterans.

This chapter describes actions that the Panel believes are required for a successful organizational change. It is based on models that have been used successfully within VA and elsewhere. These contain practical steps for building and sustaining such a strategy in VA. Finally, the chapter proposes ways to continue and deepen the recently productive partnership between VA and DoD, which is essential to the strategy's success.

#### **INTRODUCTION**

As discussed in the preceding chapters, long-term success in providing better support for recovery and reintegration of veterans will require:

- Sustaining and strengthening collaboration between VA and DoD to support transitions and support recovery and reintegration of separated service members;
- Integrating the management and operations of the VBA and the VHA as needed to ensure “no wrong door” for the veteran seeking help or information;
- Balancing centralized review of information system investments with openness to innovation at lower levels;
- Establishing a cost-effective tracking, communications, and outreach strategy for veterans, with appropriate interventions and access to continuing support; and
- Finding cost-effective ways to provide long-term support for full recovery and reintegration of returning injured veterans, including in some cases long-term institutional care of the most severely injured.

The Panel does not believe that addressing these challenges will require a major reorganization of roles and responsibilities within VA or between VA and DoD. However, it will require creative leaders and managers, with sufficient authority and control over resources to manage the change process over an indefinite period. VA, working with its partners, also must retain flexibility to adjust systems and management priorities and reallocate resources in response to changes in the numbers and geography of needs arising from military conflicts and the tension between rising medical care costs and competing demands for resources. It also will require broadening use of the existing evidence-based learning capacity that now exists in VHA—represented by the QUERI process administered by the Health Services and Research Development Service within VHA’s Office of Research and Development.<sup>244</sup> This will promote continual learning from experience and adjustment of strategies for improving service when, for example, piloting and evaluation identifies new, cost-effective means of targeted outreach, or new scientific understanding emerges of how to diagnose and treat specific illnesses and injuries.

Fortunately, VA has in its own recent experience a documented model of successful change that includes the elements needed for sustained organizational improvement.<sup>245</sup> The VHA reorganization during the last decade demonstrates that VA can manage large-scale change successfully. The success of that effort has been attributed to a combination of strong individual leadership with a well-defined vision of what the change was intended to accomplish and how to bring it about; a new management approach that combined delegation to strong regional administrators held accountable for specific results in line with the vision of improved health care; and a system of evidence-based evaluation research and testing of new clinical practices that has allowed the organization to learn and improve at a rapid pace.

According to Kenneth Kizer, the former Under Secretary for Health who led the change, systemic change at the VHA is still a work in progress.<sup>246</sup> More managerial accountability is needed, as well as greater flexibility to make difficult decisions that are inherent in organizational change. Kizer has noted that, given the numerous attempts at reforms in the years prior to his tenure and their ultimate failure, an attitude toward change efforts permeated the workforce and could be summed up as, “Well, this too will pass. It won’t be long before we get back to the old way of doing things.”<sup>247</sup> It is not easy for large organizations to sustain a process of continuous learning and improvement. That is why the best, most successful organizations consciously design and build institutional support for strategic performance-driven management.

Public organizations face special challenges in systematically changing to more effective modes of operation, given—among other factors—the complexity of their missions, the constant and often conflicting demands of various constituencies, and frequent changes in their top leadership. The net result of these pressures can be an organizational tendency to react to the latest crisis rather than to plan against long-term performance objectives. The prevailing environment can

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<sup>244</sup> Compare for example, McQueen, Mittman, and Demakis. *Overview of the Veterans Health Administration (VHA) Quality Enhancement Research Initiative (QUERI)*, Journal of the American Medical Association. September/October 11 2004. pp. 339-343.

<sup>245</sup> Phillip Longman, *Best Care Anywhere, Why VA Health Care is Better Than Yours*. PoliPoint Press, 2007.

<sup>246</sup> K. Kizer, presentation to the Institute of Medicine Roundtable on Evidence-based Medicine, April 29, 2008.

<sup>247</sup> Young, G. *Transforming Government: The Revitalization of the Veterans Health Administration*. The 2000 Presidential Transition Series. Washington, D.C.: The PricewaterhouseCoopers Endowment for The Business of Government, June 2000. p. 25.

contribute to a defensive and overly cautious resistance to change. A conscious strategy for learning and improvement can help buffer and offset these inevitable, performance-eroding pressures.

## **A STRATEGY FOR CONTINUOUS IMPROVEMENT**

At the broadest level, those responsible for improving the system of care and benefits for veterans face the challenge of organizational transformation. Success in that context depends on:

- Leadership that is prepared to communicate a clear, consistent, and compelling vision that is aligned with the organization’s statutory mission and is reinforced by a steady focus on results, measurement, and reporting systems to track progress toward desired outcomes.
- Developing and using a balanced array of performance metrics to guide change and provide accountability for results internally and externally.
- Ensuring that personnel with the appropriate skills are employed and given sufficient authority, autonomy, and incentive to achieve the goals. Internal and external relationships must ensure coordination among actors and units, and give each person a “line of sight” to the larger purposes.
- Establishing regular processes for planning and managing strategically, enabling continual improvement by learning and then adapting to the new information.

For challenges such as those presented by returning OEF/OIF veterans, successful response also will depend on how effectively VA collaborates with its partners in the federal and state governments and among the many non-governmental organizations interested in helping veterans and their families. Of particular importance to providing a continuum of care to wounded veterans and a seamless transition from active service for others is the fostering of a deeper, more effective partnership with DoD and the military services.

### **Managing Organizational Change**

Managing the complex set of changes required to make VA fully veteran-centered is a major challenge. As noted, transformation efforts can fall short for many reasons. These include fear of change, lack of thorough planning, waning commitment, insufficient accountability, and poor timing.

The core set of contributors to successful change identified by nearly all studies of such accomplishments includes the following:

- **Commitment** of leadership in both words and actions over a sustained period of time;
- **Information and communication** to all involved, explaining what the change is about, the desired outcomes, their role in the effort, and why it matters to them;

- **An enabling environment** which promotes the change by training new skills or imparting knowledge; creating new or modifying existing work processes; opening communication and data sharing channels to support those work processes; and removal of barriers, negativity and resistance to change; and
- **Enforcement** of new business rules, requiring **accountability** through use of performance metrics, and offering **incentives** for achievement of milestones and goals.

Another summary of such critical factors, drawn from a study of successful large-scale change management efforts, is included at Appendix D.

As Chapter 2 explains, VA has had plans and champions at various times for integrating its administration and systems under the banner of “OneVA.” Earlier versions of VA’s Strategic Plan placed the OneVA concept high in priority for development and implementation, and numerous concept papers and planning documents were developed for the OneVA vision. However, the Department has never had sustained success in turning those plans into progress.

VA managers note that, historically, the Department has not lacked for good plans to address a variety of issues that would move it toward becoming more veteran centered. Execution of those plans has fallen short because many of the components of successful change have been lacking.

#### *Goal Setting and Performance Improvement*

Intense activity and rapid change increase the risk that personnel at all levels of an organization will lose sight of the larger goals to which their efforts are contributing. The SOC process may be an example of this. It has been guided by the recommendations of previous commissions and groups, and, to move more quickly, each of the SOC Lines of Action has concentrated on how to implement the specific categories of recommendations within its assigned area.

While this approach has speeded the launch or piloting of new initiatives, there does not appear to be a clear statement as yet of what would constitute overall success of the joint effort. Nor is there in place a framework of targeted outcomes or indicators of progress that will allow DoD and VA to judge which of their efforts have contributed to improvements in care and benefits for veterans.<sup>248</sup>

The techniques of strategic planning and performance measurement are well understood and have been applied effectively in both DoD and VA, as evidenced by the major successful restructuring of the VHA in the 1990s. A strategic discussion at the outset of the SOC process would have required some time. The main obstacle to using these techniques in the SOC effort has been the pressure to achieve and demonstrate results quickly.

It is possible that an early effort to develop such a plan and an explicit strategy would have revealed fundamental differences in perspective and mission between DoD, the military services,

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<sup>248</sup> The SOC was considering, as of July 2008, whether to adopt a “balanced scorecard” approach to guide its future efforts. As noted in the Recommendations at the end of this chapter, a joint DoD/VA scorecard on transition management would be useful if it captured the vision and performance metrics needed to guide the DoD-VA partnership.

and the VA that would have hindered their initial progress. Deliberation regarding the basic objectives of the effort, such as whether to focus on short-term recovery or long-term reintegration into civilian society, and whether to concentrate on veterans of the current conflicts or to pursue changes that would benefit all veterans, would have raised difficult issues. In the absence of such exchanges, these underlying differences in philosophy and culture are yet to be addressed, with unclear implications for the future course of the effort.

Basic questions ultimately will be asked about whether the changes resulting from the SOC's efforts have been successful in the most fundamental terms, i.e., numbers of service members reintegrated successfully into civilian life; numbers of severely injured veterans restored to fullest possible functioning and health; and effectiveness of specific strategies for early diagnosis and treatment of PTSD, TBI, and other trauma-related mental illness. Clear goals and strong performance measurement would enable VA and DoD to answer these questions more precisely, and to use the answers to improve their efforts to facilitate transitions, as well as to demonstrate accountability to external stakeholders including Congress and the Administration. An appropriate array of performance metrics also would support internal management decisions regarding the best use of resources, technology investment, and program design.

Within VA, both Administrations have used performance measurement extensively to guide their program management. VHA has more experience than most of VBA in using performance metrics to set and monitor goals for senior managers and in applying these metrics to systematic improvement of programs.

To be fully successful, the performance framework for improving transitions must encompass both benefits/VBA and health care/VHA. To drive successful change, VA and its partners need to establish a performance framework change that will:

- set goals for improved outcomes for each category of veteran, including access to appropriate care and assistance, health and recovery, employment and earnings, and quality of life;
- provide VA and its partners with a common strategy for achieving improved outcomes by identifying actions that build on existing assets and deploy them more effectively;
- design and apply performance measures, supported by data collection, analysis, and reporting infrastructure, based on baseline performance levels and including interim and long-term improvement targets;
- establish joint administrative responsibilities for performance measurement, including data quality and reliability, related to transitions;
- develop program measures for health and quality of life outcomes for recovering veterans in order to assess program effectiveness and guide improvement;
- establish baselines against which to judge progress and provide regular feedback on results to those working to improve outcomes;
- support controlled trials of critical treatment and services changes as they are introduced and use these to guide decisions about program design; and

- link information on results to transition program management, personnel ratings and rewards, program redesign, and policy and budget development.

### *Authority and Incentives*

Productive and lasting change may emerge from the joint DoD/VA SOC process, as well as from independent work by the two Departments to aid the adjustment, recovery, and reintegration of veterans. Congress has not waited, however, to institutionalize interdepartmental policy development and collaboration through joint centers and other joint management structures to deal with severely injured veterans. The National Defense Authorization Act of 2008:

- Directs the VA and DoD Secretaries to jointly develop and implement a mechanism to provide for the electronic transfer from DoD to VA of DoD documents necessary to establish or support eligibility of a member for benefits under laws administered by VA at the time of the member's retirement, separation, or release from service;
- Establishes the DoD-VA Interagency Program Office for a Joint Electronic Health Record and requires that the Office develop and prepare a joint record which complies with applicable federal interoperability standards, for deployment by September 30, 2010; and
- Mandates joint DoD/VA standards for transition of recovering members/veterans from care and treatment by DoD to care and treatment by VA before, during, and after separation from service, VA access to military health records, and surveys and other mechanisms to measure patient and family satisfaction with DoD and VA care and services.

Such mandates impose a new layer of organizational and management challenges regarding divided authority and accountability; conflicting missions and incentive structures; and oversight by multiple Congressional committees. Control of these joint structures will, in the absence of other determinants, likely lead to dominance by whichever department receives Congressional spending authority for the operation of these structures.

Divided or disconnected management functions—as between VHA and VBA in VA, or between DoD and the military services, or between DoD and VA at different stages of the transition—create coordination problems that may impair effective service to individual veterans. To the extent that activities are managed by a cluster of personnel with overlapping roles and responsibilities to different organizations, as appears to be the case with care for the severely wounded, there is more potential for confusion and conflict. Sorting out proper roles and relationships will require both coordination across Congressional committees and close collaboration between DoD and VA and between VHA and VBA.

## **ACTIONS TO SUPPORT A STRATEGY FOR CONTINUOUS IMPROVEMENT**

To make the Department of Veterans Affairs fully veteran centered, and therefore more effective in serving the veteran is a long-term, complex process of organizational change. Sustained high-



level leadership of the required organization-wide changes will depend on establishing a new capacity directly responsible to the Secretary for the change. The Secretary should establish a process of performance-driven management and evidence-based improvement, modeled in part on the successful performance-based reinvention of VHA in the previous decade.

Effective transformation of VA to a veteran-centered Department will require revision of the performance plans of VA offices to focus on efforts that promote this objective and measure veteran satisfaction with their encounters with VA as important “process goals.” A performance-driven management structure and philosophy can be supported by specific techniques that VA and its partners can use to promote continuous improvement in outcomes for veterans. For example, experience in both private and public sectors suggests that techniques such as developing program “logic models,” organization “strategy mapping,” “balanced scorecards,” and “value stream mapping” can drive constructive change. Many large private companies and some public organizations that recognize the need for continuous improvement in their competitive environment have used such processes successfully. Their success depends on visionary leadership to achieve positive, focused change. Illustrative versions of a Strategy Map and a Balanced Scorecard to support improved service to returning veterans, including exemplary measures, are presented below in the context of other recommendations.

Previous organizational change research identifies eight steps to successful change in large organizations, with new behaviors required at each step.<sup>249</sup> These are:

1. Create a sense of urgency regarding the change—personnel will start verbalizing a recognized need to change;
2. Build the guiding team—designate a group with sufficient power and authority to guide the change and in a position to direct collaborative efforts crossing intradepartmental boundaries;
3. Elaborate a clear, simple vision of what the change entails—the guiding team develops the vision and strategy for the change effort
4. Communicate the vision and strategy to transform the organization over time into a veteran centered and more effective organization—personnel begin to accept the change because they are informed about what it is and how it will affect them;
5. Empower managers to advance the strategy by removing obstacles—more personnel are able to act and begin to do so, they have fewer obstacles or perceive less risk;
6. Produce short-term successes to demonstrate progress and create more support—personnel will be energized by successes and momentum will increase, while detractors begin to diminish;
7. Do not let up, but stay committed to achieving more successes and institutionalize the changes—so that over time more people make changes and see successes; and

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<sup>249</sup> Adapted from Kotter, J.P. and Dan S. Cohen, *The Heart of Change*. Harvard Business School Press, 2002, pp. 3-6.

8. Make the change stick by encouraging a new culture within the organization—the new behaviors continue, despite the influence of tradition or leadership turnover; the earlier and continued successes keep the momentum up for sustaining the change and it becomes the new cultural norm.

## Recommendations

### **4-1. VA should create a new performance-driven culture and management style to transform VA into a veteran-centered organization.**

The illustrative Strategy Map at Figure 4-1 shows at a high level how the principal recommendations in this report and related organizational and resource allocation decisions (first line) can support the Panel's proposed strategies to improve service to returning veterans, and how these service improvements in turn can contribute over a period of years to improved outcomes for veterans. In this case, the focus is on returning veterans, but similar maps could be developed as guides to change for all or other categories of veterans.

Such maps are one tool used by managers and leaders of transformative change in large private and public organizations.<sup>250</sup> Strategy Maps describe how an organization adds value. For a private sector organization, the desired outcomes typically include profitability and revenue growth. For a public sector organization like VA, desired outcomes relate to its mission and strategic objectives, in this case improving the lives of veterans. This version of the Map, like the report as a whole, addresses only actions and strategies consistent with current policy and legislation.

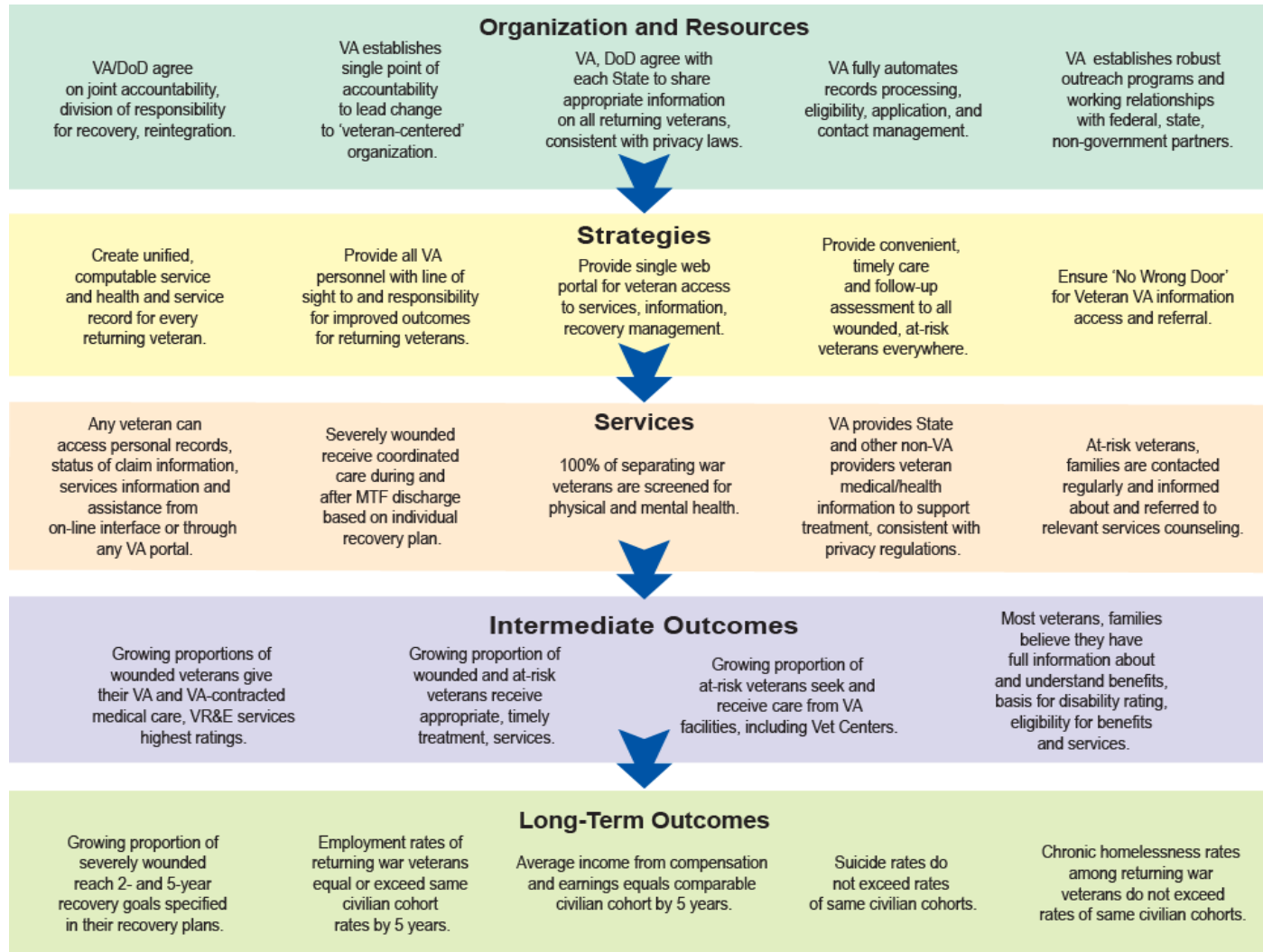
It is up to VA leadership, under the direction of the President and Congress, to decide which metrics and targets it will use to assess progress toward its goals, and to assess which changes in organization and use of resources and which strategies and service changes are most likely to lead to improved outcomes. The elements in the top rows of Figure 4-1 are consistent with, and representative of, the strategies and specific actions recommended by the Panel in Chapters 2 and 3; those in the lower rows are indicative of the improved outcomes that are expected to result.

As the change progresses, more detailed strategy maps can be used to capture the logic of the change, i.e., how each action or strategy contributes to specific improvements expected to support fuller recovery and reintegration of returning veterans. At this level of detail, it should be possible to monitor the effects of particular elements of each strategy on intermediate outcomes and, in turn, on improvements in veteran welfare. For the most important relationships, it will be useful to conduct rigorous evaluations employing randomization and other statistical controls for other influences on the result.

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<sup>250</sup> Kaplan, Robert S. and David P. Norton. *Strategy Maps, Converting Intangible Assets into Tangible Outcomes*. Boston, Mass.: Harvard Business School Press, 2004.

**Figure 4-1. Illustrative Strategy Map - Improving Service to Returning War Veterans**



Source: A Report of a Panel of the National Academy of Public Administration for the U.S. Congress and the U.S. Department of Veterans Affairs, *After Yellow Ribbons: Providing Veteran-Centered Services*, 2008.

**4-2. VA, the President, and Congress should provide leadership and a continuing commitment to achieving a veteran-centered department.**

- **the Secretary of VA should be held accountable for sustaining a commitment to achieving a veteran-centered department.**

Examples of actions to demonstrate commitment by the Secretary include:

- Creation of joint project teams across the VA Administrations;
  - Identification of business leaders to direct the teams;
  - Commitment of resources;
  - Setting timelines with milestones and goals;
  - Clear performance metrics and targets at all levels of the organization; and
  - Accountability for goal achievement, including penalties for non-performance and rewards for progress.
- **OMB should require that VA's budget submission and performance reports document its progress toward achieving a veteran-centered department; and**
  - **Congress should hold oversight hearings to examine the department's progress in achieving objectives designed to accomplish a veteran-centered VA.**

**4-3. The Secretary should establish a new Office for Veteran-Centered Change Leadership for coordinating change leadership. The new office should include a small analytical and monitoring staff and be led by a new senior executive officer who shall report directly to the Secretary.**

The Office for Veteran-Centered Change would be responsible for advising the Secretary on how to implement and sustain an overall strategy and specific changes to transform the VA into a veteran-centered service organization and to ensure timely, appropriate, effective treatment and benefits for those veterans in need. The office would monitor progress and report to the Secretary, Congress, and the public on measures effectiveness, including improved outcomes. It would advise the VA Undersecretaries for Health and Benefits and the Chief Information Officer on how they should prioritize and coordinate their efforts to ensure these improvements. The head of the office would continuously advise the Secretary on how to improve service to veterans based on rigorous evaluation of elements of the change strategy and demonstrating what works and is cost-effective.

**4-4. Congress should establish a new permanent, expert, external advisory board on veteran-centered change and require periodic reports on the progress in achieving veteran-centered service.**

This board would advise the Secretary and report to the public and Congress on administrative changes that would support veteran-centered service and improved care and benefits for veterans. It would include members with expertise in: (1) service delivery, especially those services using the internet creatively; (2) marketing (how to

reach and spark the interest of new veterans; (3) healthcare delivery (especially those in integrated systems and mental health care systems); and (4) needs of veterans and Veteran Service Organizations. This Advisory Board would have access to VA staff with expertise in veterans' benefits and programs.

- 4-5. VA should develop and use new performance metrics to monitor progress and drive change. These measures should reflect a balance of perspectives consistent with an overall strategy to improve outcomes for veterans. They also should include direct measures of the extent of recovery and reintegration by returning veterans, consistent with the goals of the joint VA/DoD effort to improve these outcomes.**

Specific proposed metrics are included in the illustrative Balanced Scorecard in Figure 4-2. A scorecard similar to this can be used by senior managers of the change to assess in the short term whether it is on track and whether it is likely to produce long-term outcomes consistent with the aims of the transformation, such as those listed in the Strategy Map (Figure 4-1).

Such instruments are “balanced” in the sense that they look at the process of change from differing perspectives, including that of an internal manager; of the customer, i.e., veteran; of those responsible for promoting organizational learning and employee growth; and of the financial manager. As with the Strategy Map, VA leadership will determine how best to measure progress and what targets to set for change in a given year, consistent with resource levels and other environmental factors.

- 4-6. VA should link new performance metrics to employee rewards and recognition for both individual and team performance in achievement of organizational results.** These results would include progress on the metrics identified in the Balanced Scorecard and other measures of improved service appropriate to each program and level of responsibility.

Some of the federal government's merit system processes do not effectively support excellence, flexibility, urgency, and clarity of mission.<sup>251</sup> VA is conducting a limited pay-for-performance pilot, and its experience may help to inform a broader application of modern merit principles to its system for rating and rewards.

- 4-7. VA should use collaborative web technology for internal and external collaboration and pursue a range of initiatives that would support veteran-centered service and would help implement and accelerate the necessary reorientation of the Department.** Implementation of this recommendation would include:

- ***Employee ‘Idea Factory’***—An internal collaborative site, similar to one used by the Transportation Security Administration, should be established where any employee can (following ground rules and with attribution) propose any new practice or policy

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<sup>251</sup> The Panel is grateful to Dr. Nancy Kingsbury, Managing Director for Applied Research and Methods at the Government Accountability Office, for sharing a working document on modern merit principles developed by a team at GAO which she led.

change (not requiring legislation) that would improve service to returning or all veterans, have these screened and presented for a vote of the collaborating employees, and then reviewed for possible adoption.

- **Partners Wiki**—A platform should be provided for any subgroup or existing network of non-VA service providers and other public or private agencies working on behalf of veterans to use to organize a collaboration regarding a particular problem related to improved service for veterans in a particular region, state, or with a particular need. Products would be proposals that could be formally endorsed or informally advanced for consideration by the VA in a fully transparent, open-ended process. Expected results would include a growing number of collaborative networks that could help disparate providers find each other, form constructive partnerships, and solve problems related to veteran service.
- **Veteran Feedback Site**—An interactive site should be built where a veteran could pose a query or post a complaint and receive both an initial automated response and, as needed, personalized follow-up and response or referral. A sampling of veterans would receive follow-up survey questions to assess their satisfaction with the response received and whether any problem identified had been corrected. Analysis of the resulting data would identify weaknesses in the existing services system and support remedial action. (*Note: See VA GI Bill web site that allows veterans to do this.*)

#### **4-8. VA should promote continuous learning for improving services to veterans that is research-driven and evidence-based.**

As previously noted, a model for this exists in the QUERI process<sup>252</sup> and performance metrics, and in its Performance Measurement Development and Life Cycle process.<sup>253</sup> Using a similar research and testing approach, the Department's strategy for improving services to returning veterans would be modified as new evidence becomes available on more cost-effective ways to achieve better outcomes for veterans. As the organization learns from systematic evaluation of what works and is cost-effective, the more detailed versions of a Strategy Map like that shown in Figure 4-1, used to model and guide the change, would be revised to reflect this learning.

## **STRENGTHENING THE VA/DOD PARTNERSHIP**

Successful change also will require sustaining and deepening the newly energized partnership with DoD. VA, DoD, and others must take specific steps to support this partnership as it evolves from high-level planning of pilot initiatives to broader sustained operational cooperation to ensure smooth transition and effective delivery of care and services to all veterans.

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<sup>252</sup> McQueen, Mittman, and Demakis (2004).

<sup>253</sup> Compare with the FY 2008 VHA Executive Career Field Performance Plan— Final, updated November 16, 2007.

As noted earlier in this report, since mid-2007 VA and DoD have engaged in an unprecedented and more productive executive-level collaboration through the SOC, to respond to the recommendations of prior study panels. It will be challenging to sustain the executive-level collaboration when the SOC disbands, possibly at the end of this year. In addition, VA and DoD must find ways to improve collaboration at VA and DoD operating levels, both on a voluntary basis and where mandated by Congress.

At crucial points, managing the transition from active service through demobilization to home, family, and veteran status requires orchestrated support by the military service, DoD, and VA. One senior VA manager suggested that to support an eventual seamless transition from active duty to veteran status properly, interaction between DoD and VA processes must start soon after a person enters the service, when baseline health information is generated.<sup>254</sup> At a later point and at different stages in the transition, the goals and incentives of the departments, services, and the service member may not align.

To address the changing status and needs of the returning veteran, personnel of one organization must communicate and coordinate with personnel of others, while remaining accountable to their own organizations. This is easier said than done. Previous studies and commissions have focused on resolving specific problems affecting the transition from service to veteran status, or from combat to care and recovery, without addressing a fundamental institutional barrier to improved care and transition, as evidenced by the limited history of DoD/VA cooperation. Institutional factors limiting joint planning, policy agreement, and operational coordination have not been analyzed in any depth. However, there appears to be general agreement among close observers that these institutional factors remain a challenge to the success of efforts to provide seamless transitions for returning war veterans.

It is too soon to judge how successful the recently increased level of cooperation between DoD and VA will be in improving transitions to recovery and reintegration. Despite the high level of effort since the Walter Reed episode, most initiatives are in the pilot stage. Prior to Walter Reed joint progress on major problems was slow. For example, GAO noted in 2007 that the two departments have been working for almost 10 years to facilitate the exchange of medical information. The Departments had collaborated mainly on a series of small health care initiatives, and had experimented in a few instances with joint development and management of medical facilities.<sup>255</sup> The continuing inability to share records electronically on a timely basis remains a major impediment to seamless transition.

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<sup>254</sup> Interview with senior VA official.

<sup>255</sup> In January 2002, the two departments established a Joint Executive Council (JEC), co-chaired by the Under Secretary of Defense for Personnel and Readiness and the VA Deputy Secretary. It includes senior DoD and VA health and benefit managers involved in sharing initiatives, meets quarterly, and submits an annual report to Congress. The JEC provides leadership oversight of interdepartmental cooperation at all levels, and encompasses the work of two subordinate councils, the Health Executive Council (HEC) and Benefits Executive Council (BEC). The JEC Joint Strategic Planning Group coordinates health and benefits policy through the development of a joint strategic plan. The 2008 – 2010 Strategic Plan, adopted in November 2007, includes goals and objectives for: (1) seamless coordination of benefits; and (2) integrated information sharing. However, as previously noted, these do not specify measurable outcomes for which the JEC intends to hold itself and the two Departments accountable.

DoD/VA collaboration is complicated on DoD's side by traditional separation and parallel systems development by the individual services. For example, the Independent Review Group's April 2007 report noted that "a common automated interface does not exist between the clinical and administrative systems with the DoD and among the Services, causing a systematic breakdown of a seamless and smooth transition from DoD to the DVA."<sup>256</sup> Also, within Office of Secretary of Defense for Personnel and Readiness, DoD transition responsibilities are spread across multiple offices.<sup>257</sup>

### **Institutionalizing cross-boundary collaboration**

Both DoD and VA senior managers have stressed the difficulty they will face in sustaining their collaboration, particularly should there be a reduction of executive-level external attention and pressure.

In general, customer-focused thinking is difficult when working across organizational boundaries, and collaboration across organizational boundaries is very difficult when participants are required and trained to think in a hierarchical way. DoD and VA have not arrived at a mechanism—whether through the White House or OMB or directly—to institutionalize cross-boundary collaboration in a hierarchical environment. This underlines the historically exceptional nature of the current, and possibly temporary, SOC collaboration, and the importance of finding ways to maintain the recent momentum it has created.

Even if the present intensive collaboration is yielding specific improvements in support of veteran transitions, it is important to consider whether products of the current collaborative effort will in the end be disjointed and piecemeal. There is a tradeoff between: (a) acting opportunistically with a sense of urgency based on a rough assessment of requirements and existing technology; and (b) pursuing a more methodical approach that grounds development of new processes and systems in a formal multi-year planning and budgeting process that integrates systems development, business process reengineering, and orderly training and adoption of changes.

Policy agreements reached with VA at the DoD level may not be fully implemented by the individual military services, with predictable results, as, for example:

- A February 2008 story on National Public Radio reported that Fort Drum Army representatives told VA officials last year to stop counseling wounded soldiers at Fort Drum on how to complete military disability paperwork. The Army Surgeon General first denied, and then, after reviewing a VA memo detailing the incident, acknowledged that the Army acted in the manner reported. VA subsequently suspended its counseling

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<sup>256</sup> Independent Review Group Report, *Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, Rebuilding the Trust*, April 2007.

<sup>257</sup> Inspectors General, U.S. Department of Defense and Department of Veterans Affairs, *DoD/VA Care Transition Process for Service Members Injured in OIF/OEF*, June 12, 2008, p. 5.



operation at the Fort. The two departments have since made a new agreement governing coordination between VA benefits advisors and personnel at Army installations.<sup>258</sup>

- The Dole-Shalala Commission noted a survey finding that 90 percent of DoD health care providers had received no training on a joint DoD/VA clinical practice guideline for Post Traumatic Stress Disorder.<sup>259</sup>

Consistent with their missions, the military services' organizational cultures emphasize unit loyalty, readiness, and chain of command. DoD reflects the cultures of its component parts, while also focusing on program costs and maintaining a highly capable fighting force. The VA's mission is to honor and serve individual veterans, and its organizational culture reflects this in emphasizing responsiveness to the needs of individuals and families arising from military service. While the goals of the departments and services are seldom in direct conflict, differences in their missions and cultures contribute in some situations to differences in priorities and to misunderstandings that have and can continue to inhibit effective cooperation.

Because operating personnel of the two departments respond to separate lines of supervision and chains of command, each with its own mandates, rules, and rewards structure, collaboration between VA and DoD personnel regarding specific tasks can never be assumed to follow from executive-level agreements. Thus, whatever the future level of commitment at a leadership level, interdepartmental and military-civilian differences in mission and organizational culture will present challenges to coordinated action and joint management of programs and facilities.

In addition to maintaining the current intensity and level of cooperation between VA, DoD, and the military services, a challenge is finding the right balance between urgency and orderly planning. In thinking about what follows the SOC, a new locus of responsibility for the collaboration must be identified and managed in a way that strikes the best balance between urgency and order. DoD and VA officials acknowledge the need to find the best organizational formula for continuing the work started by the SOC, maintaining the momentum for implementing recommendations to improve transitions, and integrating this effort with the established coordinating mechanisms for policy and planning led by the JEC.<sup>260</sup>

## **Recommendations**

Interdepartmental collaboration can continue and be productive, even as senior level involvement becomes less frequent or direct, provided that steps are taken to formalize policy level agreement and to further institutionalize joint collaborative mechanisms. Critical steps include: (1) integrating the mission and work of the SOC into the plans and structure of the JEC; (2) reinforcing the need for joint efforts through congressional mandates and incentives such as the health care sharing and incentive fund; (3) further specification of objectives for DoD/VA collaboration from the most senior levels of the Executive Branch, as exemplified by the President's Management Agenda; and (4) incorporating quantitative targets for improved

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<sup>258</sup> Secretary of the Army, Statement before the Committee on Armed Services, United States Senate, February 13, 2008.

<sup>259</sup> President's Commission on Care for America's Returning Wounded Warriors, *Serve, Support, Simplify, Subcommittee Reports and Survey Findings*, July 2007, pp. 46-47.

<sup>260</sup> Interviews with VA and DoD officials.

performance in the JEC Strategic Plan. These steps can never completely overcome the centrifugal forces that work against productive collaboration, but they can help to dampen them.

The Panel recommends the following specific actions:

**4-9. Congress, DoD, and VA should take steps to strengthen DoD/VA collaboration using the lessons learned from the Senior Oversight Committee.**

Congress' role is to ensure that interdepartmental collaboration continues to be productive, even as senior level involvement becomes less frequent. Without waiting for Congress, however, VA should work to formalize policy level agreements between DoD and VA and to further institutionalize joint collaborative mechanisms. Lessons learned in the SOC process should inform the institutionalization of a permanent productive partnership on issues of transition. Critical steps for VA include working collaboratively with DoD to:

- Explicitly integrate the mission and work of the SOC into the plans and structure of the JEC by designating a separate subgroup with a charter to improve transitions and service to returning veterans and reorganizing the JEC process to eliminate overlap in the jurisdiction of the HEC and BEC; and
- Pursue means for endorsing and monitoring specific objectives for DoD/VA collaboration at the most senior levels of the Executive Branch, possibly in the form of a new Executive Order that provides a framework for joint responsibility for certain outcomes.

**4-10. DoD and VA should adopt a joint VA/DoD scorecard and revise targets in the Joint Executive Council (JEC) Strategic Plan. The two Departments should cement their joint responsibility for the results of the VA/DoD partnership to improve service member to veteran transitions by jointly adopting a set of goals and performance targets to guide the change.** One such instrument is the illustrative balanced scorecard for VA discussed earlier. Another approach is to incorporate goals and performance targets in the JEC Strategic Plan. Specific steps for VA to pursue with DoD include:

- Adopting a joint balanced scorecard with specific short-term and long-term performance targets for improved service to transitioning injured and non-injured service members and veterans; and
- Incorporating quantitative targets for improved short-term and long-term outcomes related to the goals of recovery and reintegration of returning veterans in the JEC Strategic Plan, in place of or in addition to the current activity milestones.

## **JUDGING THE RESULT**

Success in becoming veteran centered ultimately will be measured in terms of improved outcomes for veterans, including those returning from Iraq and Afghanistan. For the latter, VA

and DoD have stated that their joint goal is to support fullest possible recovery and reintegration of returning warriors. These outcomes need to be measured in concrete terms, as described in this report. The first step by leadership to ensure success is to demand that all eyes, at all levels in the responsible organizations, are fixed on this goal.

**Figure 4-2. Illustrative VA Transition Balanced Scorecard: Improved Service to Returning War Veterans**

Objectives	Initiatives	Measures	FY 2010 Targets
<b>INTERNAL</b>			
<b>Build integrated information technology systems to facilitate service delivery for and information sharing with the veteran</b>	Accelerate the migration to electronic records.	Percentage of claims with electronic records	XX% of claims with electronic records
	Update the Web-based Veterans on Line Application (VONAPP) process	Percentage completion against timeline	YY% completed in Y time
	Align future IT application development with OneVA Goals	Percentage of IT business planning documents that explicitly link to OneVA goals	ZZ% of IT business plans linking to OneVA goals
<b>Improve VA's outreach to veterans</b>	Develop and employ e-mail communication channels with veterans	Percentage of inquiries handled through e-mail	XX% of inquiries handled through e-mail
	Add communication channels used in VA's general information outreach.	Number of new communication channels, including e-mail, web 2.0, partnering with other agencies (e.g., job fairs)	ZZ new communication channels
	Develop Targeted Outreach Efforts to Identified Sub-Groups	Number of contact lists by characteristics of interest (e.g., female, amputees, rural)	XX contact lists developed for targeted outreach
<b>Form linkages with non-VA partners</b>	Identify existing public contact opportunities with veterans other agencies engage in, and encourage those agencies to share basic information about VA benefits	Number of outreach MOAs with other agencies (e.g., DoL, SBA) and organizations	YY MOAs developed with non-VA agencies and organizations
		Number of joint outreach efforts engaged in (e.g., job fairs)	ZZ joint outreach efforts VA participated in
<b>Identify at-risk veterans and facilitate their entry into VA's continuum of care</b>	Assess who, of those identified as at-risk for mental illness, has not received care, and follow up with that veteran as appropriate	Number of PDHRA referrals to VA care facilities, including Vet Centers Percentage of referred patients seeking mental health care from VA facilities or Vet Centers (rate of follow up)	XX referrals made to VA care facilities ZZ% of referred patients seeking mental health care from VA facilities
	Request that DoD provide an option to the service member to enroll in VA health care as part of the PDHRA program for those service members, including National Guard and Reserve, who anticipate separating from the military.	Percentage of those who opt to auto-enroll in VHA at the time of the PDHRA	XX% of veterans auto-enrolled in VHA at time of PDHRA

Objectives	Initiatives	Measures	FY 2010 Targets
<b>VETERAN OUTCOMES</b>			
<b>Improve access to health and mental health care</b>	Develop a strategy for providing training to state and community providers to increase their capability to effectively treat veterans for combat-related mental illness, including PTSD, depression, and mild TBI.	Number of state and community health providers trained on best practices in care for veteran-specific issues	YY non-VA mental health care providers trained by VA in care for veteran-specific issues
	Build upon existing collaborative partnerships currently being used in the VISN networks that include aspects of referral and communication and data sharing between VHA and community and state providers, with priority for those areas underserved by mental health providers.	Number of referrals to VA health care from state and community services  Percentage of injured veterans in need of community-based rehabilitation and support services receiving such services	ZZ increase in referrals to VHA from state and community providers  XX% of veterans in need of support services and care, receiving such services
<b>Improve quality of life for veterans by using veteran-centered care management tools to facilitate recovery and reintegration of returning war veterans</b>	Use a scaled-down version of the Federal Individual Recovery Plan to a broader group of less-severely injured veterans, including those with mental illness, who are receiving case management services.	Proportion of injured or at risk veterans receiving case management services  Proportion of wounded OEF/OIF veterans with a recovery and reintegration plan	ZZ% of injured or at-risk veterans receiving case management services  XX% of wounded OEF/OIF veterans with a recovery and reintegration plan
	Make full use of applications of the online portal system MyHealthVet to house the online recovery plan, provide screening tools and educational materials to veterans and family members, and allow tracking and management of a veteran's clinical and non-clinical goals over time by care coordinators.	Proportion of veterans and their families using the online web portal for tracking and managing health care  Proportion of severely injured veterans who met FIRP short and long-term goals	YY% of veterans and their families using online portal  ZZ% of severely injured veterans meeting short and long-term goals  Unemployment at or below comparable civilian cohort rate

<b>Objectives</b>	<b>Initiatives</b>	<b>Measures</b>	<b>FY 2010 Targets</b>
<b>LEARNING AND GROWTH</b>			
<b>Increase rate of innovative change supporting a veteran-centered approach</b>	Leverage/expand use of web 2.0 IT applications	Use new collaborative sites to identify and 'vet' proposed policies and practices Use Veteran Feedback Interactive Site to monitor and respond to service failures	Collaborative sites established by XX At least YY innovative practice and policy changes adopted ZZ% of veterans using new interactive site report satisfaction with VA follow-up
<b>Continue progress toward developing new PTSD and TBI treatments</b>	Pursue collaborative studies among research bodies, both governmental and non-governmental, on PTSD and TBI	Number of collaborative studies resulting in evidence-based findings for treatment of PTSD and TBI	Reach YY% of milestones set for treatment development
<b>FINANCIAL</b>			
<b>Manage administrative costs of transitions</b>	Improve VA/DoD budget allocations to reduce administrative overlap	Average outreach spending for each returning veteran visiting VA facilities	Reduce spending per returning veteran to no more than ZZ% of total cost
<b>Ensure prompt payment of fee-basis providers</b>	Ensure timeliness standards are met for payment of contract providers	Average days from invoice to full payment	Reduce average from XX to YY days

Source: A Report of a Panel of the National Academy of Public Administration For the U.S. Congress and the U.S. Department of Veterans Affairs, *After Yellow Ribbons: Providing Veteran-Centered Services*, October 2008.

## THE NATIONAL RESPONSE TO PROVIDING CARE AND BENEFITS TO PRIOR GENERATIONS OF WAR VETERANS

Throughout its history, the federal government has repeatedly responded to the needs of veterans by establishing a variety of veterans' commissions and new programs to reward military service and compensate disabled veterans. In 1776, the Continental Congress passed a resolution to compensate disabled veterans. Until 1789, the individual states were expected to compensate the disabled, but the federal government assumed this responsibility following ratification of the Constitution. In the early 1800s, the U.S. Government opened marine hospitals for the medical care of merchant seamen. The first Soldiers' Home was established in 1851, as an "asylum for old and disabled veterans."<sup>261</sup> The predecessor to the U.S. Public Health Service was responsible for administering Marine hospitals and Soldiers' Homes.<sup>262</sup> In 1818, a needs-based pension program was created to help Revolutionary War veterans, and such a program for veterans of other wars has continued in various forms up to the present day.

Highlights of the federal government's response to veterans of World Wars I and II and the Vietnam War are described in the next two sections. Unless otherwise noted, the information is based on VA's *History in Brief* and the Veterans' Disability Benefits Commission report.<sup>263</sup>

### World Wars I and II

The need to expand hospital care for veterans became evident when approximately 200,000 discharged U.S. soldiers who required further hospitalization began returning from World War I in 1918. In 1921, following the end of World War I, President Harding created a commission to reform the veterans' benefits system. The commission recommended the formation of a single agency to streamline the delivery of veterans' benefits, which at that time was distributed across three separate federal entities—the Federal Board of Vocational Education, the Bureau of War Risk Insurance, and U.S. Public Health Service. The newly established Veterans' Bureau was responsible for medical services for war veterans, disability compensation and allowances for World War I veterans, life insurance, bonus certificates, retirement payments for emergency officers, Army and Navy pensions, and retirement payments for civilian employees. In 1930, Congress created the Veterans Administration by uniting three bureaus—the previously independent Veterans' Bureau, the Bureau of Pensions, and the National Homes for Disabled Volunteer Soldiers. During the next decade, from 1931 to 1941, the number of VA hospitals increased from 64 to 91, and the number of hospital beds available increased from 33,669 to 61,849.

The Veterans' Bureau developed the first codified rating schedule for determining disability payments on the basis of average loss of earning capacity. The rating schedule was revised as a

<sup>261</sup> <http://www.defenselink.mil/specials/heroes/history1.html>, May 2003

<sup>262</sup> Buelow, Paul A. *Veterans Hospitals.* The Electronic Encyclopedia of Chicago © 2005 Chicago Historical Society Accessed at <http://www.encyclopedia.chicagohistory.org/pages/1302.html>.

<sup>263</sup> U.S. Department of Veterans Affairs, *VA History in Brief*, May 2007 <http://www1.va.gov/opa/feature/history/docs/histbrf.pdf> May 2007; and Veterans' Disability Benefits Commission. *Honoring the Call to Duty: Veterans' Disability in the 21<sup>st</sup> Century*, October 2007. pp. 29-43.

result of the World War Veterans Act of 1924, which mandated a new rating scale, using California's Workmen's Compensation program as a model. The new compensation system was developed on the basis of assumptions about loss of skills and functions needed for specific occupations. However, the emphasis on specific occupations was eliminated with passage of the Economy Act of 1933, which reintroduced the standard of average impairment in a civilian occupation earning capacity as the basis for disability compensation. The 1945 rating schedule was created to incorporate information from medical and technological advances, but retained the average loss of earnings capacity as the standard for determining disability payments. This standard has remained in effect since 1945.<sup>264</sup>

After World War II, public sentiment for helping veterans return to civilian life was high. Congress approved aid to families of servicemen who were killed or disabled before they had an opportunity to acquire insurance. The Disabled Veterans' Rehabilitation Act of 1943 established a vocational rehabilitation program for disabled World War II veterans who served after December 6, 1941. As a result of this law, the VA provided 621,000 disabled World War II veterans with job training. In 1944, President Franklin D. Roosevelt signed the "Servicemen's Readjustment Act of 1944, "better known as the "GI Bill of Rights." Some historians consider this first GI Bill to be landmark legislation, comparable to the Homestead Act of 1862, which allowed anyone in the United States to file for ownership of free land.<sup>265</sup>

The GI bill provided for tuition, books and living expenses for up to four years of college or vocational school. The bill also provided low-interest mortgages for homeowners, low-interest loans for farms and small businesses, and a \$20 per week allowance for returning veterans looking for employment. The impact of the GI Bill was substantial, and, from 1944 to 1949, nearly 9 million veterans received almost \$4 billion from the unemployment compensation program.<sup>266</sup> In addition, over 10 million veterans had used the educational benefit by 1956.

## **Vietnam War**

In part due to the country's internal divisions over the Vietnam War and the deploying of service members individually rather than as units, Vietnam War veterans experienced more isolation on their return from combat than veterans from previous wars. To assist all Vietnam veterans, the VA took steps to inform veterans of their benefits through new outreach programs. For example, Veterans Assistance Centers were established in 21 cities to help recently separated veterans. A Vietnam-era GI bill was passed in 1966. In 1967, the VA also sent representatives to South Vietnam to assist service members before they were discharged. Congress attempted to increase Vietnam veterans' participation in education programs through various amendments to the GI Bill in the early 1970s and through the Post-Vietnam Era Veterans Educational Assistance Act, which passed in 1976. Because this Act provided benefits for a volunteer force during

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<sup>264</sup> Statement of Bradley G. Mayes , Director, Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs, February 26, 2008, p. 2.

<sup>265</sup> Public Broadcasting Service, "Veterans Benefit History", PBS NOW: Society and Community website, <http://www.pbs.org/now/society/vetbenefits.html>, May 13, 2005.

<sup>266</sup> Ibid.



peacetime, service members who participated were required to make monetary contributions for the first time.<sup>267</sup>

The need for special counseling services for the psychological impacts of combat, including Post Traumatic Stress Disorder (PTSD), was formally recognized in 1979.<sup>268</sup> PTSD, which is not limited to those who served in combat and is also found in members of the general population who have been exposed to a traumatic event, was formally recognized as a psychiatric disorder in 1980.<sup>269</sup> Congress authorized VA to establish community based Vet Centers in 1979 following extensive expert testimony on war-related readjustment problems among Vietnam veterans. The Vet Centers are staffed by small multi-disciplinary teams of counselors, many of whom are combat veterans. The treatment setting is informal and includes a range of individual and group counseling programs, such as bereavement counseling for family members, employment counseling, and assistance with filing of disability claims.

The precise number of Vietnam veterans who were suffering from PTSD following the Vietnam War was a subject of controversy. Two major studies, the National Vietnam Veterans' Readjustment Study and a study by the Centers for Disease Control (CDC), identified substantially different rates of PTSD among Vietnam veterans.<sup>270</sup> The CDC study reported that 15 percent of veterans had suffered PTSD, compared to 31 percent as estimated by the Veterans' Readjustment Study.<sup>271</sup> A 2006 study of a sample of Vietnam veterans concluded that 18.7 percent had developed PTSD during their lifetime, and 9 percent were still suffering with symptoms 11 to 12 years after the war.<sup>272</sup>

Another major health issue facing Vietnam veterans was the effect of exposure to herbicides. Congress directed VA to request the National Academy of Sciences to conduct a comprehensive review of scientific and medical information regarding the health effects of exposure to Agent Orange. The Academy's Institute of Medicine published a comprehensive report on the health

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<sup>267</sup> Smole, David P., Shannon S. Loane, *CRS Report for Congress: A Brief History of Veterans' Education Benefits and Their Value*, June 25, 2008, p. 4.

<sup>268</sup> Recognition of the psychological impacts of combat trauma occurred long before the Vietnam War, but other terms were used to describe the impacts. For example, comparable terms were "Soldiers Heart" for Civil War veterans, "shell shock" for World War I veterans, and "combat fatigue" in World War II veterans.

<sup>269</sup> Symptoms of PTSD include: (1) re-experiencing the traumatic event; (2) avoidance of anything associated with the trauma and numbing of emotions; and (3) hyper-arousal, such as difficulty sleeping and concentrating and irritability. See, Institute of Medicine and National Research Council, *PTSD Compensation and Military Service*, Washington, DC, The National Academies Press, 2007, pp.1-2.

<sup>270</sup> U.S. Centers for Disease Control and Prevention. "Health Status of Vietnam veterans. Volume I. Psychosocial characteristics. The Centers for Disease Control Vietnam Experience Study." *Journal of the American Medical Association*. 1988: 2701-2707; and Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R., et al, *The National Vietnam Veterans Readjustment Study: Tables of findings and technical appendices*, New York: Brunner/Mazel, 1990.

<sup>271</sup> Dohrenwend, Bruce P., J. Blake Turner, Nicholas A. Turse, Ben G. Adams, Karestan C. Koenen, and Randall Marshall. *The Psychological Risks of Vietnam for U.S. Veterans: A Revisit With New Data and Methods*, *Science*. August 18, 2007.

<sup>272</sup> *Ibid.*

effects of Agent Orange<sup>273</sup> and VA eventually established a list of numerous medical conditions that it had concluded could be presumptively linked due to Agent Orange exposure.<sup>274</sup>

Those seeking Cabinet-level status for the Veterans Administration had long stressed that the VA was the largest independent federal agency in budget terms and was second only to the Department of Defense in number of employees. Because one-third of the U.S. population was potentially eligible for veterans benefits, proponents argued, the agency responsible should be represented by a Cabinet secretary having direct access to the President. On March 15, 1989, the Veterans Administration became the Department of Veterans Affairs.<sup>275</sup>

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<sup>273</sup> Institute of Medicine, Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides, Division of Health Promotion and Disease Prevention. *Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam*. 1994.

<sup>274</sup>“Presumptions” enable veterans to be granted service-connected disabilities although, through no fault of their own, they are unable to establish that an injury or disease was caused by their military service. Since 1921, Congress and the VA have created numerous presumptions to assist veterans in establishing that they have a service-connected injury or disease entitling them to disability payments. See, Institute of Medicine, Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans, *Improving the Presumptive Disability Decision-Making Process for Veteran*, 2008

<sup>275</sup> Department of Veterans Affairs, Fact Sheet: *Facts About the Department of Veterans Affairs*, December 2007. Accessed at: <http://www1.va.gov/opa/fact/vafacts.asp>.

## MATRIX OF WEB 2.0 TECHNOLOGY AND GOVERNMENT

Technology	Simple Definition	Examples	Opportunity/Potential in Government
Blogs	Journal or diary with social collaboration (comments)	<a href="#">GovGab.gov</a> , <a href="#">20 federal agencies</a> , <a href="#">USA.gov government blog library</a> , <a href="#">Webcontent.gov</a>	Meaningful info delivered from a govt authority to new audiences. Puts human face on govt using informal tone. Opens public conversations
Wikis	Collaborative authoring & editing	<a href="#">GSA Collaborative Work Environment</a> , <a href="#">NASA</a> , <a href="#">US Courts</a> , Intellipedia, US Foreign Svc, Utah Politicopia, Wikipedia	Workgroup or public collaboration for project management, knowledge sharing, public input. Contributions to 3 <sup>rd</sup> party sites e.g. Wikipedia
Video Sharing (and Multimedia)	Videos, images, & audio libraries	<a href="#">USA.gov Multimedia library</a> , <a href="#">NASA YouTube</a> , <a href="#">Coast Guard Virginia YouTube Channel</a> , <a href="#">Americorps contest</a> , <a href="#">Tobacco Free Florida contest</a>	Public outreach, education, training, other communication for “connected” and on-line audiences. How To videos & audios to improve service and achieve mission.
Photo-Sharing	Photo libraries	<a href="#">USA.gov fed/state photo libraries</a> , USGS internal photo gallery with <a href="#">Flickr API</a> , EPA photo contest	Cost savings potential. New audiences. Awareness.
Podcasting	Multimedia content with an enclosure for syndicating via RSS for use on iPod TM, Mp3 players & computers	<a href="#">White House</a> , <a href="#">NASA</a> , <a href="#">USA.gov federal podcast library</a> , <a href="#">Webcontent.gov</a> , Peacecorps	More ways to get message out to “connected” and on-line audiences. How To messages. Use in emergencies. Live govt deliberations
Virtual Worlds	Simulations of environments & people (Second Life, Active Worlds, Kaneva, ProtoSphere, Entropia Universe, uWorld)	NASA, NOAA, CDC, Natl Guard, <a href="#">Dept of Energy</a> , <a href="#">Real Life Govt in 2nd Life</a> , <a href="#">Google group</a> , <a href="#">National Defense Univ</a> , <a href="#">Federal Consortium for Virtual Worlds</a>	Public outreach & other communication for niche Internet audiences. Virtual Town Halls, Education, Training. Ability to bring people together worldwide for meetings, lectures, etc.
Social Networking Sites	Connecting people globally	<a href="#">EPA Facebook group</a> , <a href="#">NASA Colab</a> , MySpace, LinkedIn	Intranet use to cross internal agency stovepipes. Cross government coordination. Public communities. Viral impact. Knowledge mgmt. Recruitment. Event announcements.
Syndicated Web Feeds	Automated notifications (think RSS)	<a href="#">USA.gov Federal RSS Library</a> , <a href="#">NOAAWatch</a>	Do more with RSS, XML/Web feeds. Expand reach. Pull content together across government. Authoritative source. Reduce duplication.
Mashups	Combine content from multiple sources for an integrated experience	<a href="#">USA Search</a> , USGS, NASA, EPA, <a href="#">Virtual Earth</a> , <a href="#">Google Earth</a> , <a href="#">Google maps</a>	Lots of potential. Improved govt reach, service, usefulness, and functionality. Integrate external data. Get licenses, stay vendor neutral. Make content available to others who create mashups
Widgets, Gadgets, Pipes	Small applications & code in Web pages or for desktop use	<a href="#">FBI widgets</a> , Veterans Affairs, <a href="#">Census Population Clock &amp; NASA Planet Discoveries</a> Desktop widgets	Increase awareness, use, and usefulness of .gov sites, information, and service. Bring content to the user’s home page (iGoogle, netvibes, etc)
Social News (Sharing, Tagging) Sites	Ways of sharing content with others	<a href="#">USA.gov</a> , <a href="#">NASA</a> , <a href="#">Govt blogs</a> , <a href="#">Digg</a> , <a href="#">Delicious</a> <a href="#">Technorati</a> <a href="#">AddThis</a>	Increase the popularity and use of .gov pages, information, and services. Viral marketing.
Micro-blogging	Form of blogging which allows brief (instant message size) text updates	Twitter, Jaiku, Cromple, Pownce, NASA Edge, USA.gov, GovGab, Univ of Mich	Seek input. Broadcast msgs: emergencies, news, announcements. Real time reportg. Recruitg.

March 3, 2008 Bev Godwin, USA.gov and Web Best Practices, GSA Office of Citizen Services

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## POSITION DESCRIPTIONS OF CASE MANAGERS WITHIN THE DOD AND VA CONTINUUM OF CARE<sup>276</sup>

### Case Managers at Military Treatment Facilities

#### 1. **Medical Care and Non-Medical Care Case Managers**

When a wounded service member enters the military health system, his/her medical needs are assessed. Those with more severe injuries are admitted to an inpatient MTF and are assigned a Medical Care Case Manager (MCCM) – usually a registered nurse or social worker. If an injured service member is in outpatient status, he/she may be assigned an MCCM depending on their care needs and the organizational structure of the Wounded Warrior Program. Outpatient care is arranged for the recovering service members through the Warrior Transition Unit (WTU), which is supported by a triad of care managers.<sup>277</sup>

Recovering service members are sometimes assigned Non-Medical Case Managers, although currently there is not standardized system of assignment among Wounded Warrior Programs.<sup>278</sup> If inpatient or outpatient service members need transition assistance to VA, VA Liaison officials receive referrals and coordinate the transition with the VA’s OEF/OIF Case Management Program.

#### 2. **Warrior Transition Unit “Transition Triad” (DoD Employees)**

Warrior Transition Units (or Brigades) are located at MTFs and are designed for service members going through the disability evaluation process and/or requiring complex care lasting longer than six months. Each service member in the WTU is assigned a “transition triad” of care consisting of a squad leader to help with “soldier issues,” a nurse case manager to help with appointments, medication and health care consultations, and a primary care manager to manage care plans and all medical needs. There were about 40 case managers to handle the 700 patients in the WTU at Walter Reed as of February 2008. The WTU is designed to provide service members the level of care needed to become fit for duty, or to help them transition to civilian life and into VA’s system of health care and benefits.

WTU case managers interact with on-site VHA and VBA Liaisons in order to coordinate transition to veteran status and secure the appropriate care and benefits. To ensure a seamless transition between military and veteran medical care, Walter Reed co-located the VHA and VBA liaisons with the Warrior Transition Unit case managers to support a continuum of care and benefits.

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<sup>276</sup> Information in this appendix is a synthesis of interviews with VA and DoD staff at Walter Reed Army Medical Center, Philadelphia VA Medical Center, Tampa Polytrauma Center, and various VHA directives or other documents as noted throughout.

<sup>277</sup> DoD/VA Senior Oversight Committee Line of Action on Case/Care Management Reform. *Interim Report on Policy Improvements on the Care, Management and Transition of Recovering Service Members*. February 2008, p. 21.

<sup>278</sup> Ibid.

### 3. VHA Nurse Liaisons to MTF – Inpatient and Outpatient

The primary role of the Nurse Liaison is to ensure the smooth transition of inpatients and families from the MTF to the appropriate VHA facility. The VA Liaisons work closely with MTF clinical and administrative staff, service members, and their families to ensure priority access to both health care services and education regarding VHA benefits are available. The liaisons report administratively to the VHA facility closest to the MTF and report indirectly to VHA’s Office of Care Management.

The Inpatient Nurse Liaison works closely with VA Polytrauma sites, Spinal Cord Injury centers, and acute inpatient or sub-acute rehabilitation services. The primary role is as a “nursing bridge” between the medical staff at the MTF and those on the receiving end at the Polytrauma site, ensuring that all necessary information is passed along. The Nurse Liaison meets with the family and provides counsel on what to expect within the polytrauma system and what the nursing care will consist of at the VA facility. This position, in effect, “passes the baton” in a nursing handoff between the two facilities, and often provides important information about the patient that may not necessarily be visible from a record (e.g., communicating to the receiving nursing staff that the patient will become agitated if approached from the left side, etc.).

The VHA Nurse Liaison (outpatient) is stationed at the MTF and serves as a VHA representative. The primary role of the Nurse Liaison is to ensure the smooth transition of outpatients from the MTF to the appropriate VHA facility. The Outpatient Nurse Liaisons work closely with the Nurse Case Managers within the Warrior Transition Unit. The VHA Outpatient Liaison is assigned to a company within the WTU. Their primary role is to assist active duty service members who need VHA services. The WTU case manager may refer a service member to the outpatient liaison who would then coordinate needed services with the VA. The liaisons also meet with the service members to explain their VHA healthcare benefits and to assess and organize their ongoing long-term health care.

### 4. VHA Social Work Liaison to MTF – Inpatient and Outpatient

Similar to the VHA Inpatient Nurse Liaison, the Social Work Inpatient Liaison’s primary role is to ensure the smooth transfer of health care for inpatients from the Military Treatment Facility (MTF) to the appropriate VHA facility. Liaisons work on site at the MTFs and work closely with MTF staff, service members, and families. Specifically, the Social Work Liaison “collaborates with the MTF social workers, nurses, case managers, managed care staff, and discharge planners to identify patients ready for discharge to VHA, and to obtain clear referral information and authorization for VHA to treat those still on active duty.”<sup>279</sup>

The Social Work Liaison meets with the service member and/or family to provide an educational overview of VHA health benefits and resources that are relevant given the medical and psychosocial issues specific to the service member and family. According to

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<sup>279</sup> Department of Veterans Affairs. *VHA Handbook 1010.01 – Transition Assistance and Case Management of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans*. Washington, D.C., May 31, 2007, p. D2.

the VHA Transition Handbook, “In collaboration with the MTF treatment team, the liaison must use advanced clinical skills to assess the patient and/or family's psychosocial situation, their ability to comprehend and comply with the VA treatment plan that has been determined by the MTF staff and any special needs of the patient and/or family that may impact reaching optimal psychosocial functioning.”<sup>280</sup>

The Social Worker Liaison communicates often with the patient and family in regards to the transfer to a VA facility and the transition of care, or any other need unique to the family. Finally, the Social Work Liaison maintains contact with the OEF/OIF Program Manager at the VAMC, as well as the MTF staff to ensure the transfer of all necessary information.

VHA Outpatient Social Workers attempt to facilitate the process of entry and access to the VAMC by printing out a map with directions to the VA health care center closest to the veterans, a list of appointments that have been set up, and the name of their OEF/OIF coordinator.

Although VA Outpatient Liaisons originally were expected to contact the injured service members at an MTF during the early stage of their stay, they no longer do so because it was illogical and counterproductive to be “just another person” they had to talk to about benefits they were not yet interested in learning about. The timing of the visit has been adjusted so that the VA liaisons make contact with the service members shortly before discharge from the MTF.

The outpatient VA liaisons have been included as part of an out-processing regimen of visits that all discharges from the MTF are required to carry out before leaving. At that point, the liaisons explain the VA benefits that are relevant to the service member and encourage them to enroll in the VA system.

Since December 2007, VA outpatient liaisons at Walter Reed have been receiving a monthly discharge list from the WTU. The liaisons then check that list against those they have met with to identify whether any service members have “slipped through the cracks” and follow up with the service member’s WTU case manager to determine the service member’s status. The liaisons may ask the WTU case manager for a “referral” so they can have access to the service member’s contact information and contact him/her at home to let them know of the VA medical benefits available to them and help them get “plugged into the system.” When contacted, service members only rarely state that they are uninterested in VA services.<sup>281</sup> Rather, the major barrier to getting them enrolled in the VA system is the fact that they feel healthy and young at the time and do not foresee themselves needing to seek care at a VA facility. The liaisons underscore the importance of registering in the system so they will have access to it if they ever do need care.

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<sup>280</sup> *VHA Handbook 1010.01*, May 31, 2007, p. 2.

<sup>281</sup> Interviews with VHA Nurse Case Managers.

As of February 2008, there were 16 VHA liaisons for health care (outpatient) at 11 Military Treatment Facilities, with most sites preparing for a new position to be added.<sup>282</sup>

### **Case Managers at VA Medical Centers/Polytrauma Centers**

#### **1. DoD Military Liaisons**

Tampa VAMC indicated there are seven “military liaisons” on the medical campus that interacted with polytrauma patients. The military liaison position was described as one that coordinates flight information and patient transfers from the military to the VA (also a role described under the VHA liaison positions at MTFs) and meets the patient and his family at the airport. The military liaison works to take the burden off the patient and family, puts them at ease in knowing that someone will meet them, and helps walk them through the steps of being in a new facility. Given that many of the wounded are still on active duty, the presence of “uniforms” on the VAMC campus reminds the service member that they are still in the military and remain subject to the rules and regulations of the military. The military liaisons will often organize formations to promote team integrity within the military system, appoint a platoon sergeant, and maintain the chain of command while they are at the VAMC.

The WTU Case Managers will follow up with the military patient while the patient is at the VAMC Polytrauma Center, and again after he/she leaves. At Tampa VAMC, there are two representatives from the Army’s Wounded Warrior Program (no official title given) whose overarching goal is to assist with military benefits and provide benefits guidance.

#### **2. OEF/OIF Nurse Case Manager (Polytrauma Site, SCI Center, acute inpatient)**

The OEF/OIF Nurse Case Managers are located at VA Medical Centers where they report to the facility-level OEF/OIF Nurse Program Manager and provide clinical case management of inpatient and outpatient severely-injured or ill service members, and for those otherwise in need of case management services. The nurse case manager begins the case management process prior to the patient’s admission to the VAMC via communication with staff and/or case managers from MTFs or other VHA facilities. Upon the service member’s arrival at the VAMC, the Nurse Case Manager is responsible for the following: providing an in-depth assessment of functional status, acuity level, prognosis, and need for treatment services and resources; initiating contact with the patient and family; ensuring a smooth transition between facilities and levels of care; monitoring patient status while the patient is receiving care at the facility; and communicating and coordinating with the Interdisciplinary Team (medical, nursing, rehab, therapy, social work, etc.) to develop treatment plans. The Case Manager communicates and coordinates with the Interdisciplinary Team to develop treatment plans for the patient.

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<sup>282</sup> Interviews with VHA case managers.



### 3. OEF/OIF Social Work Case Manager

OEF/OIF Social Work Case Managers are located at VA Medical Centers where they assist in assessing and treating the complicated psychosocial problems of inpatient and outpatient service members and providing supportive services to families. The Social Work Case Manager assists service members/veterans in coping with acute illness, chronic illness, combat stress, the residuals of TBI, community adjustment, addictions, and other health and mental health problems; addresses home care needs, homelessness, and transition across levels and sites of care; facilitates access to needed services at the facility, at other VA facilities and in the community; and assists patients and their families to maximize rehabilitation and treatment potential and achieve more functional and satisfying emotional and social function. The Social Work Case Manager works closely with the nurse case manager, the Transition Patient Advocate, and the Interdisciplinary Team to develop an appropriate case management plan and psychosocial intervention.

The Social Work Case Manager reports programmatically to the facility OEF/OIF Program Manager. The caseload for Nurse and Social Work Case Managers will typically be no more than twenty-five to thirty patients per case manager. According to the Transition Handbook, “Ideally, a Nurse Case Manager and Social Work Case Manager will function as a team to ensure the medical, mental health, emotional and psychosocial needs of OIF and OEF veterans are addressed.”<sup>283</sup>

### 4. Transition Patient Advocate

The Transition Patient Advocate (TPA) serves as the VISN Director’s liaison between the medical centers, the patients, employees of the medical centers and the community regarding patients’ rights and advocacy. “As the liaison the patient advocate acts as a communicator, facilitator and problem solver. Activities will cross all lines of authority and responsibility and encompass all medical centers, services within a medical center and throughout the VISN.”<sup>284</sup> The TPA serves as a personal advocate for severely wounded patients as well as a point of contact to assist the patient and family in transitioning to veteran status; travels to MTFs to introduce himself/herself to the injured/ill service member and family; and sometimes escorts the patient during transfer to the VAMC.

The TPA is responsible for contacting the facility from which the service member is transitioning and ensuring that enrollment in the VHA system has taken place and that all clinical records have been transferred.<sup>285</sup> The TPA helps to ensure that patients complete their appointments for medical care. In addition to providing advice on eligibility in the VA system and assisting with aspects of the case management plan in collaboration with Social Work and Nurse Case Managers, the TPA also performs ad hoc actions as needed

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<sup>283</sup> Department of Veterans Affairs. *VHA Handbook 1010.01 – Transition Assistance and Case Management of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans*. Washington, DC., May 31, 2007, p. 5.

<sup>284</sup> Department of Veterans Affairs. “VA Internal and External Vacancy Announcement, Transition Patient Advocate.” Announcement number MP-07-104-MP. Issued April 27, 2007.

<sup>285</sup> *VHA Handbook 1010.01*, May 31, 2007. p. 5.

by the veteran (e.g. a wheelchair has broken and the patient needs a new one taken to his/her house, or the veteran is \$150 short on making a mortgage payment and the TPA can tap into community fundraising resources to help).

The TPA is assigned to a VISN and is directly supervised by the facility level OEF/OIF Program Manager. According to the Transition Handbook, each VISN must have between three and eight OEF/OIF Transition Patient Advocates, distributed across VAMCs based on the number of OEF/OIF veterans treated at each facility.<sup>286</sup> The duty stations for the TPAs are at medical centers with Polytrauma Centers and Network Sites within the VISN, but VA Central Office funds the positions.

### **5. Polytrauma Centers Case Managers**

If the VAMC is considered to be one of the four Polytrauma Centers, the composition of the case management team varies depending on the nature of the injury and expressed interest of the patient. Members of the team may include the following:

1. Supervisor for case management for polytrauma, rehabilitation and spinal cord injury
2. Inpatient Polytrauma Social Work Case Managers
3. Social Work follow-up case managers this position is responsible for following up via telephone with discharged patients for the lifespan of the patient. If a patient receives care from a VA facility near their home, the follow-up case manager from the Polytrauma Center maintains contact with the patient's point of contact at the new facility. Case manager indicated this could be a long-term role.<sup>287</sup>
4. Social Work Case Manager who works with the polytrauma team, TBI outpatient clinic, and general rehabilitation department
5. Social Work Case Manager who works with the transitional rehabilitation program, TBI outpatient clinic, and day treatment clinic
6. Spinal Cord Injury Case Manager (where relevant)
7. OEF/OIF Transition Patient Advocates (for inpatients and outpatients)
8. Military Liaison

The composition of the "Interdisciplinary Team" for a patient at one of the 17 Polytrauma Network Sites varies depending on the nature of the injury and expressed interest of the patient. Members of the team may include the following:<sup>288</sup>

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<sup>286</sup> *VHA Handbook 1010.01*, May 31, 2007, p. 3.

<sup>287</sup> Interviews with polytrauma social work case managers who served in a follow-up capacity indicated they believe it is their responsibility to monitor the patient as long as necessary to achieve recovery, which could possibly involve a life-long relationship. Also, VHA Directive 2005-024, Polytrauma Rehabilitation Centers, June 8, 2005, p. 3. states that "social case work case management services continue through the rehabilitation process and post-discharge, providing assistance with transitions to the referring military treatment facility or other VHA facility, or to the home and community."

<sup>288</sup> Information provided by Philadelphia Medical Center, which is a Polytrauma Network Site.

1. Medical Director, Psychiatrist
2. Nurse Practitioner
3. Nurse Case Manager (this is a separate position from the OEF/OIF Nurse Case Manager)
4. Social Work Program Director (this is a separate position from the OEF/OIF Program Manager)
5. Social Work Case Manager (this is a separate position from the OEF/OIF Social Work Case Manager)
6. Physical Therapist
7. Occupational Therapist
8. Speech Therapist
9. Recreation Therapist
10. Orthotist<sup>289</sup>
11. Blind Rehab Occupational Specialist
12. Psychologist

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<sup>289</sup>An Orthotist is a health care professional who is skilled in making and fitting orthopedic appliances.

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## KEY FACTORS IN LEADING ORGANIZATIONAL TRANSFORMATION

Factor	Description
<b>Transforming Leadership</b>	Strong, widespread leadership throughout the organization providing a foundation for change.
<b>Stakeholder Communication and Collaboration</b>	Understanding the perceptions of key stakeholder groups, designing appropriate communication and collaboration strategies to involve stakeholders in the change effort.
<b>Change-Supportive Organizational Culture</b>	Organizational cultures, structures, policies and procedures that support change initiatives.
<b>Change Mechanisms</b>	The development of specific change structures that take responsibility for leading the change effort.
<b>Performance Management Systems</b>	Operative performance measurements systems and the capacity to develop metrics to measure the success of change.
<b>Socio-Political Environment</b>	Understanding and taking advantage of favorable environmental factors (while mitigating adverse factors) is important in any change initiative.
<b>Risk Mitigation</b>	Effective analysis of the risk factors in a change effort and the development of mitigation strategies to deal with those risks.

Source: Adapted from Newcomer, Kathryn E. and Kee, James Edwin, *Transformational Stewardship: Leading Change in the Public Interest*, Management Concepts, 2008.

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## APPENDIX E

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## SELECTED BIBLIOGRAPHY

## ARTICLES

CBS News. *VA Hid Suicide Risk, Internal E-Mails Show*. April 21, 2008.

Centers for Disease Control and Prevention. *Health status of Vietnam Veterans. Volume I. Psychosocial Characteristics. The Centers for Disease Control Vietnam Experience Study*. Journal of the American Medical Association. 1988.

CNN, Washington A.P. *Injured Iraq War Vets Sue VA Over Delays*. July 23, 2007.

Demakis, John G., Lynn McQueen, and Brian S. Mittman. *Overview of the Veterans Health Administration (VHA) Quality Enhancement Research Initiative (QUERI)*. The Journal of American Medical Informatics Association. September-October 2004.

Department of Veterans Affairs, National Center for PTSD. *Fact Sheet: How Common is PTSD?* February 27, 2008.

Dohrenwend, Bruce P., J. Blake Turner, Nicholas A. Turse, Ben G. Adams, Karestan C. Koenen, and Randall Marshall. *The Psychological Risks of Vietnam for U.S. Veterans: A Revisit with New Data and Methods*. Science. August 18, 2007.

Downes, Lawrence. *For Wounded Veterans and Their Families, A Journey Without Maps*. The New York Times. March 24, 2008.

Hoge, Charles W., Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting, and Robert L. Koffman. *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*. New England Journal of Medicine. July 1, 2004.

Hubler, David *Accenture expands Norway's citizen centric portal*, Washington Technology. July 14, 2008. [http://www.washingtontechnology.com/online/1\\_1/33153-1.html?topic=&CMP=OTC-RSS](http://www.washingtontechnology.com/online/1_1/33153-1.html?topic=&CMP=OTC-RSS).

Kaplan, Mark S., Natalie Huguet, Benston H. McFarland, Jason T. Newsom, *Suicide Among Male Veterans: A Prospective Population-Based Study*, Journal of Epidemiology and Community Health, 2007.

Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., et al. *The National Vietnam Veterans Readjustment Study: Tables of findings and technical appendices*. New York: Brunner/Mazel. 1990.

Lopez, C. Todd. *SecArmy: Soldiers Moved to Heaven, Earth to Fix Care*. Army Military News, February 8, 2008.

- Miliken, Charles S., Jennifer Auchterlonie, and Charles Hoge. *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning From the Iraq War*, Journal of the American Medical Association, November 14, 2007.
- Morales, Mauricio Cmdr., Bureau of Medicine and Surgery, *NOSC Baltimore Hosts Navy Reserve's First PDHRA Site Visit*. February 1, 2007.
- Mosquera, Mary. *OMB Says Agencies Must Shed More Gateways*. Federal Computer Week. July 10, 2008.
- Oliver, Adam. *The Veterans Health Administration: An American Success Story?* London School of Economics & Political Science. *Milbank Quarterly*, Vol. 85, No. 1. January 2007.
- RAND Corporation. *Research Highlights, Invisible Wounds, Mental Health and Cognitive Care Needs of America's Returning Veterans*. Santa Monica, CA. 2008
- Ross, J.W., Weill, P., and D.C. Robertson. *Enterprise Architecture as Strategy*, Boston, Massachusetts; Harvard Business School Press. August 8, 2006.
- Stone, Andrew M. *Dual Agency for VA Clinicians: Defining an Evolving Ethical Question*. Military Psychology, 2008.
- Substance Abuse and Mental Health Administration, Department of Health and Human Services, Federal Partner in Spotlight: U.S. Department of Veterans Affairs, Mental Health Transformation Trends: A Periodic Briefing, May/June 2005.
- Tester, Jon. *Senators: Military Personnel, Vets to Receive 2nd Mental Health Screening*, Press Release, United States Senator for Montana., February 12, 2008.
- Vestal, Katharine W., Fralicx, Rodney D., and Scott Spreier. Fall 1997. *Organizational culture: The critical link between strategy and results*. Hospital & Health Services Administration; Alumni—Research Library.
- Zoraya, Gregg. *Staffing at Vet Centers Lagging*. USA Today; April 18, 2007.

## REPORTS, STUDIES, AND BOOKS

- Center for Health Care Strategies, Inc., *Care Management Definition and Framework*, 2007. Available at: [http://www.chcs.org/usr\\_doc/Care\\_Management\\_Framework.pdf](http://www.chcs.org/usr_doc/Care_Management_Framework.pdf). Adapted from Mechanic, R., *Will Care Management Improve the Value of U.S. Health Care?* Background Paper for the 11<sup>th</sup> Annual Princeton Conference, May 20, 2004.
- Commission on the National Guard and Reserves. *Second Report to Congress: Strengthening America's Defenses in the New Security Environment*. Virginia: March 2007.

Davis, Carol, Sidath Viranga Panagala, and Christine Scott. CRS Report to Congress: *Veterans Benefits: An Overview*. June 25, 2008.

Department of Defense, Armed Forces Health Surveillance Center, Medical Surveillance Monthly Report. *Deployment Health Assessments, U.S. Armed Forces, April 2008*. May 2008.

Department of Defense. *The Department of Defense Plan to Achieve the Vision of the DoD Task Force on Mental Health*, Report to Congress, September 2007.

Department of Defense and Department of Veterans Affairs. *VA/DoD Joint Executive Council Strategic Plan Fiscal Years 2008-2010*. Washington, D.C. November 2007.

Department of Defense and Department of Veterans Affairs Wounded, Ill, and Injured Senior Oversight Committee. *Memorandum: Department of Defense (DoD) and Department of Veterans (VA) Affairs Implementation of Recommendations of the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Report)*. Washington, D.C. 2007.

Department of Defense Task Force on Mental Health. *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health*. Falls Church, VA, Defense Health Board, 2007.

Department of Veterans Affairs. *2001 National Survey of Veterans (NSV) Final Report*. Washington, D.C. March 2003.

Department of Veterans Affairs. *Federal Benefits for Veterans and Dependents*. Washington, D.C. 2008.

Department of Veterans Affairs. *FY 2007 Performance and Accountability Report*. Washington, D.C. November 2006.

Department of Veterans Affairs Office of Inspector General. *Audit of the Veterans Health Administration's Outpatient Waiting Times*. Washington, D.C. September 2007.

Department of Veterans Affairs Office of Inspector General. *Audit of Vocational Rehabilitation and Employment Program Operations*. Washington, D.C. December 2007.

Department of Veterans Affairs, Office of Information and Technology. *ONEVA IT VISION*. March 1999.

Department of Veterans Affairs, Office of the Secretary. *Strategic Plan FY 2006-2011*. Washington, D.C. October 2006.

Department of Veterans Affairs, Public and Intergovernmental Affairs. *VA Vet Centers Coming to 39 Communities*. July 9, 2008.

Department of Veterans Affairs. Veterans Benefits Administration, Office of Performance Analysis and Integrity, *VA Benefits Activity, Veterans Deployed to the Global War on Terror (Draft)*, June 30, 2008.

Department of Veterans Affairs, Veterans Benefits Administration. *Survey of Veterans Satisfaction with the VA Compensation and Pension Claims Process: 2005 Summary Report National and Regional Office Results and Performance Trends*. Washington, D.C. June 2006.

Department of Veterans Affairs, Veterans Health Administration, *Considerations for VA Support For the Department of Defense Post Deployment Health Reassessment (PDHRA) Program For Returning Deployed Service Members*, VHA Directive 2006-038, June 26, 2006.

Department of Veterans Affairs, Veterans Health Administration. *Hospital Report Card to the House Appropriations Committee, In response to House Appropriations Report No. 110-186, accompanying Public Law 110-161, The Consolidated Appropriations Act, 2008*. June 3, 2008.

Department of Veterans Affairs, Veterans Health Administration. *Workforce Succession Strategic Plan FY 2008-2012*. Washington, D.C. October 2007.

Department of Veterans Affairs. *Volume II, Medical Programs & Information Technology Programs*. Congressional Budget Submission FY 2009, Performance Summary Table: Veterans Health Administration, February 2008.

Deputy Commander Clinical Operations, Western Regional Medical Command, *The Warrior Transition Unit: What Works (Presentation)*. Presented at TRICARE West Sub-Regional Conference on Warrior Care Coordination, Tacoma, WA: December 4-5, 2007.

DoD/VA Senior Oversight Committee Line of Action on Case/Care Management Reform, *Interim Report on Policy Improvements on the Care, Management and Transition of Recovering Service Members*, February 2008.

Fischer, Hannah, Kim Klarman, and Mari-Jana Oboroceanu. CRS Report to Congress: *American War and Military Operations Casualties, Lists and Statistics*. Washington, D.C. May 14, 2008.

IBM Global Business Services. *U.S. Department of Veterans Affairs, Veterans Benefits Administration, Claims Processing Improvement Study, Gap Analysis – FINAL*. Washington, D.C. February 2008.

Independent Review Group. *Rebuilding the Trust: Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center*. Washington, D.C. April 2007.

Inspectors General, U.S. Department of Defense and Department of Veterans Affairs. *DoD/VA Care Transition Process for Service Members Injured in OIF/OEF*. June 12, 2008.

Institute of Medicine. *A 21<sup>st</sup> Century System for Evaluating Veterans for Disability Benefits*. The National Academies Press. 2007.

Institute of Medicine and National Research Council. Committee on Veterans' Compensation for Posttraumatic Stress Disorder, *PTSD Compensation and Military Service*. Washington, D.C. The National Academies Press. 2007.

Institute of Medicine, Committee on Evaluation of the Presumptive Disability Decision-Making Process for Veterans. *Improving the Presumptive Disability Decision-Making Process for Veterans*. 2008.

Institute of Medicine, Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides, Division of Health Promotion and Disease Prevention. *Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam*. 1994.

Institute of Medicine, *Envisioning a National Health Care Quality Report*, 2001, as referenced in Center for Policy Studies in Family Medicine and Primary Care, Robert Graham Center, *The Patient Centered Medical Home, History, Seven Core Features, Evidence and Transformational Change*. November 2007.

Institute of Medicine. *Treatment of PTSD: An Assessment of the Evidence*. Washington, D.C.: The National Academies Press. October 2007.

Kaplan, Robert S. and David P. Norton. *Strategy Maps, Converting Intangible Assets into Tangible Outcomes*. Boston, Mass.: Harvard Business School Press, 2004.

Kotter, J.P. and Dan S. Cohen. *The Heart of Change*. Harvard Business School Press, 2002.

Longman, Phillip. *Best Care Anywhere: Why VA Health Care is Better Than Yours*. Sausalito, CA: PoliPoint Press. 2007.

Montana PDHRA Task Force, *PDHRA Task Force Report: Assessment and Recommendations*. June 2007.

National Academy of Public Administration, Report by a Panel of the National Academy of Public Administration for the U.S. Congress and the U.S. Department of Veterans Affairs. *Management of Compensation and Pension Benefits Claims Processes for Veterans*. August 1997.

Newcomer, K. and Kee, J. *Transformational Stewardship: Leading Change in the Public Interest*. Management Concepts. 2008.

President's Commission on Care for America's Returning Wounded Warriors. *Subcommittee Reports & Survey Findings: Serve, Support, Simplify*. Washington, D.C.: July 2007.

President's Task Force to Improve Health Care Delivery to Our Nation's Veterans. *Final Report*. Washington, D.C. 2003.

RAND Corporation. *Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA. 2008.

Roebuck, Linda. *New Mexico Military & Veteran Family Support Collaborative Phase 1*. New Mexico Behavioral Health Purchasing Collective, National Association of State Mental Health Program Directors. PowerPoint presentation. Tennessee. 2007.

Scott, Christine. CRS Report to Congress, *Veterans Affairs: Historical Budget Authority, Fiscal Years 1940 through 2007*, Washington, D.C. June 13, 2008.

Smole, David P., Shannon S. Loane. CRS Report for Congress, *A Brief History of Veterans' Education Benefits and Their Value*. June 25, 2008.

Stiglitz, Joseph and Linda J. Bilmes. *The Three Trillion Dollar War: The True Cost of the Iraq Conflict*. New York, NY: W.W. Norton & Company, Inc. 2008.

Sundararaman, Ramya, Sidath Viranga Panangala, and Sarah A. Lister. CRS Report to Congress, *Suicide Prevention Among Veterans*. Washington, D.C.: May 5, 2008.

Task Force on Returning Global War on Terror Heroes, *Task Force Report to the President: Returning Global War on Terror Heroes*. April 19, 2007.

The Commonwealth Fund. *A 2020 Vision of Patient Centered Primary Care*, October 2005.

Government Accountability Office. *DoD Needs to Establish a Strategy and Improve Transparency over Reserve and National Guard Compensation to Manage Significant Growth in Cost*. GAO-07-828. Washington, D.C.: June 2007.

VA Claims Processing Task Force Report to the Secretary of Veterans Affairs, 2001.

Veterans' Disability Benefits Commission. *Honoring the Call to Duty: Veterans' Disability Benefits in the 21<sup>st</sup> Century*. Washington, D.C.: October 2007.

WESTAT. *Survey for the President's Commission on Care for America's Returning Wounded Warriors: Survey Methodology Memo*. Maryland: July 2007.

Young, Gary J. *Transforming Government: The Revitalization of the Veterans Health Administration*. Pricewaterhouse Coopers Endowment for Business Government. Arlington, Virginia. June 2000.



## OTHER SOURCES

- Center for Health Care Strategies, Inc. *Care Management Definition and Framework*, 2007.  
Available at: [http://www.chcs.org/usr\\_doc/Care\\_Management\\_Framework.pdf](http://www.chcs.org/usr_doc/Care_Management_Framework.pdf). Adapted from Mechanic, R., *Will Care Management Improve the Value of U.S. Health Care?* Background Paper for the 11<sup>th</sup> Annual Princeton Conference, May 20, 2004.
- Department of Health and Human Services Press Release *Protecting the Privacy of Patients Health Information*. April 14, 2003.
- Department of Veterans Affairs. *2007 Organizational Briefing Book*. May 2007
- Department of Veterans Affairs Advisory Committee on Women Veterans. *Meeting Minutes*. October 31-November 2, 2006.
- Department of Veterans Affairs. Briefing on MyHealth<sub>Vet</sub> for NAPA Staff. July 9, 2008.
- Department of Veterans Affairs. *Center of Excellence Mental Health Crisis/Suicide Hotline YTD 08 Referral Breakdown*. October 2007 - June 2008.
- Department of Veterans Affairs. Department of Veterans Affairs FY 2009 Congressional Budget Submission, Performance Measures by Program. February 2008.
- Department of Veterans Affairs. *FY 2008 VHA Executive Career Field Performance Plan – Final*, updated November 16, 2007.
- Department of Veterans Affairs. *OEF/OIF Cumulative Program Data*, FY 2002 through 1<sup>st</sup> quarter of FY 2008.
- Department of Veterans Affairs. *OEF/OIF Fact Sheet*. February 2008.
- Department of Veterans Affairs. Office of Public and Intergovernmental Affairs. *Nicholson Announces 100 New Patient Advocates for Wounded*, March 6, 2007.
- Department of Veterans Affairs, Office of Public and Intergovernmental Affairs. *VA's 2003 Enrollment Decision Q & A*. January 2003.
- Department of Veterans Affairs, Office of Public Health and Environmental Hazards (OPHEH), Women Veterans Health Strategic Health Care Group, *VA Programs for Women Veterans*. Updated April 5, 2007.
- Department of Veterans Affairs, *Memorandum: Mental Health Initiatives*, Sent from Deputy Under Secretary for Health for Operations and Management (10N) to Network Directors. June 1, 2007.

Department of Veterans Affairs. *Mental Health: 14 Day Monitor by Facility Results for February 2008*. February 2008.

Department of Veterans Affairs Office of Public and Intergovernmental Affairs. News Release. *VA Announces On-line Claims Applications*. July 16, 2008.

Department of Veterans Affairs, Office of Public and Intergovernmental Affairs. News Release: *VA Vet Centers Coming to 39 Communities*. July 2008.

Department of Veterans Affairs, Office of Public and Intergovernmental Affairs. News Release. *VA Creating Advisory Panel on Rural Health*. February 20, 2008.

Department of Veterans Affairs, Office of the Under Secretary for Health. *Under Secretary for Health's Information Letter: Clinical Reminder Regarding Veterans of the Recent Conflicts in Afghanistan and Iraq*. February 6, 2004.

Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, New Release. *VA Begins Next Phase of Combat Vet Outreach*. May 30, 2008.

Department of Veterans Affairs, *Project HERO General Overview Briefing (Presentation)*, January 23, 2008.

Department of Veterans Affairs, *Press Release: VA's Suicide Hot Line Begins Operations*, July 30, 2007.

Department of Veterans Affairs Strategic Plan 2001-2006 (Office of the Secretary, July 2001)

Department of Veterans Affairs Strategic Plan 2006-2010 (Office of the Secretary, October 2006).

Department of Veterans Affairs. *VA National Suicide Prevention Hotline Call Report Totals YTD, FY 2007 through June 30th FY 2008*.

Department of Veterans Affairs, Veterans Health Administration. *Hospital Report Card to the House Appropriations Committee, In response to House Appropriations Report No. 110-186, accompanying Public Law 110-161, The Consolidated Appropriations Act, 2008*, June 3, 2008, pp. 22, 23.

Department of Veterans Affairs, Veterans Health Administration. *Polytrauma Rehabilitation Centers*, VHA Directive 2005-024, June 8, 2005.

Department of Veterans Affairs, Veterans Health Administration. VHA Handbook 1010:01: *Transition Assistance and Case Management of Operation Iraqi Freedom and Operation Enduring Freedom*. May 2007.

Department of Veterans Affairs. *Veterans Health Administration State Benefits Seamless Transition Program Issue Brief*, May 14, 2008

Department of Veterans Affairs, VHA Chief Business Office, Project HERO, Performance Metrics (Presentation). May 2008.

Department of Veterans Affairs, *VHA Performance Measurement Development and Life Cycle*, Received from VA on July 25, 2008.

Department of Veterans Affairs. *VHA Telehealth Activity and VHA OEF/OIF Telehealth Activity, FY 2007 through 3<sup>rd</sup> Quarter FY 2008*.

Environmental Protection Agency, Web Workgroup. *Web 2.0 Whitepaper*. February 2008.

Kizer, Ken. Presentation to the Institute of Medicine Roundtable on Evidence-based Medicine, April 29, 2008.

Litz, Brett T. *Fact Sheet: The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq*. VA National Center for PTSD, Department of Veterans Affairs, May 22, 2007.

Memorandum from Assistant Secretary of Defense for Health Affairs regarding Pre and Post-Deployment Health Assessments and Blood Samples, October 1998.

Memorandum from Assistant Secretary of Defense for Health Affairs regarding Traumatic Brain Injury Questions for the Post-Deployment Health Assessment. March 8, 2007.

Overview of Post 9-11 Veterans Educational Assistance Act of 2008 (PL 110-252) Briefing by Keith Wilson, Director Education Service. July 8, 2008.

National Institute of Mental Health Press Release. *Mental Illness Exact Heavy Toll, Beginning in Youth*. June 2005.

Shalev, Arieh Y., Director of Center for Traumatic Stress at Hadassah University Hospital, Presentation at American College of Neuropsychopharmacology: 46th Annual Meeting, December 2007.

## TESTIMONY

Statement of Mahdulika Agarwal, Chief Officer, Patient Care Services Veterans Health Administration, Department of Veterans Affairs, before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations. March 13, 2008.

Statement of Cynthia A. Bascetta, Director, Education, Workforce, and Income Security, *Vocational Rehabilitation: VA Has Opportunities to Improve Services, but Faces*

*Significant Challenges*, Testimony before the Subcommittee on Economic Opportunity, Committee on Veterans' Affairs, House of Representatives. April 20, 2005.

Statement of Daniel Bertoni, Director, Education, Workforce, and Income Security, Government Accountability Office. *Veterans Disability Benefits, Claims Processing Challenges Persist, while VA Continues to Take Steps to Address Them*. Testimony Before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, House of Representatives. February 14, 2008.

Testimony of Gunnery Sergeant Tai Cleveland, USMC, ret. before the House Committee on Veterans' Affairs, January 29, 2008.

Statement of Gerald Cross, Principal Deputy Under Secretary for Health before the Subcommittee on Health, Committee on Veterans' Affairs U.S. House of Representatives. January 17, 2008.

Statement of Col (Ret) Peter Duffy, Deputy Director of Legislative Affairs, National Guard Association of the United States, before Senate Committee on Veterans' Affairs, October 16, 2007.

Statement of Rear Admiral Patrick W. Dunne, USN (Ret), Acting Under Secretary for Benefits, Veterans Benefits Administration, Department of Veterans Affairs. *Hearing on Examining the Claims Processing System*. Testimony before the Senate Committee on Veterans' Affairs. July 9, 2008.

Statement of Ruth A. Fanning, Director, Vocational Rehabilitation & Employment Service, VBA. Testimony before the Senate Committee on Veterans' Affairs. February 5, 2008.

Opening Statement by Honorable Bob Filner, Chairman, House Committee on Veterans' Affairs, *Truth About Veteran Suicides*. May 6, 2008.

Secretary of the Army Pete Geren, Statement before the Committee on Armed Services, United States Senate. February 13, 2008.

Statement of Charles Hoge, U.S. Army Director, Division of Psychiatry and Neuroscience, Walter Reed Army Institute of Research. *Hearing on Post Traumatic Stress Disorder Treatment and Research: Moving Ahead Toward Recovery*. Testimony before the House Committee on Veterans' Affairs, Subcommittee on Health. April 1, 2008.

Statement of Michael J. Kussman, Undersecretary for Health, Department of Veterans Affairs, before the Senate Committee on Veterans' Affairs, June 3, 2008.

Statement of Bradley Mayes, Director, Compensation and Benefits, Veterans Benefit Administration, U.S. Department of Veterans Affairs. Testimony before the House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs. February 26, 2008.

Statement of the Honorable James Peake, Secretary of Veterans Affairs, before the House Committee on Veterans' Affairs. Washington, D.C. February 7, 2008.

Statement of James B. Peake, Secretary, U.S. Department of Veterans Affairs. *Hearing on The Truth About Veteran Suicides*. Testimony before the House Veterans' Affairs Committee. May 6, 2008.

Statement of Allison Percy, Principal Analyst, Congressional Budget Office on Future Medical Spending by the Department of Veterans Affairs. Testimony before the House Subcommittee on Military Construction, Veterans Affairs, and Related Agencies Committee on Appropriations. February 15, 2007.

.Statement of Michael Shepherd, Physician, Office of Healthcare Inspections Office of the Inspector General, U.S. Department of Veterans Affairs. Hearing on *The Truth About Veteran Suicides*. Testimony before the House Veterans' Affairs Committee. May 6, 2008.

Statement of Paul A. Tibbits, M.D., Deputy Chief Information Officer For the Office of Enterprise Development, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, U.S. House of Representatives, September 26, 2007.

Statement of Michael Walcoff, Associate Deputy Under Secretary for Field Operations, Veterans Benefits Administration. Hearing on *Personal Cost of the Claims Backlog*. Testimony before the House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs, House of Representatives. Washington, D.C. October 9, 2007.

Statement of Jon A. Wooditch, Deputy Inspector General, Department of Veterans Affairs. Testimony Before Subcommittee on Oversight and Investigations, Committee on Veterans Affairs, House of Representatives, Hearing on Disability Claims Ratings and Benefits. October 16, 2007.

Statement of Antonette Zeiss, Associate Chief Consultant, Office of Mental Health Services, Veterans Health Administration, Department of Veterans Affairs, before House Committee on Veterans' Affairs, Subcommittee On Health, March 11, 2008, p. 3.

Testimony of David A. Powner, Director of Information Technology Management Issues, Government Accountability Office, before the Senate Committee on Homeland Security and Government Affairs. July 31, 2008

Testimony of Elizabeth O'Herrin before the House Committee on Veterans' Affairs, Oversight and Investigations Subcommittee, July 15, 2008.

Testimony of Randal Omvig before the Senate Committee on Veterans Affairs, April 15, 2007;  
Testimony of Gunnery Sergeant Tai Cleveland, USMC, ret. before the House Committee  
on Veterans' Affairs, January 29, 2008

## LEGISLATIVE AND BUDGET DOCUMENTS

Budget of the United States Government. FY 2009. Historical Tables.

House of Representatives floor debate on H.R. 3681. Congressional Record, May 20, 2008.

House of Representatives Conference Report, Making Appropriations for Military Quality of Life Functions of the Department of Defense, Military Construction, the Department of Veterans Affairs, and Related Agencies for the Fiscal Year Ending September 30, 2006, and for Other Purposes, 109<sup>th</sup> Congress (1<sup>st</sup> Session), House Report 109-305, November 18, 2005.

House Report 110-107, Making Emergency Supplemental Appropriations for the Fiscal Year Ending September 30, 2007 and for Other Purposes.

National Defense Authorization Act for FY 2008 (H.R. 4986), *Title XVI – Wounded Warrior Matters, Sec. 1611 Comprehensive Policy on Improvements to Care, Management, and Transition of Recovering Service Members*. January 28, 2008.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (H.R. 2206).

Veterans For Common Sense, et al versus Department of Veterans Affairs, C 07 3758 (USD Ct. ND Ca. 2007).

## WEBSITES

### DoD

DoD Deployment Health Clinical Center. *Traumatic Brain Injury*.  
<http://www.pdhealth.mil/TBI.asp> (September 2008)

Defense and Veterans Brain Injury Center, *Blast Injury FAQs*, Accessed at:  
[http://www.dvbic.org/cms.php?p=Blast\\_injury](http://www.dvbic.org/cms.php?p=Blast_injury) (2006).

U.S. Soldiers' and Airmen's Home.  
<http://www.defenselink.mil/specials/heroes/history1.html> (May 2003)

**Other**

Buelow, Paul A. "Veterans' Hospitals." Encyclopedia of Chicago website. <http://www.encyclopedia.chicagohistory.org/pages/1302.html> (2005)

Public Broadcasting Service. "Veterans Benefit History." PBS NOW: Society and Community website. <http://www.pbs.org/now/society/vetbenefits.html> (May 13, 2005)

Substance Abuse and Mental Health Service Administration, National Mental Health Information Center, *Mental Health Services Locator*. Accessed at: <http://mentalhealth.samhsa.gov/databases/>. (2008)

TechEncyclopedia: Web 2.0  
<http://www.techweb.com/encyclopedia/defineterm.jhtml;jsessionid=VENRMYH2LN2D4QSNDLPSKHSCJUNN2JVN?term=Web+2.0&x=29&y=11> (2008)

Women In Military Service For America Memorial Foundation, Inc. *Statistics on Women in the Military*, updated July 17, 2006. Accessed at: <http://www.womensmemorial.org/PDFs/StatsonWIM.pdf>

**State Information**

Louisiana Department of Social Services No Wrong Door Policy at: [http://www.dss.state.la.us/departments/dss/No\\_Wrong\\_Door.html](http://www.dss.state.la.us/departments/dss/No_Wrong_Door.html) (April 2008)

Virginia's Department for the Aging No Wrong Door Policy at: <http://www.vda.virginia.gov/nowrongdoor.asp> (2007)

**Universities**

Ball State University  
<http://www.bsu.edu/alumni/iconnect>. (2008)

McComb's School of Business at the University of Texas at Austin  
<http://www.mcombs.utexas.edu/alumni/emailforwarding>. (November 19, 2007)

Oregon State University  
<http://tss.oregonstate.edu/OCH/resources/?page=lifetime>. (June 7, 2006)

Pepperdine University  
<http://www.pepperdine.edu/alumni/onlineservices/email.htm>. (2008)

**Department of Veterans Affairs**

Department of Veterans Affairs. *FY '09 VA Budget Request Highlights*. February 4, 2008.  
<http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1448>

Department of Veterans Affairs, Office of Public Health and Environmental Hazards (OPHEH), Women Veterans Health Strategic Health Care Group. *VA Programs for Women Veterans*. Updated April 5, 2007. Accessed at:  
<http://www1.va.gov/wvhp/page.cfm?pg=26>.

Department of Veterans Affairs. *VA History in Brief*.  
<http://www1.va.gov/opa/feature/history/docs/histbrf.pdf>. May 2007

*VA Benefits & Health Care Utilization*, updated on July 22, 2008. Accessed at:  
[http://www1.va.gov/vetdata/docs/4X6\\_summer08\\_sharepoint.pdf](http://www1.va.gov/vetdata/docs/4X6_summer08_sharepoint.pdf).

VAMCs as Polytrauma Centers and 17 as Polytrauma Network Sites, updated April 9, 2007.  
Accessed at: <http://www.polytrauma.va.gov/faq.asp#FAQ1>.

Vet Center data, update as of September 10, 2008. [www.vetcenter.va.gov](http://www.vetcenter.va.gov).



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## GLOSSARY OF TERMS

Term	Definition
<b>At-risk veterans</b>	Veterans who may be experiencing symptoms of combat-related mental illness or traumatic brain injury and who have not sought or received mental health care services.
<b>Business Process Reengineering (BPR)</b>	A radical improvement approach that critically examines, rethinks, and redesigns mission product and service processes within a political environment.
<b>Claim</b>	Any application, document inquiry, or other issue requiring adjudication action.
<b>Continuum of Care</b>	The provision of comprehensive care throughout treatment, including from hospital to home, which advocates the pooling together of medical and social services within the community and the creation of linkages between community care initiatives at all levels of the health care system. The goal of the continuum is to prevent gaps or breaks in treatment by means of a comprehensive set of services ranging from preventive and ambulatory services, to acute care, to long term and rehabilitative services.
<b>Disability</b>	A broad term that includes work disability and quality of life.
<b>Disability Compensation</b>	A monthly payment made to a veteran because of disability incurred in or aggravated during military service.
<b>Disability evaluation</b>	The process of determining the degree to which a medical condition disables a veteran, or the result of such a determination (i.e., “a disability evaluation of 30 percent”).
<b>Enterprise Architecture (EA)</b>	Enterprise Architecture is an IT design for the arrangement and interoperation of business components (e.g., policies, operations, infrastructure, information) that together make up the enterprise's means of operation.
<b>Federal Individualized Recovery Plan (FIRP)</b>	Provides an individualized, integrated, longitudinal, medical/non-medical service plan across the continuum of care for severely wounded service members, veterans and their families. The FIRP template includes 20 subject areas, including those that identify key partners who will be involved in the recovery process and those that focus exclusively on the service member/veteran such as accommodations and daily living, behavioral health, career planning, and education, for which there are short-term and long-term goals. The Federal Recovery Coordinator monitors and regularly modifies the FIRP in collaboration with the Multi-Disciplinary Teams (MDTs).

Term	Definition
<b>Federal Recovery Coordinator</b>	A new position established jointly by DoD and VA, but operationalized by VA in response to the Dole-Shalala report. The FRCs coordinate clinical and non-clinical care for severely injured/ill military service member/veteran from initial admission to the Military Treatment Facilities, and ensure that service members/veterans and their families have access to all clinical and non-clinical case management services. They also oversee the implementation of an individualized recovery plan for each severely injured service member.
<b>Federal Recovery Coordinator Program (FRCP)</b>	<p>A program that provides close coordination of clinical and non-clinical care management for severely injured service members, veterans, and their families across the lifetime continuum of care. VA and DoD initiated this program in October 2007 in response to the President's Commission on Care for America's Returning Wounded Warriors. The FRCP has three components:</p> <ul style="list-style-type: none"> <li>• a Federal Recovery Coordinator who is dedicated to work with the service member/veteran and his family as well as various case managers to monitor progress and rehabilitation through out his/her lifetime,</li> <li>• a federal individualized recovery plan (FIRP) that is tailored to the service member's specific treatment and rehabilitation needs, and</li> <li>• a web-based national resource directory of care providers that would be searchable by diagnosis, geographic location, and service affiliation.</li> </ul>
<b>HIPAA</b>	The Health Insurance Portability and Accountability Act of 1996, including its provisions providing for privacy of medical information about individuals. This legislation also is meant to prevent health care fraud and abuse, improve access to long-term care services and coverage, and simplify the administration of health insurance.
<b>Impairment</b>	Loss of physiological integrity in a body function or anatomical integrity in a body structure; caused by disease, injury, or congenital defect (WHO, 2001)
<b>Intermediate Outcome</b>	An intermediate outcome is expected to lead to an end outcome, but in itself, is not the desired result. Intermediate outcomes can be measured in the near term, and are indicators of long-term outcomes. Intermediate outcomes often relate to customer satisfaction, which can be measured by means of customer surveys or interviews.



Term	Definition
<b>Multi-Disciplinary Teams (MDTs)</b>	Consist of approximately 12 different health care and rehabilitation specialists. The MDTs work together to case-manage, develop treatment goals, and treat the severely wounded veteran. Members of the MDT may include: Medical Director, Psychiatrist; Nurse Practitioner; Nurse Case Manager; Social Work Program Director; Social Work Case Manager; Physical Therapist; Occupational Therapist; Speech Therapist; Recreation Therapist; Orthodontist; Blind Rehab Occupational Specialist; and Psychologist
<b>My Health<sub>g</sub>Vet</b>	An awarding-winning online portal that provides veterans access to trusted health information, links to Federal and VA benefits and resources, a Personal Health Journal and online prescription refill.
<b>No Wrong Door Policy</b>	The idea that a customer or client can enter a services system at one of many points and be: (1) given accurate information about his/her issue or question; (2) informed of services or benefits they might be eligible for other than that delivered at that location or organization element, and (3) directed to the appropriate point of contact for more specific information.
<b>OneVA</b>	A concept for guiding VA's approach to internal coordination of data and services, that is supported by several series of information technology initiatives intended unify the work of the department, specifically, that of VBA and VHA.
<b>Original claim</b>	A claimant's initial application for a particular benefit.
<b>Pension</b>	Generally, a monthly payment to eligible wartime veterans and survivors based upon total non-service-connected disability and/or monetary need.
<b>Post-Deployment Health Assessment (PDHA)</b>	Mandatory DoD-sponsored health assessment of separating service persons conducted between 30 days prior to leaving a deployment location and within 30 days after returning from deployment. .
<b>Post-Deployment Health Reassessment (PDHRA)</b>	A DoD program which provides for a health assessment three-to-six months after the return from deployment. This is in addition to the post-deployment health assessment which is done within 30 days. The purpose of this screening is to review each service member's current health, mental health or psychosocial issues Commonly associated with deployments and follow-up on any issues from the 30-day assessment.
<b>Post Traumatic Stress Disorder (PTSD)</b>	A type of anxiety disorder that can occur after experiencing a traumatic event that involved the threat of injury or death. PTSD may occur soon after a major trauma, or it can be delayed for more than six months after the event.
<b>Quality of life</b>	Includes the cultural, psychological, physical, interpersonal, spiritual, financial, political, temporal, and philosophical dimensions of a person's life; reflects changes in people and the environment over time across many of its domains (Tal et. al., 1996); the perception of physical and mental health over time (CDC, 2007)

Term	Definition
<b>Service-connected or Service connection</b>	A disability is considered to be service connected if it was incurred or aggravated during a period of active military service from which the veteran was discharged under conditions other than dishonorable and was not due to willful misconduct of the veteran. A service-connected disability evaluated 10 percent or more disabling by the VA entitles a veteran to receive disability compensation.
<b>Traumatic Brain Injury (TBI)</b>	A blow or trauma to the head or a penetrating head injury that interferes with the functioning of the brain. Severity may range from mild (a brief change in mental status) to severe (prolonged unconsciousness or amnesia.)
<b>Transition Assistance Program/ Disabled Transition Assistance Program</b>	Joint efforts of the departments of Defense, Labor, and Veterans Affairs that statutorily provide programs to furnish employment assistance. Job training assistance, and other transition services, including counseling on the full range of VA benefits and services, to service members who are scheduled for separation from active duty.
<b>Veteran-Centered</b>	A business philosophy and practice that puts the veteran and his/her various needs and circumstances as the top priority and serves as a way to orient all the work conducted within the Department.
<b>VETSNET</b>	A suite of applications used to process claims; the VETSNET platform was intended to replace the Benefits Delivery Network.
<b>VistA</b>	Veterans Health Information Systems and Technology Architecture VHA's enterprise-wide electronic health record system.

## ACRONYMS

Acronym	Stands For
<b>BDD</b>	Benefits Delivery at Discharge
<b>BEC</b>	Benefits Executive Council
<b>CBOC</b>	Community Based Outpatient Clinic
<b>CM</b>	Contact Management
<b>CRM</b>	Customer Relationship Management
<b>COO</b>	Chief Operating Officer
<b>DoD</b>	Department of Defense
<b>DoL</b>	Department of Labor
<b>DTAP</b>	Disabled Transition Assistance Program
<b>FIRP</b>	Federal Individual Recovery Plan
<b>FRC</b>	Federal Recovery Coordinator
<b>FRCP</b>	Federal Recovery Coordination Program
<b>FY</b>	Fiscal Year
<b>GAO</b>	U.S. Government Accountability Office
<b>GC</b>	General Counsel
<b>HEC</b>	Health Executive Council
<b>HIPAA</b>	Health Insurance Portability and Accountability Act of 1996
<b>IOM</b>	Institute of Medicine
<b>IT</b>	Information Technology
<b>JEC</b>	Joint Executive Council
<b>LoA</b>	Line of Action
<b>LSW</b>	Licensed Social Worker
<b>MOA</b>	Memorandum of Agreement
<b>MTF</b>	Military Treatment Facility
<b>NDAA</b>	National Defense Authorization Act
<b>OEF</b>	Operation Enduring Freedom
<b>OIF</b>	Operation Iraqi Freedom
<b>OI&amp;T</b>	Office of Information and Technology

Acronym	Stands For
<b>OMB</b>	Office of Management and Budget
<b>PDHA</b>	Post-deployment Health Assessment
<b>PDHRA</b>	Post-deployment Health Reassessment
<b>PDR</b>	Post-Decision Review
<b>PTSD</b>	Post Traumatic Stress Disorder
<b>R&amp;E</b>	Registration and Eligibility
<b>REALines</b>	Recovery and Employment Assistance Lifelines
<b>RMC</b>	Records Management Center
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SBA</b>	Small Business Administration
<b>SCI</b>	Spinal Cord Injury
<b>SOC</b>	Wounded, Ill, and Injured Senior Oversight Committee
<b>TAP</b>	Transition Assistance Program
<b>TBI</b>	Traumatic Brain Injury
<b>TPA</b>	Transition Patient Advocate
<b>VA</b>	Department of Veterans Affairs
<b>VAMC</b>	Department of Veterans Affairs Medical Center
<b>VARO</b>	VA Regional Office
<b>VBA</b>	Veterans Benefits Administration
<b>VETSNET</b>	Veterans' Service Network
<b>VHA</b>	Veterans Health Administration
<b>VISN</b>	Veterans' Integrated Service Network
<b>VISTA</b>	Veterans Health Information Systems and Technology Architecture
<b>VONAPP</b>	Veterans On-line Application
<b>VR&amp;E</b>	Vocational Rehabilitation and Employment
<b>VRC</b>	Vocational Rehabilitation Counselor
<b>VSO</b>	Veterans' Service Organization
<b>VSR</b>	Veterans Service Representative
<b>VTA</b>	Veterans' Tracking Application
<b>WTU</b>	Warrior Transition Unit

## SCOPE AND METHODOLOGY

The rapid pace of planning, piloting, and activity regarding veterans programs that has been underway at VA and DoD during the past year and a half posed challenges to the Panel and study team. Rather than reviewing a static reality, the Panel and team have been pursuing a work in progress. In many instances, change has been too recently implemented to permit sound conclusions about its actual or potential benefits. Another result of this situation is that the change process itself became a principal focus of observation and analysis.

Even if there had been no substantial change underway, the responsibility that was given to the Academy by Congress—to evaluate the overall management and organization of VA and its capacity to provide high quality health care and benefits to all veterans—presented significant challenges given the time and resources that were available to conduct the study. Thus, the Panel and study team found it necessary to develop approaches that would narrow the focus and facilitate meaningful evaluation of VA’s capacity to address specific issues raised by the return of veterans from Iraq and Afghanistan. Many of the findings, although focused on this group and the responses to recent questions about care of those who are wounded, have broader application to efforts to improve service to all generations of veterans. The approaches taken by the Panel and study team evolved and built on one another over the course of their work and are explained below.

### 1. EVOLUTION OF STUDY METHODOLOGY

#### **Eight Principal Research Issues**

Consistent with the Congressional mandate for its work, the Academy engaged in discussions with VA officials at the outset of the study to identify specific issues of interest to the Department. Based upon VA’s interest in having the Academy answer the following eight research questions, they were incorporated into the Academy’s technical proposal:

1. Whether there is a seamless transition mission statement that is universally understood throughout VA?
2. What health care services and benefit issues are faced by active duty personnel who are transitioning to veteran status, along with the issues faced by their eligible family members?
3. Which VA Health Administration (VHA) case management services and organizations in clinical specialties, such as social work and nursing, are OEF/OIF (Iraq and Afghanistan conflict) veterans encountering in transition from active duty to veteran status?
4. Whether effective management structures and inter-agency coordination processes, such as Benefits Delivery at Discharge (BDD), are in place between VA and the Department of Defense to ensure that VA services are provided in a timely and efficient manner?

5. What is the most effective organizational placement of the VA Office of Seamless Transition and what staffing levels are needed for optimum functionality?
6. Which organizational factors may obstruct or enable VA's ability to provide appropriate and timely mental health care services to returning service members transitioning to veteran status, including the unique role of Vet Centers and their relationship to VHA mental health services programs?
7. What are the advantages and disadvantages of current "continuum of care" options for catastrophically injured service members returning from Afghanistan and Iraq, including care options when maximum medical improvement has been reached?
8. Are VA Office of Seamless Transition and other relevant key VA performance measures and metrics for measuring results adequate and how do they compare when benchmarked to best measurement practices?

The first stage of the study thus involved the development of a research strategy to examine these issues and others related to VA organization and management of transition and service to veterans.

### **Initial Research Strategy**

A research strategy was developed in the first weeks of the study to focus and guide data collection and analysis, consistent with the Congressional mandate and VA's eight primary research issues described above. It was designed to: (1) build on and complement the work and recommendations of previous panels, GAO, and other groups that had recently examined the system of care and benefits for veterans; (2) focus on the organizational and administrative requirements for successful change; (3) enable the Panel to identify innovative strategies most likely to yield major improvements in care for OEF/OIF and other veterans; and (4) produce information needed to address general issues and answer each of the eight specific research questions posed by VA. The strategy was intended to accomplish the following goals:

**Overall Goals: (1) Identify changes in VA organization, management practices, and systems or processes necessary to implement the major recommendations of earlier panels to assist OEF/OIF and other veterans; (2) Identify barriers to change; (3) Identify innovative strategies most likely to overcome those barriers and yield cost-effective improvements in care that will result in better outcomes for veterans.** Improvement requires careful definition and specification of expected outcomes and other performance measures. It is assumed that improved care will require improved and timely diagnosis, needs assessment, and eligibility determination; appropriate, timely, and coordinated services and benefits as experienced by recipients; and sustained contact or tracking and periodic reassessment of recipients' progress and ongoing service needs.

The strategy consisted of the following steps:

**Step 1—Identify a manageable number of major recommendations of earlier panels for improvements to the system of care and benefits.** This list excluded recommendations for changes in policy, such as eligibility or level of benefits, because those matters were considered to be outside the scope of this study. It also excluded changes that are relatively easily made and likely to have modest impact. An important assumption here is that the preceding panels, collectively, had identified most if not all of the major changes in policy and operations necessary to improve outcomes for OEF/OIF and other veterans. Overlapping or parallel recommendations were combined and contradictory courses recommended by different panels, if any, were noted. These were then mapped to the eight primary research issues identified by VA to ensure that those issues are covered.

To help identify the biggest organizational and management challenges facing the Department of Veterans Affairs and its partners in improving service to OEF/OIF and other veterans, over 200 recommendations of the following prior studies of VA were reviewed:

- **President’s Commission On Care For America’s Returning Wounded Warriors (*Dole-Shalala*)**
- **Task Force on Returning Global War on Terror Heroes (*GWOT*)**
- **Veterans’ Disability Benefits Commission (*Disabilities*)**
- **Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center (*IRG*)**
- **President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans (*2003*)**

Each of these prior studies recommended both policy and administrative changes to improve service to veterans. Recommendations for changes in legislative authorities, funding levels, or broad policies were eliminated. As a result of this review, 41 of the recommendations that remained were selected because they appeared to pose the most significant organizational and management challenges to VA regarding transitions and improved service to veterans. Included at the end of this section are a few significant examples of the selected recommendations (Table 2) and a complete list of all 41.

**Step 2—For each major recommendation identified in Step 1, collect relevant information through interviews with VA officials and staff, representatives of veterans' organizations, experts, and other stakeholders and through observation of activity at VA facilities and other data collection.** Interview guides were developed to address potential obstacles to successful implementation and to establish:

- a. Current circumstances: What is the weakness identified by one or more panel reports, GAO, or others? What is the evidence regarding how this affects performance and results, including outcomes for OEF/OIF and other veterans?

- How is this affecting care to veterans? Who has clear responsibility and authority for the improvement? What are the incentives for improvement?
- b. Nature of the required change: What changes in organization, management practice, systems, and processes are needed to implement the recommendation? Who should have responsibility for leading and implementing the change?
  - c. Recent or planned actions: What actions have been taken recently or are planned by the VA and others to address the problem?
  - d. What would success look like: How should success be measured? What outcomes for veterans would demonstrate that the change was effective?
  - e. Barriers to/Enablers of the required change: What are the main barriers to (and enablers of) making required changes? Authority (legal, assignments, discretion)? Incentives? Information? Staffing? Other resources? Other?
  - f. Strategies: What innovative strategies should be considered to overcome barriers to implementation and successfully implement the recommendation? What are the implications of each strategy for organization, systems, and management practices of the VA and others?
  - g. Likely impact on care for and well-being of returning and other veterans: What quantified improvement can be expected, over what period of time, in the care received by OEF/OIF and other veterans (or specific classes of veterans) and in their well-being if the recommendation is successfully implemented? What additional measures or analysis will be needed to demonstrate the effects of the change?

**Step 3—With regard to the entire set of previous panel recommendations, review evidence of barriers and strategies for common elements and develop an overall organizational and management assessment of the scope and nature of the required change and of VA/DoD capacity to implement the change.** Specify elements of a change strategy that takes account of changes already underway and is likely to yield the greatest, most rapid improvement in care for OEF/OIF and other veterans. Also, assess the ability to address fully each of the eight primary research issues specified by VA, and collect and analyze additional information as necessary. A final round of interviews with VA policy officials, representatives of major veterans groups, and experts helped refine and validate the proposed change strategy.

**Step 4—Specify requirements for success of the change strategy identified in Step 3, including an implementation road map and timeline.** Assess the probable impact of successful implementation of the strategy on outcomes for OEF/OIF and other veterans. This step relied heavily on expert judgments, including those of the Academy Panel, which assessed all the evidence and developed its recommendations.

### **Identification of Implementation Challenges**

Applying the research strategy, the Panel and study team were able to identify the management and organizational challenges that VA must deal with in attempting to implement the selected recommendations for improvement in its provision of care and services to veterans. These were categorized initially in the following way:



***Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration***  
***Implementation Challenge #2 : Improving Intra-Agency Coordination***  
***Implementation Challenge #3: Strengthening Services and Benefits***  
***Implementation Challenge #4: Improving the Examination and Rating Process***  
***Implementation Challenge #5: Developing a Targeted Outreach Strategy***  
***Implementation Challenge #6: Sustaining Continuous Improvement***

Based on information acquired through interviews and document review, analyses were prepared and presented to the Panel that explained each of these challenges and discussed approaches that would assist VA in dealing with them.

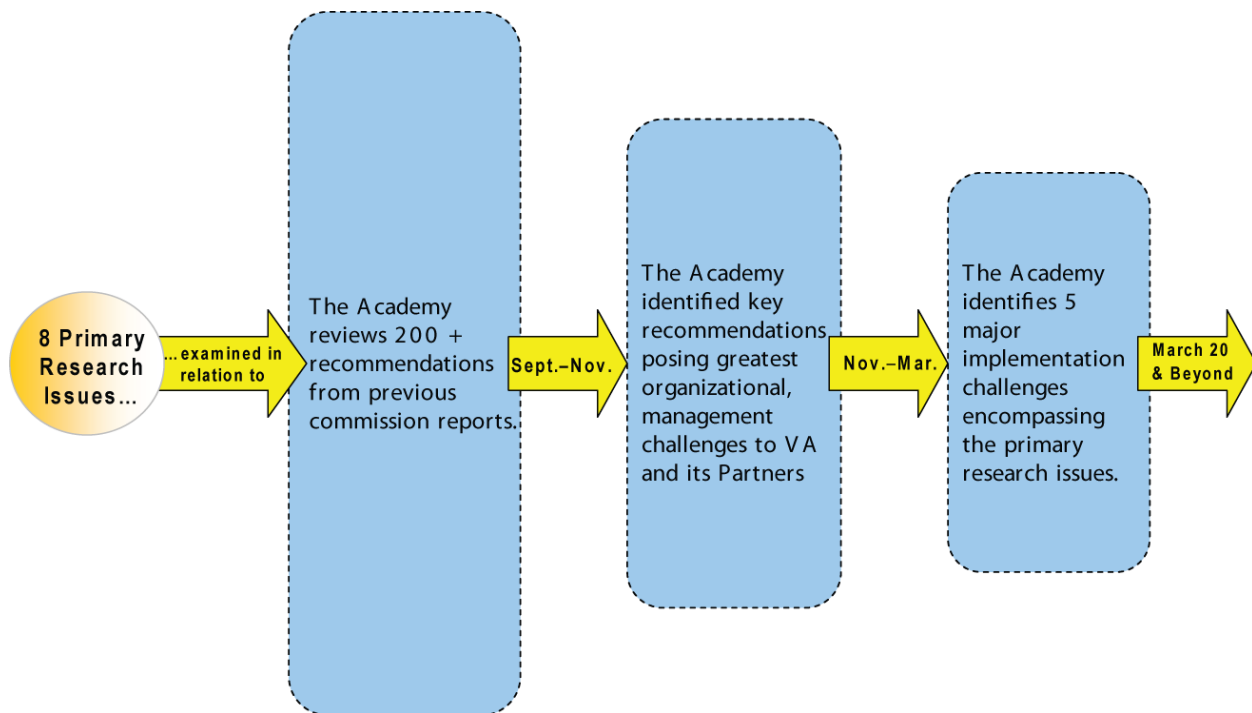
### **Determination of Recommendations for Addressing Challenges**

In the final step, the Panel determined that successful implementation of the selected recommendations from prior panels, in the context of the implementation challenges that had been analyzed, would require VA to take action in several areas. The specific rationales and recommendations for achieving improvements in each area of these areas are described in this report:

***Creating a Veteran-Centered Care Management Approach***  
***Intra-VA Collaboration/Partial Examinations and Rating***  
***Targeted Outreach***  
***Strengthening Care***  
***VA/DOD Coordination***  
***Continuous Improvement Strategies for VA/DOD***

### **Summary of Study Approach**

The figure below illustrates the relationship between the original set of eight primary research questions and the methodology followed by the Panel and study team in addressing them and assessing the management and organization of VA. It indicates schematically how the initial focus on the primary research questions led to identification of the management challenges raised by prior panel recommendations for improvement, and how these questions led in turn to development of strategies responding to those challenges, and to recommendations that will allow VA and its partners to succeed in improving care and benefits for OEF/OIF and other veterans.



## 2. RESEARCH AND ANALYSIS METHODOLOGY

The principal data sources for the study were:<sup>290</sup>

- interviews with 98 VA officials and staff members at all levels in VA headquarters, the Washington, DC, Nashville, Philadelphia, and Tampa Medical Centers, Regional Offices and Insurance Centers, and the Brooke and Walter Reed Army Medical Centers;
- interviews with 18 senior DoD and military services officials;
- interviews with representatives of Veterans Service Organizations (VSOs) and representatives of associations representing the interests of Reserve Officers and the National Guard;
- interviews with state veterans affairs, health, and mental health officials;
- interviews with a wide variety of public administration and subject matter experts, including staff of previous panels examining transitions;
- discussions with members of the Advisory Committee on OEF/OIF Veterans and Families;
- field visits to regional VA medical centers, Vet Centers, VA Regional Benefits Offices, a VA polytrauma center, and other VA facilities;
- a visit to Walter Reed Army Medical Center, including meetings with key VA and DoD staff;
- review of reports of Congressional hearings;

<sup>290</sup> See Appendices F and G for complete list of interview and documentary sources.

- review of published documents and press reports bearing on the administrative organization and work processes of VA and other agencies related to transitions and service to returning (and other) veterans;
- review of external reports and testimony by GAO, the VA Office of the Inspector General, and other independent reviews;
- reviews of scientific studies of disability and treatment methods and their efficacy and of technical issues concerning the VA disability rating process, conducted by the Institute of Medicine, RAND Corporation, and others; and
- reviews of a variety of scholarly publications bearing on organizational change, evidence-based management, coordination of care, and many other organizational and management problems relevant to the issues facing VA and its partners in improving service to veterans.

It is important to note that the scope and mandate of the study did not permit surveying of a representative group of veterans to obtain their views on services and care. Rather, the study team relied on secondary sources and on a number of interviews with individuals and organizations that represent veterans. These included representatives of Veterans Service Organizations, National Guard, and Reserve Officers; state veterans affairs officers; and members of an advisory committee to the VA Secretary on OEF/OIF veteran and family issues.

Data collection began in October 2007 and concluded in July 2008. In the initial round of interviews, an interview guide was used to ensure consistency. Interviews focused initially on implementation challenges presented by the selected recommendations of previous studies. As potential management challenges were identified, additional candidates for interviews on particular subjects were identified. Subsequent rounds of interviews focused on more specific issues of implementation. As information was developed from the first rounds of interviews and review of related documentary sources, the nature of the management and organization challenges facing the VA and its partners began to come into focus. Subsequent interviews, field visits, and other data collection focused on developing insights into those challenges; both the selection of people to be interviewed and the focus of the questioning became more targeted to that end.

After the first five months of the study, the study team presented its initial observations regarding the organizational and management challenges of improving service to returning veterans to its expert study Panel. The Panel provided reactions and guidance that shaped the next phase of data collection, lasting from March until June 2008. This round of interviews and other data collection focused on developing strategies that would have the greatest potential to help VA and its partners implement improvements to the system of benefits and care for OEF/OIF and other veterans. Five such strategies, described in this report as “strategies for success,” resulted from this effort. This stage of the inquiry also was aimed at identifying specific actions, consistent with the strategies for success, that would provide a road map to carrying out these organizational strategies in a sustained way over the next few years. This data collection effort is represented in the figure below and the details for each research question are shown at the end of this appendix.

Summary of Relationship Between Eight VA Contract Primary Research Questions and the Ongoing Work of the Academy Panel

Eight VA Contract Primary Research Issues, September 2007, with Explanation of Links	Excerpts from Academy Work in Progress Summary: "Organizing Care for Returning War Veterans," October 2007	Selected Excerpts from Academy Staff Implementation Challenges, March 2008	Excerpts from Strategies Identified by Academy Panel, March 20, 2008
<p><i>I. Whether there is a seamless transition mission statement that is universally understood throughout VA.</i></p> <p>VA's strategic plan and VA/DOD Joint Executive Committee (JEC) strategic plan both include goals related to "seamlessness". Achieving seamless transition is one of VA's four strategic goals and one of the Secretary's five priorities. The Joint DoD/VA Executive Committee strategic plan also includes a strategic goal for the seamless coordination of benefits. Employees' understanding of these goals is a function whether there is a "a line of sight" between the strategic goals and individual employee's work. The team's work will identify barriers/enablers to this</p>	<p><i>• whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></p> <p><i>• whether VA's management, staffing and other resources, and management policies and processes are adequate...;</i></p> <p><i>• what performance measures are appropriate for managing and determining the effectiveness of VA's efforts to provide a seamless transition;</i></p>	<p><b>Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration</b>  ". . . . To address the changing status and needs of the returning veteran, personnel of one organization must listen to and coordinate with personnel of others while remaining accountable to their own organizations. . . ."</p> <p><b>Implementation Challenge # : Improving Intra-Agency Coordination</b>  ". . . .The challenge is to refine and manage the key integration points between VBA and VHA in order to insure timely, effective, seamless care and benefits appropriate for each veteran. . . ."</p> <p>". . . .VHA/VBA intra-agency coordination is critical to the "seamlessness" of service member transitions to civilian life. . . ."</p> <p>". . . .The line between VHA's disability examiners, who develop a medical finding, and VBA's disability raters, who rely on that finding to establish a compensation level, is a key coordination point or "seam." Although the process is not well understood by most veterans, this seam has contributed to delayed disability decisions with adverse effects on the veterans affected. . . ."</p>	<p><b>Creating a Veteran-Centered Care Management Approach</b>  ". . . . a broad organizational reorientation that will require consistent vision and leadership over a long horizon. Part of the work will be to assess the reasons why the One VA vision articulated in the past and the major reorientation of systems, roles, and organization required to realize this vision, have not been fully realized. . . ."</p> <p>". . . ."</p> <ul style="list-style-type: none"> <li>Implementation would require the VA to restructure its internal and external communications and information systems to support ready access to integrated veterans records.</li> <li>In its use of IT, the reorientation would require the VA to eliminate redundant data entry and create a virtual data warehouse linking all pertinent veteran records, including those from military service;</li> <li>VA and its partners would need to continue developing a web-based portal for easy veteran access to all relevant service information and personal records.</li> <li>Changes in roles and organization, perhaps requiring different competencies.</li> <li>Reorientation of internal and external communications."</li> </ul> <p>Intra-VA Collaboration/Partial Examinations and Rating  ". . . Administrative changes that will be delineated . . . include, in addition to integration of VBA and VHA records and systems awards for multiple disability claims (allowing partial payments as disabilities are verified); and support for the move being considered to centralizing ratings of self-reported conditions such as PTSD (center of excellence)."</p>

Thus, the findings, conclusions, and recommendations in this report are supported by extensive interview with a variety of substantive experts and sources of information, as well as documentary data from a wide variety of archival sources, the professional literature, Congressional reports and testimony, and other dependable, high quality sources. All conclusions and recommendations are the responsibility of the Academy Panel that guided the work. VA, which provided valuable assistance in the execution of the work, provided a technical review of a draft of this report, and its comments have been considered and addressed as appropriate.

**Examples of Significant Prior Recommendations  
Posing Organization and Management Challenges to VA**

- **The Secretaries of VA and DoD should revise their health care organizational structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments. (2003)**
- Develop a joint DoD/VA process for disability benefit determinations by establishing a cooperative Medical and Physical Evaluation Board process within the military service branches and VA. **(GWOT)**
- VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment. **(Disabilities)**
- Aggressively prevent and treat Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). DoD and VA must rapidly improve prevention, diagnosis, and treatment of both PTSD and TBI. At the same time, both Departments must work aggressively to reduce the stigma of PTSD. **(Dole-Shalala)**
- Immediately create comprehensive recovery plans to provide the right care and support at the right time in the right place. **(Dole-Shalala)**
- Expand collaboration between VA and the Department of Health and Human Services to improve access to returning service members in remote or rural areas. **(GWOT)**
- Require VA to provide full support at Post-Deployment Health Reassessments for Guard and Reserve members to enroll eligible members and schedule appointments. **(GWOT)**.
- DoD and VA should jointly develop an interactive “My eBenefits” website that provides a single information source for service members. **(Dole-Shalala)**

**Abbreviations Key**

- President’s Commission On Care For America’s Returning Wounded Warriors *(Dole-Shalala)*
- Task Force on Returning Global War on Terror Heroes *(GWOT)*
- Veterans’ Disability Benefits Commission *(Disabilities)*
- Independent Review Group On Rehabilitative Care And Administrative Processes At Walter Reed Army Medical Center And National Naval Medical Center *(IRG)*
- President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans *(2003)*

## Compilation of 41 Selected Prior Panel Recommendations for Improvements in VA's System of Care and Benefits

The prior panels were:

- President's Commission On Care For America's Returning Wounded Warriors (*Dole-Shalala*)
- Task Force on Returning Global War on Terror Heroes (*GWOT*)
- Veterans' Disability Benefits Commission<sup>291</sup> (*Disabilities*—\*) indicates one of 14 priority recommendations)
- Independent Review Group On Rehabilitative Care And Administrative Processes At Walter Reed Army Medical Center And National Naval Medical Center (*IRG*)
- President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (*2003*)

### Management structures/policy coordination/strategic management

1. **Improvements in functioning of the Joint Executive Committee (JEC):** These recommendations are relevant because the JEC will most likely assume responsibilities for implementing many of the changes being considered by the current SOC.
  - a. **VA and DoD should enhance the JEC's strategic plan by including specific milestones and designating an official to be responsible for ensuring that the milestones are reached.** (*Disabilities*)
  - b. **Department of Labor and SSA should be included in the JEC to improve the transition process.** (*Disabilities*)
  - c. **Congress should amend the fiscal year 2003 National Defense Authorization Act to create a broader charter beyond healthcare for the interagency leadership committee. Additionally, consideration should be given to using civilian experts as consultants to the committee to bring in new perspectives regarding collaboration and sharing.** (*2003*)
  - d. **The Secretaries of VA and DoD, based on the recommendations of the interagency leadership committee, should provide significantly enhanced authority, accountability, and incentives to health care managers at the local and regional levels in order to enhance standardized and collaborative activities that improve health care delivery and control costs.** (*2003*)
  - e. **The Departments should consistently utilize a joint strategic planning and budgeting process for collaboration and sharing to institutionalize the development of joint objectives, strategies, and best practices, along with accountability for outcomes.** (*2003*)

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<sup>291</sup>Seven of the recommendations in the Disability Benefits Commission's report were labeled "no action required" and therefore were not included in the categories in this document.

- f. **The Departments should jointly develop metrics (with indicated accountability) that measure health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing and desired outcomes. In the annual report prescribed in Recommendation 1.1, the interagency leadership committee should include these results and discuss the coming year's goals. (2003)**
2. **The Secretaries of VA and DoD should revise their health care organizational structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments. (2003)**
3. Develop a plan for augmenting research capability within DoD and VA to more systematically generate evidence on the health of veterans. *(Disabilities)*
  - a. Develop a strategic plan for research on the health of veterans, particularly those returning from conflicts in the gulf and Afghanistan. *(Disabilities)*
4. Congress should establish an executive oversight group to ensure timely and effective implementation of the Commission recommendations. This group should be co-chaired by VA and DoD and consist of senior representatives from appropriate departments and agencies. It is further recommended that the Veterans' Affairs Committees hold hearing and require annual reports to measure and assess progress. *(Disabilities\*)*

**Restructure the disability rating process/improve rating quality**

5. Completely Restructure the Disability and Compensation Systems *(Dole-Shalala)*

There was general consensus that DoD should determine fitness of duty and VA should determine disability, and a single medical examination be used to meet the needs of both Departments. The Dole report proposes that DoD conduct the exam. According to GAO, the medical examination pilot may include different scenarios with respect to who conducts the exam and the role of the individual Services and DoD in determining fitness. Specific recommendations are below.

- a. DoD maintains authority to determine fitness to serve. For those found not fit for duty, DoD shall provide payment for years served. VA then establishes the disability rating, compensation, and benefits. *(Dole-Shalala)* VA and DoD should realign the disability evaluation process so that the services determine fitness for duty and service members who are found unfit are referred to VA for disability rating. All conditions that are identified as part of a single, comprehensive medical examination should be rated and compensated. *(Disabilities\*)*
  - i. The Secretary of Defense should provide recommendations to Congress to amend Title 10 United States Code, Chapter 61, and Title 38 United States Code, to allow the 'fitness for duty' determination to be

adjudicated by the Department of Defense and the disability rating be adjudicated by the Department of Veterans Affairs. **(IRG)**

- ii. Following the changes to the United States Code, the Secretary of Defense, should quickly promulgate regulatory guidelines and policy to the Service Secretaries. **(IRG)**
- iii. Implement the single physical exam. Review the 1998 Department of Defense memorandum of understanding (MOU) between the Department of Defense and Department of Veterans Affairs, implement a common physical for use by the Services and the Department of Veterans Affairs for those service members in the physical disability evaluation system, and allow flexibility in the timelines test or procedures that would eliminate redundant efforts. **(IRG)**
  - a. VA and the Department of Defense should conduct a comprehensive multidisciplinary medical, psychological, and vocational evaluation of each veteran applying for disability compensation at the time of service separation. **(Disabilities)**
  - b. The Departments should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. **(2003)**
  - c. DoD should mandate that separation examinations be performed on all service members. **(Disabilities)**
- iv. Develop a joint DoD/VA process for disability benefit determinations by establishing a cooperative Medical and Physical Evaluation Board process within the military service branches and VA. **(GWOT)**
  - a. The Under Secretary of Defense (Personnel & Readiness) should completely overhaul the physical disability evaluation system to implement one Department of Defense level Physical Evaluation Board/Appeals Review Commission with equitable Service representation and expand what is currently the Disability Advisory Council. **(IRG)**
  - b. The Secretary of Defense and Secretary of Veterans Affairs should establish one solution. Develop and utilize one disability rating guideline that remains flexible to evolve and be updated as the trends in injuries and supporting medical documentation/treatment necessitate. Revise the current process of updating the disability ratings system to include an operation update that pushes changes to the field on a weekly, or as needed basis. **(IRG)**



- c. VA and DoD should adopt a consistent and uniform policy for rating disabilities, using the VA Schedule for Rating Disabilities *(Disabilities)*
    - v. The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should direct the transition process be streamlined for the service member separating from the Department of Defense and entering the Department of Veterans Affairs. *(IRG)*
- 6. The rating process should have built-in checks or periodic evaluations to ensure inter-rater reliability as well as the accuracy and validity of rating across impairment categories, ratings, and regions. *(Disabilities)*
  - a. Educational and training programs for VBA raters and VHA examiners should be developed, mandated, and uniformly implemented across all regional offices with standardized performance objectives and outcomes. These programs should make use of advances in adult education techniques. External consultants should serve as advisors to assist in the development and evaluation of the educational and training programs. *(Disabilities)*
- 7. VA should establish a recurring assessment of the substantive quality and consistency, or inter-rater reliability, of examinations performed with the templates and, if the assessment finds problems, take steps to improve quality and consistency, e.g., by revising the templates, changing the training, or adjusting the performance standards for examiners. *(Disabilities)*
- 8. VA raters should have ready access to qualified health-care experts who can provide advice on medical and psychological issues that arise during the rating process (e.g., interpreting evidence or assessing the need for additional examinations or diagnostic test. *(Disabilities)*
- 9. The Secretary of Defense should request the Secretary of Veterans Affairs to update the Code of Federal Regulations, Title 38, Part IV to account for the unique disabilities and needs of traumatic amputees and burn victims, focused on a loss of function and post-service needs. This would require an expedited process for publishing the change. *(IRG)*

**Improve diagnosis, treatment, and prevention of Post Traumatic Stress Disorder and Traumatic Brain Injury**

- 10. Aggressively prevent and treat Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI).) DoD and VA must rapidly improve prevention, diagnosis, and treatment of both PTSD and TBI. At the same time, both Departments must work aggressively to reduce the stigma of PTSD *(Dole-Shalala)*
  - a. VA should provide care for any veteran of the Afghanistan and Iraq conflicts who has PTSD. *(Dole-Shalala)*
    - i. Screen all GWOT veterans seen in VA health care facilities for mild to moderate TBI. *(GWOT)*

- ii. A national standardized training program should be developed for VA and VA-contracted clinicians who conduct compensation and pension psychiatric evaluations. This training program should emphasize diagnostic criteria for PTSD and comorbid conditions with overlapping symptoms, as set forth in the Diagnostic and Statistical Manual. *(Disabilities)*
- iii. Psychological testing for PTSD should be conducted at the discretion of the examining clinician. *(Disabilities)*
- iv. VA should establish a holistic approach that couples PTSD, compensation, and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness. *(Disabilities\*)*
- v. VA should collect more detailed research on military sexual assault and PTSD and develop and disseminate reference materials for raters. *(Disabilities)*
- vi. VA should develop and implement new criteria specific to PTSD in the VA Schedule for Rating Disabilities. Base those criteria on the Diagnostic and Statistical Manual of Mental Disorders and consider a multidimensional framework for characterizing disability due to posttraumatic stress disorder. *(Disabilities\*)*
- vii. VA should immediately begin to update the current Rating Schedule, beginning with those body systems addressing the evaluation and rating of post-traumatic stress disorder (PTSD) and other mental disorders and of traumatic brain injury (TBI). Then proceed through the other body systems until the Rating Schedule has been comprehensively revised. The revision process should be completed within five years. VA should create a system for keeping the Rating Schedule up to date, including a published schedule for revising each body system. [Consider first part related to PTSD.](Disabilities\*)
- viii. VA should establish a certification program for raters who deal with PTSD claims, as well as provide training to support the certification program and periodic recertification. PTSD certification requirements should be regularly reviewed and updated to include medical advances and to reflect lessons learned. The program should provide specialized training on the psychological and medical issues (including comorbidities) that characterize the claimant population, and give guidance on how to appropriately manage commonly encountered rating problems. *(Disabilities)*

- ix. VA should consider a baseline level of benefits described by Institute of Medicine to include health care as an incentive for recovery for posttraumatic stress disorder as it relapses and remits. *(Disabilities)*
- b. The Assistant Secretary of Defense (Health Affairs) should
  - i. expand the Millennium Cohort study to include traumatic brain injury and PTSD. *(IRG)*
  - ii. in conjunction with the Services, develop and implement functional and cognitive measurements upon entry to military service for all recruits. *(IRG)*
  - iii. develop coding guidelines for traumatic brain injury and disseminate Military Health System-wide. This represents an interim measure until updates in the International Classification of Diseases and Diagnostic and Statistical Manual of Mental Disorders occur. *(IRG)*
  - iv. include functional and cognitive screening on the post-deployment health assessment and reassessment. *(IRG)*
  - v. develop and issue a policy requiring ‘exposures to blasts’ be noted in a patient’s medical record. *(IRG)*
  - vi. develop comprehensive and universal clinical practice guidelines for blast injuries and traumatic brain injuries with post traumatic stress disorder overlay, and disseminate Military Health Systemwide. This is an urgent requirement. *(IRG)*
- c. The Army Surgeon General should ensure behavioral specialists are assigned to the Medical Hold and Holdover Companies to meet the needs of patients with traumatic brain injury and PTSD. Additional staff is needed to help identify patients who exhibit mental health problems such as depression, substance abuse, and suicidal behavior. *(IRG)*
- d. The Services should implement training for interpreters of the screening tools to recognize potential cases of traumatic brain injuries and PTSD. *(IRG)*.
- e. The Services should commence cognitive remediation for service members experiencing any decreases in cognitive ability, from their baseline, occurring during their service. *(IRG)*
- f. The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should establish a center of excellence for traumatic brain injury and post traumatic stress disorder, seeking support from the private sector where appropriate. *(IRG)*

- The center should combine existing research platforms within the Department of Defense and the Department of Veterans Affairs.
  - The center should include the breadth of research, training, and clinical services.
  - The center should define the military uniqueness of traumatic brain injury.
11. VA and DoD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events. *(2003)*

**Coordination of services/individual plans and increased access to services; improved case management and access to information to facilitate seamless transition; optimum care**

12. Immediately create comprehensive recovery plans to provide the right care and support at the right time in the right place. *(Dole-Shalala)*
- a. Create a patient-centered Recovery Plan for every seriously injured service member that provides the right care and support at the right time in the right place. A corps of well-trained, highly-skilled Recovery Coordinators must be swiftly developed to ensure prompt development and execution of the Recovery Plan. *(Dole-Shalala)*
  - b. VA and DoD should jointly create an intensive case management program for severely disabled veterans with an identifiable lead agent. *(Disabilities)*
  - c. Develop a system of co-management and case management for returning service members to facilitate ease of transfer from Department of Defense care to VA care. *(GWOT)*
  - d. Standardize VA Liaison agreements across all Military Treatment Facilities. *(GWOT)*
  - e. The Assistant Secretary of Defense (Health Affairs), in conjunction with the Service Surgeons General, should
    - i. provide the resources to staff and train case managers at all Military Treatment Facilities in accordance with the Department of Defense guidelines. *(IRG)*
    - ii. immediately develop or modify existing Tri-Service policy and regulatory guidelines for case management services in line with currently accepted medical practice, to ensure the efficient and effective transfer of the patient throughout the continuum of care.

These guidelines should include the identification of outcome criteria and establish measurements to assess compliance. **(IRG)**

- f. The Assistant Secretary of Defense (Health Affairs) should modify the Department of Defense TRICARE Management Activity Medical Management Guide to define clear standards, qualifications, and training requirements for case managers. **(IRG)**
  - g. The Service Surgeons General, in conjunction with the Commanders of military treatment facilities, should ensure proper initial and recurring training is conducted for case management personnel in line with the guidance set forth in the revised Department of Defense TRICARE Management Activity Medical Management Guide. **(IRG)**.
  - h. The Army Surgeon General should review patient populations and nature of injury and illness and determine if patients can be moved from the Walter Reed Army Medical Center campus to medical treatment facilities close to the service members' homes or home units. This will provide a better environment for patients and their families and may prove more economical for the government. **(IRG)**
  - i. The Army Surgeon General should develop and institute a training program for the Medical Holdover Cadre that contains a specific focus on the care of wounded, ill, and injured service members, assistance to families, and the administrative care of patients in a hospital setting. Follow-up action and inspection of training effectiveness should be accomplished within 60 days of training implementation. **(IRG)**
13. Expand collaboration between VA and the Department of Health and Human Services to improve access to returning service members in remote or rural areas. **(GWOT)**
14. Increase attendance at the Transition Assistance and Disabled Transition Assistance Programs (TAP/DTAP) for active duty, Guard, and Reserve. **(GWOT)**
15. VA and DoD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. **(2003)**
- a. One-stop shopping should provide: (1) a standard discharge examination suitable to document conditions that might indicate a compensable condition; (2) full outreach; (3) claimant counseling; and (4) when appropriate, referral for a Compensation and Pension examination and follow-up claims adjudication and rating. **(2003)**
  - b. DoD and VA should make transitioning service members aware of Social Security Disability Insurance. **(Disabilities)**

- c. VA and DoD should collaborate on policy and program changes, through local sharing arrangements, which would permit prescriptions written by either VA or MTF providers to be filled for dual users by the other Department's pharmacies. *(2003)*
  - d. DoD should require a mandatory benefits briefing to all separating military personnel, including Reserve and National Guard components, prior to discharge from service. *(Disabilities)*
16. Require VA to provide full support at Post-Deployment Health Reassessments for Guard and Reserve members to enroll eligible members and schedule appointments. *(GWOT)*.
  17. The Secretary of Defense should pursue partnerships with the Secretary of Veterans Affairs to provide treatment; promote education and research in prosthesis care, production, and amputee therapy. *(IRG)*
  18. The Administration should direct HHS to declare the two Departments to be a single health care system for purposes of implementing Health Insurance Portability and Accountability Act regulations. *(2003)*
  19. All applicants for Individual Unemployability should be screened for employability by vocational rehabilitation and employment counselors. *(Disabilities)*
  20. In addition to medical evaluations by medical professionals, VA should require vocational assessment in the determination of eligibility for individual unemployability benefits. Raters should receive training on how to interpret findings from vocational assessments for the evaluation of individual unemployability claims. *(Disabilities)*
  21. The administration of the Vocational Rehabilitation and Employment Program should be enhanced by increased staffing and resources, tracking employment success beyond 60 days, and conducting satisfaction surveys of participants and employers. *(Disabilities)*
  22. VA should develop and test incentive models that would promote vocational rehabilitation and return to gainful employment among veterans for whom this is a realistic goal. *(Disabilities)*
  23. The VA Global War on Terrorism newsletter mailed quarterly to returning service members will be modified to provide consistent summaries and awareness of available Federal services and benefits. *(GWOT)*

**Improved processing, tracking, including records exchange, timely diagnosis and rating, and rating quality**

There is general consensus regarding the need for improvements in data exchange, interoperability of DoD and VA data, and the need for more complete patient information,

particularly with respect to exposure. This has been a longstanding issue--2003 task report highlighted the need for changes in this area. Exposure data will be the responsibility of DoD.

#### 24. Rapidly Transfer Patient Information Between DoD and VA (*Dole-Shalala*)

- a. DoD and VA must move quickly to get clinical and benefit data to users. (*Dole-Shalala*)
- b. Expand VA access to DoD records to coordinate improved transfer of a service member's medical care through patient "hand-off." (*GWOT*)
- c. VA and DoD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards-based. (*2003*)
- d. Improve the data linkage between the electronic health record data systems used by DoD and VA—including capabilities for handling individual soldier exposure information that is included as part of the individual's health record. (*Disabilities/Institute of Medicine*)
- e. DoD should provide an authenticated electronic DD 214 to VA (*Disabilities*); Upon separation, DoD should transmit an electronic DD214 to VA. (*2003*)
- f. VA and DoD should improve electronic information record transfers and address issues of lost, missing, and unassociated paper records. (*Disabilities*)
- g. Create a DoD/VA interface for health care providers to have access to data on combat theater injured service members. (*GWOT*)
- h. VA and DoD should expedite development and implementation of compatible information systems including a detailed project management plan that includes specific milestones and lead agency assignment. (*Disabilities\**)
- i. By fiscal year 2004, VA and DoD should initiate a process for routine sharing of each service member's assignment history, location, occupational exposure, and injuries information. (*2003*)
- j. DoD should standardize the definition of the term "severely injured" among the services and with VA, and create a common database of severely disabled service members. (*Disabilities*)
- k. Rapidly develop a standard automated systems interface for both clinical and administrative systems that allows bilateral electronic exchange of information. Review and implement the recommendations of the 2003 President's Task Force. (*IRG*) Develop a data interface that allows VA to access the electronic exposure data systems used by DoD. (*Disabilities*)

1. DoD and VA should establish and implement mechanisms to identify, monitor, track, and medically treat individuals involved in research and other activities that have been classified and are secret. **(Disabilities)**
25. DoD and VA should jointly develop an interactive “My eBenefits” website that provides a single information source for service members. **(Dole-Shalala)**
26. VA and DoD should integrate clinical pharmacy initiatives through the coordinated development of: 1) a national joint core formulary; and 2) a single, common clinical data screening tool by fiscal year 2005 that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DoD dual users across both systems. **(2003)**
27. Improve claims cycle time by:
  - establishing a simplified and expedited process for well documented claims, using best business practices and maximum feasible use of information technology; and
  - implementing an expedited process by which the claimant can state the claim information is complete, and waive the time period (60 days) allowed for further development. **(Disabilities\*)**
28. Assist the VA enrollment process by modifying the VA 10-10EZ form for GWOT service members, enhance the on-line benefits package to self-identify GWOT service member, and expand the use of DoD military service information to establish eligibility for health care benefits. **(2003)**
29. Enhance the Computerized Patient Record System (CPRS) to more specifically track GWOT service members. **(GWOT)**
  - a. Develop a Veterans Tracking Application and identifiers to improve monitoring of returning GWOT service members. **(GWOT)**
  - b. Create a Polytrauma identifier to increase recognition of additional needs of those injured service members. **(GWOT)**
  - c. Create a Traumatic Brain Injury (TBI) database to track patients who have experienced TBI. **(GWOT)**
30. Assess the potential for enhancing research through record linkage using the DoD and VA administrative and health record databases. **(Disabilities)**
31. Reduce the appellate workload by focusing on improved accuracy in the initial decision-making process, enhance the appeals process by ensuring adequate resources to dispose of existing workload on a timely basis, and deploy technology for electronic records transfer between field offices and the Board of Veterans Appeals. **(Disabilities)**



32. Create an “Embedded Fragment” surveillance center to monitor returning service members who have possibly retained fragments of materials in order to provide early medical intervention. **(GWOT)**
33. Establish registries of service members and veterans based on exposure, deployment, and disease histories. **(Disabilities)**
34. Ensure implementation of the DoD strategy for improved exposure assessment and exposure data collection. **(Disabilities)**
35. Conduct a critical evaluation of gulf war troop tracking and environmental exposure monitoring data so that improvements can be made in this key DoD strategy for characterizing exposures during deployment. **(Disabilities)**
36. VA and DoD should be directed to collect and study appropriate data, with due restrictions to ensure privacy. These agencies should be granted statutory authority to obtain appropriate data from the Social Security Administration and the Office of Personnel Management only for the purpose of periodically assessing appropriate benefits delivery program outcomes. **(Disabilities)**

#### National Guard/Reserve-Related

37. The Service Secretaries should review and update applicable directives to ensure there is no distinction in the care management and disability processing of Active Component and activated Reserve Component service members. **(IRG)**
38. Benefit Delivery at Discharge should be available to all disabled exiting service members (to include National Guard, Reserve, and medical hold patients). **(Disabilities)**
39. The Secretary of Defense should initiate a thorough review of post-service Reserve Component health care and develop systems and policies that assure quality care is delivered for service connected illness and injuries. **(IRG)**
40. The Secretary of Defense, in conjunction with the Service Secretaries, should establish a program that returns previously deployed Reserve Component service members back to an active status for a Post Deployment Health Reassessment and an evaluation by a medical professional, six months post demobilization. **(IRG)**
41. The Secretary of the Army should continue to build the success of the Community Based Health Care Organization program and expand where possible. Other Services should be encouraged to use this program. **(IRG)**

**Summary of Relationship Between Eight VA Contract Primary Research Questions and the Work of the Academy Panel**

<p align="center"><b>Eight VA Contract Primary Research Issues, September 2007, with Explanation of Links</b></p>	<p align="center"><b>Excerpts from Academy Work in Progress Summary: “Organizing Care for Returning War Veterans,” October 2007</b></p>	<p align="center"><b>Selected Excerpts from Academy Staff Implementation Challenges, March 2008</b></p>	<p align="center"><b>Excerpts from Strategies Identified by Academy Panel, March 20, 2008</b></p>
<p><b>1. Whether there is a seamless transition mission statement that is universally understood throughout VA.</b></p> <p>VA’s strategic plan and VA/DOD Joint Executive Committee (JEC) strategic plan both include goals related to “seamlessness”. Achieving seamless transition is one of VA’s four strategic goals and one of the Secretary’s five priorities. The Joint DoD/VA Executive Committee strategic plan also includes a strategic goal for the seamless coordination of benefits. Employees’ understanding of these goals is a function of whether there is “a line of sight” between the strategic goals and an individual employee’s work. The team’s work will identify</p>	<ul style="list-style-type: none"> <li>• <i>whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></li> <li>• <i>whether VA’s management, staffing and other resources, and management policies and processes are adequate. . . ;</i></li> <li>• <i>what performance measures are appropriate for managing and determining the effectiveness of VA’s efforts to provide a seamless transition;</i></li> </ul>	<p><b>Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration</b>          “. . . . To address the changing status and needs of the returning veteran, personnel of one organization must listen to and coordinate with personnel of others while remaining accountable to their own organizations. . . .”</p> <p><b>Implementation Challenge #2 : Improving Intra-Agency Coordination</b>          “. . . .The challenge is to refine and manage the key integration points between VBA and VHA in order to insure timely, effective, seamless care and benefits appropriate for each veteran. . . .”</p> <p>“. . . .VHA/VBA intra-agency coordination is critical to the “seamlessness” of service member transitions to civilian life. . . .”</p> <p>“. . . .The line between VHA’s disability examiners, who develop a medical finding, and VBA’s disability raters, who rely on that finding to establish a compensation level, is a key coordination point or “seam.” Although the process is not well understood by most veterans, this seam has contributed to delayed disability decisions with adverse effects on the veterans affected. . . .”</p>	<p><b>Creating a Veteran-Centered Care Management Approach</b>          “. . . . a broad organizational reorientation that will require consistent vision and leadership over a long horizon. Part of the work will be to assess the reasons why the <i>One VA</i> vision articulated in the past and the major reorientation of systems, roles, and organization required to realize this vision, have not been fully realized. . . .”</p> <p>“. . . .</p> <ul style="list-style-type: none"> <li>• Implementation would require the VA to restructure its internal and external communications and information systems to support ready access to integrated veterans records.</li> <li>• In its use of IT, the reorientation would require the VA to eliminate redundant data entry and create a virtual data warehouse linking all pertinent veteran records, including those from military service;</li> <li>• VA and its partners would need to continue developing a web-based portal for easy veteran access to all relevant service information and personal records.</li> <li>• Changes in roles and organization, perhaps requiring different competencies.</li> <li>• Reorientation of internal and external communications.”</li> </ul> <p><b>Intra-VA Collaboration/Partial Examinations and Rating</b>          “. . . Administrative changes that will be delineated . . . include, in addition to integration of VBA and VHA records and systems awards for multiple disability claims (allowing partial payments as disabilities are verified); and support for</p>

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<p>barriers/enablers to this line of sight, including the use of performance measures, common definitions for different categories of veterans that require VA services, and integrated business processes and information systems.</p>		<p><b>Implementation Challenge #3 : Strengthening Services and Benefits</b>                      “Recent commission reports on how to improve transitions of those returning from Iraq and Afghanistan have focused primarily on improving the system of care for [severely injured service members (about 3,000)]. The challenge for this group focuses on developing a patient-centered and integrated system of care across the military and VA health care systems, . . .”</p> <p><b>Implementation Challenge #4 : Improving the Examination and Rating Process</b>                      “Concern over excessive delays in the process of reviewing and rating Compensation and Pensions . . . claims and in processing appeals is long standing. Further, the need to identify ways to achieve more timely, accurate, and consistent disability rating decisions was identified by all of the commissions that have reviewed VA issues. . . .”</p> <p><b>Strategy for Continuous Improvement</b>                      “ These challenges will require creative management solutions that reallocate authority and control over resources and allow for continuing adjustment to, for example, advances in scientific understanding of how to diagnose and treat specific illnesses and injuries.”</p>	<p>the move being considered to centralizing ratings of self-reported conditions such as PTSD (center of excellence).”</p> <p><b>Continuous Improvement Strategies for VA/DOD</b>                      “. . . a further assessment of the types of measures (e.g., balanced scorecard being developed by the SOC) that are now helping guide the effort to provide seamless transition. . . .”</p>

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<p><b>2. What health care services and benefit issues are faced by active duty personnel who are transitioning to veteran status, along with the issues faced by their eligible family members.</b></p> <p>This question will be addressed by analyzing (1) results of over 75 interviews within and outside VA, (2) several hundred recommendations from past commission studies (3) more recent studies (RAND and IBM) and journal articles, and (4) recent congressional testimony related to seamless transition. Also, we will be analyzing survey responses to the Dole/Shalala survey by veteran category—National Guard, Reserve, or former active military. Site visits have been conducted at Philadelphia Regional Office, Philadelphia Medical</p>	<ul style="list-style-type: none"> <li>• <i>whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></li> <li>• <i>whether VA’s management, staffing and other resources, and management policies and processes are adequate. . . ;</i></li> <li>• <i>the roles of service providers such as nursing and social work organizations in transition;</i></li> <li>• <i>unique conditions or issues applicable to returning national guard and reservists;</i></li> </ul>	<p><b>Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration</b>          “The transition from active combat through demobilization to home, family, and veteran status is often challenging for the individual, especially where there are medical considerations involved as well. . . .”</p> <p>“Previous studies and commissions have focused on identifying and recommending fixes for specific problems affecting the transition from service to veteran status or from combat to care and recovery without addressing the institutional barriers to improved care and transition, notably the limited history of DoD/VA cooperation. Institutional factors limiting joint planning, policy agreement and operational coordination have not been analyzed in any depth.”</p> <p><b>Implementation Challenge #2 : Improving Intra-Agency Coordination</b>          “. . . The line between VHA’s disability examiners, who develop a medical finding, and VBA’s disability raters, who rely on that finding to establish a compensation level, is a key coordination point or “seam.” Although the process is not well understood by most veterans, this seam has contributed to delayed disability decisions with adverse effects on the veterans affected. . . .”</p>	<p><b>Creating a Veteran-Centered Services Management Approach</b>          “. . . Part of the work will be to assess the reasons why the <i>One VA</i> vision articulated in the past and the major reorientation of systems, roles, and organization required to realize this vision, have not been fully realized. . . .”</p> <p><b>Intra-VA Collaboration/Partial Examinations and Rating</b>          “. . . in the absence of fundamental restructuring of the disability ratings system, administrative changes can have only limited impact on the speed and quality of claims filing. Lessons may be drawn from a review of the BDD experience. Administrative changes that will be delineated . . . include, in addition to integration of VBA and VHA records and systems addressed as part of the overarching strategy:</p> <ul style="list-style-type: none"> <li>• further automation of records transfer and sharing between VBA and VHA;</li> <li>• implementation of rolling disability awards for multiple disability claims (allowing partial payments as disabilities are verified); and</li> <li>• support for the move being considered to centralizing ratings of self-reported conditions such as PTSD (center of excellence).”</li> </ul> <p><b>Targeted Outreach</b>          “. . . identify actions to improve cost-effective outreach and assistance to returning war veterans and their family members in understanding benefits, seeking advice and assistance, and accessing appropriate services. [I]dentify working systems for managing care to dispersed or elusive populations and their use to proactively find those at risk and support preventive intervention.”</p>

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<p>Center, Tampa Medical Center, Washington DC Medical Center, two Vet Centers, and Walter Reed. The analysis of this information will identify gaps in services or care for particular groups, including the less severely injured, those returning to communities distant from VA facilities, and those with signs of PTSD, milder TBI, or other stress-related emotional problems.</p>		<p><b>Implementation Challenge #3 : Strengthening Services and Benefits</b>                      “. . . The second group, who may suffer from PTSD and other mental conditions, are, in some respects more complex. This group may be reluctant to seek care because of perceived stigma associated with being diagnosed with a mental illness, may not recognize they need care, or may want to avoid care because of fears of revisiting the trauma. Those willing to seek care may see the VA as an organization that serves older veterans or does not provide care in locations or at hours that accommodate their individual work and family circumstances.”</p> <p><b>Implementation Challenge #4 : Improving the Examination and Rating Process</b>                      “Another challenge in the examination and rating process is the limited availability of integrated data and shared tools within VA. While . . . considerable attention has been paid to better integration of medical records between VHA and DoD, less effort has been devoted to improving data sharing between VHA and VBA. CAPRI and the Veteran’s Tracking Application (VTA) are the only systems . . . .”</p> <p><b>Implementation Challenge #5 : Developing a Targeted Outreach Strategy</b>                      “. . . Two recent commission reports made recommendations related to increasing attendance at the general TAP briefings, one of VA’s outreach vehicles. It is unclear from</p>	<p><b>Strengthening Care</b>                      “. . . will describe models for broader use of individual recovery plans (for less seriously injured veterans and those with emotional illnesses) with the goal of reintegration into civilian society, and review administrative roles of case managers and organizations in clinical specialties such as nursing and social work encountered by returning veterans[;] specify possibilities for expanding use of fee–basis care for veterans without ready access to care, including those in the National Guard and Reserve forces [; and] include a review of the Project HERO demonstration.”</p> <p><b>VA/DOD Coordination</b>                      “. . . Our principal focus should be on improving VA’s capacities to react and respond to, and to achieve positive outcomes regarding, veteran health and benefit needs once information is received from DOD. Effective collaboration will be supported by the development of outcome goals and measures . . . and their use to guide joint planning and separate accountability for improving outcomes for returning veterans.”</p>

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		<p>these reports whether the lack of a DoD requirement to attend them is the only reason for less than full participation. Perhaps, younger veterans who are accustomed to conducting business via the internet are less interested in traditional face-to-face briefings. Also, as GAO noted, quick demobilization of Guard and Reservists may limit their opportunities to attend the briefings. Ideally, benefits information tailored to the veteran’s individual’s circumstances in an electronic format may be more useful than a general face-to-face briefing. . . .”</p> <p><b><i>Strategy for Continuous Improvement</i></b>  “ These challenges will require creative management solutions that reallocate authority and control over resources and allow for continuing adjustment to, for example, advances in scientific understanding of how to diagnose and treat specific illnesses and injuries.”</p>	

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<p><b>3. Which VA Health Administration (VHA) case management services and organizations in clinical specialties, such as social work and nursing, are OEF/OIF veterans encountering in transition from active duty to veteran status.</b></p> <p>The team is collecting information on the various types of case management services veterans face in transitioning from DoD to VA medical care. In addition, obstacles and gaps that limit the performance of those components will become apparent. This will extend to both case management and clinical organizations, and include the roles of social work and nursing.</p>	<ul style="list-style-type: none"> <li>• <i>whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></li> <li>• <i>whether VA’s management, staffing and other resources, and management policies and processes are adequate. . .;</i></li> <li>• <i>the roles of service providers such as nursing and social work organizations in transition;</i></li> </ul>	<p><b>Implementation Challenge #2 : Improving Intra-Agency Coordination</b>  “[VHA] operates through a decentralized Veteran’s Integrated Service Network (VISN) structure, in which a great degree of autonomy is afforded individual VA hospitals and Hospital Directors in managing both resources and patient care. This decentralization and local control is appropriate for engaging in the highly personal relationships that VHA staff must maintain with veterans who require medical care and attention.<sup>2</sup> In furtherance of this approach, VHA has created a number of positions during the past year that are designed to manage all aspects of care and transition, including clinical case managers and others dedicated to helping veterans manage the various non-clinical aspects of reintegrating into civilian life.”</p> <p><b>Implementation Challenge #3 : Strengthening Services and Benefits</b>  “ . . . . The VA and its partners face different sets of challenges in Strengthening Services and Benefits for two different groups of OEF/OIF service members: (1) a relatively small population of severely injured service members (about 3,000) who may enter the VA system after initial care at a Military Treatment Facility (MTF), and who are likely to become veterans; and (2) a much larger OEF/OIF veteran population--100,580 in FY 2007—who have a potential diagnosis</p>	<p><b>Creating a Veteran-Centered Care Management Approach</b>  “. . . It is a broad organizational reorientation that will require consistent vision and leadership over a long horizon. Part of the work will be to assess the reasons why the <i>One VA</i> vision articulated in the past and the major reorientation of systems, roles, and organization required to realize this vision, have not been fully realized. . . .”</p> <p><b>Strengthening Care</b>  “. . . will describe models for broader use of individual recovery plans (for less seriously injured veterans and those with emotional illnesses) with the goal of reintegration into civilian society, and review administrative roles of case managers and organizations in clinical specialties such as nursing and social work encountered by returning veterans. . . .”</p> <p><b>Targeted Outreach</b>  “[I]dentify actions to improve cost-effective outreach and assistance to returning war veterans and their family members in understanding benefits, seeking advice and assistance, and accessing appropriate services [and] working systems for managing care to dispersed or elusive populations and their use to proactively find those at risk and support preventive intervention.”</p>

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		<p>of a mental disorder.</p> <p>“ . . . The challenge for this [relatively small]group focuses on developing a patient-centered and integrated system of care across the military and VA health care systems, including provision of longer-term recovery support for those who need it. The challenges in caring for the second group, who may suffer from PTSD and other mental conditions, are, in some respects more complex. This group may be reluctant to seek care because of perceived stigma associated with being diagnosed with a mental illness, may not recognize they need care, or may want to avoid care because of fears of revisiting the trauma. Both parts of this analysis raise questions about longer-term recovery support”</p> <p><b><i>Implementation Challenge #4 : Improving the Examination and Rating Process</i></b></p> <p><b><i>Implementation Challenge #5 : Developing a Targeted Outreach Strategy</i></b></p> <p><b><i>Strategy for Continuous Improvement</i></b>          “ These challenges will require creative management solutions that reallocate authority and control over resources and allow for continuing adjustment to, for example, advances in scientific understanding of how to diagnose and treat specific illnesses and injuries.”</p>	



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<p><b>4. Whether effective management structures and inter-agency coordination processes, such as Benefits Delivery at Discharge (BDD), are in place between VA and the Department of Defense to ensure that VA services are provided in a timely and efficient manner.</b></p> <p>The team has collected data on VA/DoD collaboration at a strategic level as well as at the operational level at several points during the transition process. These include the ongoing pilot of a single medical examination to support VA’s and DoD’s disability decisions, DoD/VA’s efforts to improve interoperability of medical records, and DoD’s sharing of the results of its Post Deployment Health Reassessments. Interviews have been</p>	<ul style="list-style-type: none"> <li>• <i>whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></li> <li>• <i>whether coordination is sufficient between DoD and VA;</i></li> <li>• <i>whether VA’s management, staffing and other resources, and management policies and processes are adequate. . . ;</i></li> <li>• <i>the roles of service providers such as nursing and social work organizations in transition;</i></li> <li>• <i>unique conditions or issues applicable to returning national guard and reservists;</i></li> </ul>	<p><b>Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration</b></p> <p>“ . . . to properly support an eventual seamless transition from active duty to veteran status, the interaction between DoD and VA processes must start soon after a person enters the service, given that important information is generated then and that the person becomes eligible even while on active duty for certain VA benefits such as insurance.”</p> <p>“ . . . To address the changing status and needs of the returning veteran, personnel of one organization must listen to and coordinate with personnel of others while remaining accountable to their own organizations. . . .”</p> <p>“A performance-driven management structure and philosophy supported by specific techniques can help VA and its partners drive continuous improvement in outcomes for veterans.”</p> <p>“ . . . The two primary measures used to assess VA performance for OIF/OEF wounded veterans were developed by the Office of Seamless Transition in cooperation with VHA’s Office of Quality and Performance. . . .”</p> <p><b>Implementation Challenge #3 : Strengthening Services and Benefits</b></p> <p>“ . . . . The VA and its partners face different sets of challenges in Strengthening Services and Benefits for two different groups of OEF/OIF service members: (1) a relatively</p>	

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<p>conducted with key DoD officials on the Senior Oversight Committee as well as staff at Walter Reed. VA officials are being asked to comment about how the degree of DoD coordination and information sharing affects their ability to do their jobs.</p>		<p>small population of severely injured service members (about 3,000) who may enter the VA system after initial care at a Military Treatment Facility (MTF), and who are likely to become veterans; and (2) a much larger OEF/OIF veteran population--100,580 in FY 2007-- who have a potential diagnosis of a mental disorder. . . .”</p> <p><b><i>Implementation Challenge #4 : Improving the Examination and Rating Process</i></b>  “Concerns about whether the disability program and the rating schedule were achieving their intended purpose led Congress in 2004 to create a Veterans’ Disability Benefits Commission (VDBC). The Commission, whose report was issued in October 2007, addressed the appropriateness and purpose of benefits, benefit levels, and payment rates, as well as the processes and procedures used to determine eligibility. Additional concerns, triggered by media reports about lapses in the post-acute care treatment of injured service personnel at Walter Reed Medical Center, led to the creation of the Presidents’ Commission on Care for America’s Returning Wounded Warriors (Dole/Shalala), which examined perceived inadequacies and disparities in both military service medical discharge policies and in VA disability benefits. The recommendations of these commissions for fundamental revision of the disability ratings system raise complex policy questions that go to the underlying purposes</p>	

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		<p>and objectives of the entire program . . .                      [T]he focus here is on improvements that can be addressed through administrative and organizational changes without regard to the fundamental policy and legislative bases for the disability rating system.”</p> <p><b><i>Implementation Challenge #5 : Developing a Targeted Outreach Strategy</i></b>                      “There are three aspects to VA’s outreach challenges. These are to: (1) effectively partner with DoD to obtain access to the relevant medical and service records of veterans who may be at risk for behavioral health issues; . . . .”</p> <p><b><i>Strategy for Continuous Improvement</i></b>                      “Even without such a fundamental revision of the disability and compensation system, VA and DoD could revise their procedures and systems to incorporate long-term recovery plans and goals for veterans. These could be scaled down from the individual recovery plans now being developed for severely injured veterans. Further, VBA benefits such as vocational rehabilitation and education could be integrated with VHA’s health services as part of a single plan for the fullest possible recovery and reintegration into civilian society. This change in approach and philosophy would be an organizing principle for a complex effort to refocus and redesign the work of the VA and its partners.”</p>	

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<p><b>5. What is the most effective organizational placement of the VA Office of Seamless Transition and what staffing levels are needed for optimum functionality.</b></p> <p>This question has been somewhat overtaken by events since the Office of Seamless Transition has been eliminated at VA. However, the functions of that Office are being performed in other locations within VA, and the issue of the proper placement of activities relating to transition issues is being explored explicitly or implicitly in a broad array of interviews and document reviews.</p>	<ul style="list-style-type: none"> <li>• <i>whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></li> <li>• <i>whether coordination is sufficient between DoD and VA;</i></li> <li>• <i>whether VA’s management, staffing and other resources, and management policies and processes are adequate. . . ;</i></li> <li>• <i>what performance measures are appropriate for managing and determining the effectiveness of VA’s efforts to provide a seamless transition;</i></li> </ul>	<p><b>Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration</b>          “. . . To address the changing status and needs of the returning veteran, personnel of one organization must listen to and coordinate with personnel of others while remaining accountable to their own organizations. . . .”</p> <p><b>Implementation Challenge #2 : Improving Intra-Agency Coordination</b>          “. . . The challenge is to refine and manage the key integration points between VBA and VHA in order to insure timely, effective, seamless care and benefits appropriate for each veteran. . . .”</p> <p>“. . . VHA/VBA intra-agency coordination is critical to the “seamlessness” of service member transitions to civilian life. . . .”</p> <p>“. . . The two primary measures used to assess VA performance for OIF/OEF wounded veterans were developed by the Office of Seamless Transition in cooperation with VHA’s Office of Quality and Performance. . . .”</p> <p><b>Implementation Challenge #5 : Developing a Targeted Outreach Strategy</b>          “. . . [the Physical Evaluation Board] (PEB) process determines whether a service member is fit to continue service or must be discharged or retired. In September 2005,</p>	<p><b>Creating a Veteran-Centered Care Management Approach</b>          “. . . .</p> <ul style="list-style-type: none"> <li>• Implementation would require the VA to restructure its internal and external communications and information systems to support ready access to integrated veterans records.</li> <li>• Changes in roles and organization, perhaps requiring different competencies.</li> <li>• Reorientation of internal and external communications.”</li> </ul> <p><b>VA/DOD Coordination</b>          “. . . Effective collaboration will be supported by the development of outcome goals and measures . . . and their use to guide joint planning and separate accountability for improving outcomes for returning veterans. “</p> <p><b>Continuous Improvement Strategies for VA/DOD</b>          “. . . the types of measures (e.g., balanced scorecard being developed by the SOC) that are now helping guide the effort to provide seamless transition. . . .”</p>

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		<p>DoD required that each of the military services provide a list of service members undergoing the PEB process to VA. A month later, VA’s Office of Seamless Transition reported it received its first PEB list from DoD.”</p> <p><b><i>Strategy for Continuous Improvement</i></b>                      “ These challenges will require creative management solutions that reallocate authority and control over resources and allow for continuing adjustment to, for example, advances in scientific understanding of how to diagnose and treat specific illnesses and injuries.”</p>	

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<p><b>6. Which organizational factors may obstruct or enable VA’s ability to provide appropriate and timely mental health care services to returning service members transitioning to veteran status, including the unique role of Vet Centers and their relationship to VHA mental health services programs.</b></p> <p>Providing appropriate and timely mental health care services is one of the key health care challenges the team is examining as it could potentially affect hundreds of thousands of veterans. Work will involve interviewing key federal and state stakeholders and reviewing recent research and evaluation reports. The team is also collecting information on VA’s initiatives to increase access to mental health services.</p>	<ul style="list-style-type: none"> <li>• <i>whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></li> <li>• <i>whether coordination is sufficient between DoD and VA;</i></li> <li>• <i>whether VA’s management, staffing and other resources, and management policies and processes are adequate. . . ;</i></li> <li>• <i>the roles of service providers such as nursing and social work organizations in transition;</i></li> <li>• <i>unique conditions or issues applicable to returning national guard and reservists;</i></li> </ul>	<p><b>Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration</b>  <i>“ . . . Joint progress on major problems has been slow. For example, GAO noted last year that the two departments have been working for almost 10 years to facilitate the exchange of medical information. Yet, the continuing inability to share records electronically on a timely basis remains a major impediment to seamless transition. . . ”</i></p> <p><i>“ The Act also mandates that the two Secretaries direct joint planning by DoD, the military departments, and VA for the prevention, diagnosis, mitigation, treatment, and rehabilitation of, and research on, traumatic brain injury, post-traumatic stress disorder, and other mental health conditions in service members, including planning for their seamless transition from DoD care to VA care.”</i></p> <p><b>Implementation Challenge #3 : Strengthening Architecture for Services and Benefits</b>  <i>“ . . . The challenge for this group focuses on developing a patient-centered and integrated system of care across the military and VA health care systems, including provision of longer-term recovery support for those who need it. The challenges in caring for the second group, who may suffer from PTSD and other mental conditions,</i></p>	<p><b>Intra-VA Collaboration/Partial Examinations and Rating</b>  <i>“ . . . in the absence of fundamental restructuring of the disability ratings system, administrative changes can have only limited impact on the speed and quality of claims filing. Lessons may be drawn from a review of the BDD experience. Administrative changes that will be delineated . . . include, in addition to integration of VBA and VHA records and systems addressed as part of the overarching strategy: further automation of records transfer and sharing between VBA and VHA; implementation of rolling disability awards for multiple disability claims (allowing partial payments as disabilities are verified); and support for the move being considered to centralizing ratings of self-reported conditions such as PTSD (center of excellence).”</i></p> <p><b>Strengthening Care</b>  <i>“ . . . will describe models for broader use of individual recovery plans (for less seriously injured veterans and those with emotional illnesses) with the goal of reintegration into civilian society, and review administrative roles of case managers and organizations in clinical specialties such as nursing and social work encountered by returning veterans. . . . will specify possibilities for expanding use of fee–basis care for veterans without ready access to care, including those in the National Guard and Reserve forces. . . . will include a review of the Project HERO demonstration. . . .”</i></p> <p><b>Targeted Outreach</b>  <i>“[I]dentify actions to improve cost-effective outreach and assistance to returning war veterans and their family members in understanding benefits, seeking advice and assistance, and accessing appropriate services [and] working systems for managing care to dispersed or elusive populations and their use to proactively find those at risk and support preventive</i></p>

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		<p>are, in some respects more complex. This group may be reluctant to seek care because of perceived stigma associated with being diagnosed with a mental illness, may not recognize they need care, or may want to avoid care because of fears of revisiting the trauma. Those willing to seek care may see the VA as an organization that serves older veterans or does not provide care in locations or at hours that accommodate their individual work and family circumstances.”</p> <p>“Mental health care is provided at each of VA’s 153 medical centers and 882 outpatient clinics. With respect to PTSD, the Dole/Shalala report characterized the VA as “the recognized leader in the treatment of combat-related PTSD with an extensive network of specialized inpatient, outpatient, day hospital, and residential treatment programs.”<sup>23</sup> VA operates a network of more than 160 specialized PTSD treatment programs.<sup>24</sup> In addition to VA’s National Center for PTSD, VA has 10 Mental Illness Research, Education, and Clinical Centers, including one that was established at the Durham Medical Center in 2004 to focus on post-deployment health issues.”</p> <p><b>Implementation Challenge #4 : Improving the Examination and Rating Process</b></p> <p>“...in the case of Post-Traumatic Stress Disorder (PTSD), documentary evidence is compiled regarding the veteran’s exposure to trauma and combined with medical</p>	<p>intervention.”</p> <p><b>VA/DOD Coordination</b></p> <p>“... achieve positive outcomes regarding, veteran health and benefit needs once information is received from DOD. Effective collaboration will be supported by the development of outcome goals and measures . . . and their use to guide joint planning and separate accountability for improving outcomes for returning veterans. ”</p>

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		<p>assessments of the current extent of the condition. The claim package typically includes DoD medical treatment records and military service records, VA medical records (including specific examinations ordered by VBA’s rater in the course of the review), and any supporting material necessary to compile a complete picture of the veteran’s condition. VBA reports that there are significant problems with claims by National Guard/Reserve members with OIF/OEF service. Such claims are the most incomplete, and VBA has difficulty obtaining records from the local units. Further, there are inconsistencies between the major components of the National Guard and Reserve system. Obtaining records from the Army Reserve is more difficult than from National Guard, because of the Army Reserve’s more centralized organizational structure and a lack of full-time support personnel at Reserve units to fulfill the requests.”</p> <p><b><i>Implementation Challenge #5 : Developing a Targeted Outreach Strategy</i></b>            “There are three aspects to VA’s outreach challenges. These are to: (1) effectively partner with DoD to obtain access to the relevant medical and service records of veterans who may be at risk for behavioral health issues; (2) provide important health and benefit information to soon-to-be veterans in an understandable and timely manner; and (3) target outreach to veterans</p>	



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		<p>who are most in need of medical care.”</p> <p>“With respect to outreach for service members who have potential mental health issues, a troubling aspect of the JEC plan is that a key performance measure for assessing progress in whether post deployment health referrals that result in medical care will not be developed until September 30, 2009.”</p> <p><b><i>Strategy for Continuous Improvement</i></b>                      “Basic questions inevitably will be asked about whether the changes resulting from the SOC’s efforts have been successful in the most fundamental terms, i.e., numbers of service members reintegrated successfully into civilian life; numbers of seriously injured restored to fullest possible functioning and health; and effectiveness of specific strategies for early diagnosis and treatment of signs of PTSD, TBI, and other trauma-related mental illness.”</p>	

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<p><b>7. What are the advantages and disadvantages of current “continuum of care” options for catastrophically injured service members returning from Afghanistan and Iraq, including care options when maximum medical improvement has been reached.</b></p> <p>The team has learned that the term “catastrophic” has a particular significance with respect to care and benefits. As the team continues to examine care from an administrative perspective, it will include questions in interviews related to this category of veterans.</p>	<ul style="list-style-type: none"> <li>• <i>whether VA’s management, staffing and other resources, and management policies and processes are adequate . . . ;</i></li> <li>• <i>the roles of service providers such as nursing and social work organizations in transition;</i></li> </ul>	<p><b>Implementation Challenge #3 : Strengthening Services and Benefits</b>  “ . . . . The VA and its partners face different sets of challenges in Strengthening Services and Benefits for two different groups of OEF/OIF service members: (1) a relatively small population of severely injured service members (about 3,000) who may enter the VA system after initial care at a Military Treatment Facility (MTF), and who are likely to become veterans; and (2) a much larger OEF/OIF veteran population-- 100,580 in FY 2007-- who have a potential diagnosis of a mental disorder. ”</p> <p><b>Implementation Challenge #4 : Improving</b>  “Veterans presenting multiple conditions, particularly the seriously injured, require a more complicated analysis of data by the raters, as the examination results may indicate varying degrees of disability for different conditions. At present, there is no standard approach or protocol for applying a complex set of examinations into a single rating determination and only there is limited use of automated computation support. Tools, such as those for data mining, to search records or artificial intelligence to apply complex principles to the fact set for a particular veteran are unavailable. ”</p>	<p><b>Strengthening Care</b>  “ . . . will describe models for broader use of individual recovery plans (for less seriously injured veterans and those with emotional illnesses) with the goal of reintegration into civilian society, and review administrative roles of case managers and organizations in clinical specialties such as nursing and social work encountered by returning veterans. , , will specify possibilities for expanding use of fee–basis ‘ care for veterans without ready access to care, including those in the National Guard and Reserve forces. . . . will include a review of the Project HERO demonstration.”</p>

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<p><b>8. Are VA Office of Seamless Transition and other relevant key VA performance measures and metrics for measuring results adequate and how do they compare when benchmarked to best measurement practices.</b></p> <p>This is a recurring question in interviews and document reviews. The study team has reviewed the VA’s array of current performance measures for transitions as reported in the Department’s Performance and Accountability report and in the budget documents. The VA officer responsible for coordinating preparation of the Department’s annual performance plan has been interviewed. Several experts on performance measurement in VHA have been questioned about the current measures and their plans and views on</p>	<ul style="list-style-type: none"> <li>• <i>whether health care and benefits are provided in a way that is seamless, effective, efficient, and equitable;</i></li> <li>• <i>what performance measures are appropriate for managing and determining the effectiveness of VA’s efforts to provide a seamless transition;</i></li> </ul>	<p><b>Implementation Challenge #1 : Sustaining Effective VA/DoD Collaboration</b></p> <p>“The VA and DoD have engaged in an unprecedented and productive executive-level collaboration through the Senior Oversight Committee (SOC) since mid-2007 to respond to the recommendations of prior study panels. The challenge is to how to sustain the executive-level collaboration when the SOC disbands, most likely by the end of this year. In addition, VA/DoD need to improve collaboration at VA and DoD operating levels, both on a voluntary basis and where mandated by Congress.”</p> <p><b>Implementation Challenge #2 : Improving Intra-Agency Coordination</b></p> <p>“... The two primary measures used to assess VA performance for OIF/OEF wounded veterans were developed by the Office of Seamless Transition in cooperation with VHA’s Office of Quality and Performance. . . .”</p> <p>“The primary linkages between VHA and VBA exist at the operational level between VHA doctors who conduct the C&amp;P exams and the Veterans Service Center staff who process the claims. Service Center Managers are typically engaged with their clinical counterparts, as well as medical administrative staff, to coordinate physician training in the examination templates and processes, as well as training for raters on</p>	<p><b>VA/DOD Coordination</b></p> <p>“... Effective collaboration will be supported by the development of outcome goals and measures . . . and their use to guide joint planning and separate accountability for improving outcomes for returning veterans.”</p> <p><b>Continuous Improvement Strategies for VA/DOD</b></p> <p>“... the types of measures (e.g., balanced scorecard being developed by the SOC) that are now helping guide the effort to provide seamless transition. . . .”</p>

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<p>alternative or supplemental measures. Similar questions about appropriate measures and indicators of long-term outcomes as well as intermediate outcomes and other indicators of performance have been posed in interviews with DoD officials involved in the work of the SOC and with VA program, concerning the expected outcomes of specific programs and the SOC lines of action. Review of the JEC also included an assessment of the adequacy and appropriateness of performance targets for improving transitions. A request to review the balanced scorecard developed by the SOC is pending.</p>		<p>medical principles. Senior VA management executives are not operational stakeholders in the integration, but use metrics associated with the lack of it (e.g., delays in claim processing). There is no formal relationship between the VBA and VHA executive levels relating to consultation on integration issues, . . . .”</p> <p>“VBA is responsible for metrics associated with time to process disability claims. The VHA physicians are part of this process, but are not formally held accountable for their performance, timeliness, or thoroughness in servicing this veteran transition point. Historically, VBA has tracked “inadequate” examination rates (i.e., the percentage that have had to be redone because they were inadequate for disability evaluation purposes). This metric was tracked at the local level by administrators, but was not necessarily used as the basis for physician accountability. Additional information is necessary to determine whether and to what extent this continues to be true.</p> <p>If recovery and reintegration of wounded, injured, or ill war veterans is a shared goal of VHA and VBA, joint tracking and accountability for measures of their success in restoring war veterans to the full enjoyment of their lives as civilians would be expected. However, each organization appears to be continuing to work separately on performance measures.”</p>	

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		<p><b><i>Implementation Challenge #3 : Strengthening Architecture for Services and Benefits</i></b>                      “Developing comprehensive, automated, customized recovery plans with appropriate metrics: Academy staff have not yet had an opportunity to review the prototype for the IRP. To add value to the existing care process, the IRPs should be tailored to different types of severe injuries and include specific goals/accomplishments for rehabilitation and reintegration of the service member into the community. Baseline information about the patient’s pre-injury cognitive/physical abilities would be an essential ingredient in establishing these goals. . . .”</p> <p><b><i>Implementation Challenge #4 : Improving the Examination and Rating Process</i></b>                      “Metrics related to this topic exist for two processes: 1) Claim processing time (a VBA metric); and 2) Examination efficiency and quality (a VHA metric tracked by CPEP). Claim processing time is measured several ways, including the average duration in calendar days and the extent of the inventory/backlog of claims. VBA has strategic goals of 125 days to process a C&amp;P claim<sup>7</sup> (actual duration was 177 days in April 2007) and 100 days for processing seriously injured veteran claims.<sup>8</sup> Durations for DES pilot claims are 245 days, as this process includes both MEB and PEB</p>	

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		<p> durations and multiple points in the process for appeals and rating reconsideration. From the VBA standpoint, shortened time periods occur mainly in the examination period during the first 80 days of the process, as all examinations must be completed within 35 days, rather than 70 or more under the existing process.”</p> <p> “A number of performance metrics have been identified to measure the success of the pilot. These include “timeliness” (measured at every phase of the process, or handoffs within and among DoD and VA10) and “effectiveness.” The effectiveness metrics address differences in outcomes (e.g., total disability ratings, average rating percent per condition) between pilot and current processes, though it is not clear whether higher ratings equate with better ratings. Modifications to the approach and a decision to scale up will be taken later this year when these metrics have been collected and a formative evaluation of the pilot is completed by Booz Allen Hamilton. CPEP is measuring several aspects of performance to assess the impact of using the automated examination templates. These include efficiency measures (e.g., time spent conducting the examination), and “quality” as indicated by reduced errors of omission, and more thorough results. This in turn affects time spent reviewing the record during rating, another measure of efficiency.”</p>	

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		<p><i>Strategy for Continuous Improvement</i>                      “Clear goals and strong performance measurement would enable VA and DoD to improve their efforts to facilitate transitions demonstrate accountability to external stakeholders including Congress and the Administration. They will also support internal management decisions regarding the best use of resources, technology investment, and program design.”</p> <p>“A performance-driven management structure and philosophy supported by specific techniques can help VA and its partners drive continuous improvement in outcomes for veterans.”</p>	



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