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Veterans Health Administration

The **Veterans Health Administration** (**VHA**) is the component of the United States Department of Veterans Affairs (VA) led by the Under Secretary of Veterans Affairs for Health[2] that implements the healthcare program of the VA through the administration and operation of numerous VA Medical Centers (VAMC), Outpatient Clinics (OPC), Community Based Outpatient Clinics (CBOC), and VA Community Living Centers (VA Nursing Home) Programs.

Many evaluations have found that by most measures VHA care is equal to, and sometimes better than, care provided in the private sector, when judged by standard evidence-based guidelines.[5][6][7][8][9][10][11][12][13][14]

The VHA is distinct from the U.S. Department of Defense Military Health System of which it is not a part.

The VHA division has more employees than all other elements of the VA combined.

Agency overview	
Formed	1865[1]
Jurisdiction	Federal government of the United States
Headquarters	Veteran Affairs Building 810 Vermont Avenue NW., Washington, D.C., United States 38°54′03″N 77°02′05″W
Employees	348,389 (2020)[2]
Annual budget	$85 billion USD (2020)[2]
Agency executives	Robert Wilkie[3], Secretary Vacant, Under Secretary for Health Richard A. Stone, M.D.[4], Executive in Charge, Veterans Health Administration
Parent agency	United States Department of Veterans Affairs

Contents

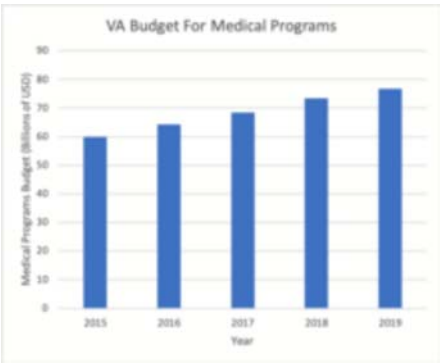
Website	www.va.gov /HEALTH/ (https://www.va.gov/HEALTH/)

VHA Nationalized Healthcare System

The Veterans Health Administration is a form of nationalized healthcare service in the United States that provides healthcare to Veterans. What makes this type of healthcare different from other forms in the United States is that everything is owned by and operated by the Department of Veterans Affairs as opposed to private companies which is what we see in other parts of the health care market. This means that all the medical facilities that are part of the VHA are owned by the US Government and all

the doctors and workers at the facilities are paid by the government.[15] What is a more common model in the United States is that consumers have private health insurance and the medical facilities used are all privatized. As of 2017 the Census found that 67.2% of Americans have private health coverage.[16] Since the VHA is nationalized they receive funding from the Department of Veterans Affairs, which is allocated funds by the federal government.[17] Because of this, Veterans that qualify for VHA healthcare do not pay premiums or deductibles for their healthcare, but may have to make copayments depending on what procedure they are having.[18][19] The funding the VA receives is split into mandatory, which is an amount of spending dictated by law, and discretionary spending, which is spending that can be adjusted year to year. In 2020 the budget given to the VA was $220.2 billion, of which 56% was mandatory spending and 44% was discretionary. From the discretionary funding, 87.6% was allocated to medical programs which came to a total VHA budget of $85 billion.[17]

History



Medical Program Budget Allocation 2015-2019. Data comes from VA budget submissions.[17]

The first Federal agency to provide medical care to veterans was the Naval Home in Philadelphia, Pennsylvania. The home was created in 1812 and was followed by the creation of Soldiers Home in 1853 and St. Elizabeth's Hospital in 1855. Congress created the National Home for Disabled Volunteer Soldiers in 1865 in response to the high number of Civil War casualties. These homes were initially intended to be room and board for disabled veterans. However, by the late 1920s, the homes were providing a level of care comparable to hospital care.

President Hoover created the Veterans Administration (VA) in 1930 to consolidate all veteran services. General Omar N. Bradley was appointed to VA administrator and Bradley appointed Major General Paul Hawley as director of VA medicine, both in 1945. Hawley successfully established a policy that affiliated new VA hospitals with medical schools. Hawley also promoted resident and teaching fellowships at VA hospitals. Ultimately, Hawley was responsible for starting the hospital-based research program at the VA. Bradley resigned in 1947. However, upon resignation, 97 hospitals were in operation and 29 new hospitals had been built. As a result, the VA health system was able to serve a much larger population of veterans than it had served in previous years.

In 1988, President Reagan signed the Department of Veterans Affairs Act, which elevated the VA to Cabinet-level, then becoming known as the Department of Veterans Affairs. The Department of Veterans Affairs oversees the Veterans Health Administration.[20]

In the mid-1980s the VHA was criticized for their high operative mortality. To that end, Congress passed Public Law 99-166 in December 1985 which mandated the VHA to report their outcomes in comparison to national averages and the information must be risk-adjusted to account for the severity of illness of the VHA surgical patient population. In 1991 the National VA Surgical Risk Study (NVASRS) began in 44 Veterans Administration Medical Centers. By December 31, 1993 there was information for 500,000 non-cardiac surgical procedures. In 1994 NVASRS was expanded to all 128 VHA hospitals that performed surgery. The name was then changed to the National Surgical Quality Improvement Program.[21]

Beginning in the mid-1990s VHA underwent what the agency characterizes as a major transformation aimed at improving the quality and efficiency of care it provides to its patients. That transformation

included eliminating underutilized inpatient beds and facilities, expanding outpatient clinics, and restructuring eligibility rules. A major focus of the transformation was the tracking of a number of performance indicators—including quality-of-care measures—and holding senior managers accountable for improvements in those measures.[22]

Veterans Health Administration scandal of 2014

In 2014, Congress passed the VA Access, Choice and Accountability Act. (https://indypendent.org/2020/05/as-covid-rages-will-the-va-be-there-for-future-generations-of-veterans/) VA Secretary Robert Wilkie assured veterans that the VA wouldn't be privatized and that veterans would still be able to get the same quality of care they had been receiving.[23] In May 2014, major problems with scheduling timely access to medical care became public. According to a retired doctor at the center interviewed by CNN, at least 40 veterans died waiting for care at the Phoenix, Arizona Veterans Health Administration facilities. An investigation of delays in treatment throughout the Veterans Health Administration system was conducted by the Veterans Affairs Inspector General, but it only found six deaths during the delay.[24][25] On May 30, 2014, Secretary of Veterans Affairs Eric Shinseki resigned from office due to the fallout from the scandal.[26] Despite the negative exposure and the subsequent vows by Washington lawmakers to take action, the major problems still exist.[27][28]

On June 24, 2014, Senator Tom Coburn, Republican from Oklahoma, and a medical doctor, released a report called Friendly Fire: Death, Delay, and Dismay at the VA which detailed the actions and misconduct of employees of the Department of Veteran Affairs. The report is based on yearlong investigations conducted by Senator Coburn's office on Veterans Health Administration facilities across the nation. The report details the many veterans who have died waiting for health care as a result of the VA misconduct. Secret waiting lists, poor patient care, the millions of dollars that are intended for health care that has gone unspent every year and reports of bonuses paid out to employees who have lied and covered up statistics are also detailed in the report.[29]

However, a VA Inspector General's report issued on August 26, 2014, reported that six, not forty, veterans had died experiencing "clinically significant delays" while on waiting lists to see a VA doctor, and in each of these six cases, "we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans."[30][31]

Since the 2014 scandal in which the quality administration of health care by the VA was brought into question due to long wait times and secret waiting lists, the VA claims wait times have improved.[32] According to a study conducted by the Journal of the American Medical Association, JAMA, in 2014 the average wait times to receive health care from the VHA was a little longer, but still comparable to wait times to see private doctors. The 2014 wait times JAMA found were 22.5 and 18.7 days for the VHA and private doctors respectively. The study also found that three years later, in 2017, VHA wait times were significantly shorter than wait times to see a private doctor. The wait times in 2017 were 17.7 and 29.8 days for the VHA and private doctors respectively.[33]

VA Health Reform

1993 Clinton Healthcare Reform

The Clinton Healthcare Plan was a health care reform proposed by the Clinton Administration. Even

though the reform was not successful, a task force was created in response to the Clinton Healthcare Reform proposal to determine if the VA was ready for managed care.[34] The negative results of market research forced the VA system to re-evaluate its current operations. Research revealed that three out of four veterans would leave the VA network if a national healthcare system were adopted. They also found that there was a high demand for primary care throughout the VA system. Research showed that many VA facilities believed that 55 percent of patients would choose to receive primary care at the VA facility if a primary care system was fully implemented in 1993. The study also showed that the VA facilities believed that 83 percent of veterans would choose to receive primary care at the VA if fully implemented by 1998. These results made it clear to the administration that it was time for a reform.[35]

1994 VA Primary Care Directive

This directive required all VA facilities to have primary care teams by year 1996.[36] As a result, percentage of patients receiving primary care at the VA increased from 38 percent to 45 percent to 95 percent, during 1993, 1996, and 1999.[35] This mandate served as the foundation for the VA reorganization under Dr. Kenneth W. Kizer.

Dr. Kenneth W. Kizer and the VA Reform

Dr. Kizer, a physician trained in emergency medicine and Public Health, was appointed by President Bill Clinton as Director of U.S. Veterans Health Administration in 1994. He was hired to update and modernize the VA health system in order to eliminate negative perception and to align the system with current market trends. Core issues included:

- Advancements in technology and biomedical knowledge
- Aging and socioeconomically disadvantaged Medicare patients
- Coordinating care
- Rising healthcare costs

There was much opposition to a major reform. Many legislators preferred an incremental change over a wide-scale reform. However, Kizer was known as being very innovative. To publicize his vision he expressed his mission and vision of the "new VHA" and outlined seven key principles to guide change. His ultimate goal was to provide coordinated, high quality care at a low cost.

He launched his reorganization plan in 1995 by decentralizing the VA system. He organized all VA operating units into 22 geographic based networks known as Veterans Integrated Service Networks (VISNs). This allowed networks to manage themselves and adapt to the demographics of their location. Patients were then assigned to a group of doctors who would provide coordinated care. One director was hired for each VISN network. Instead of hiring all directors internally, a third of the newly hired VISN directors were hired outside of the VA system. The directors were responsible for meeting performance goals and improving upon measurable key efficiency and quality indicators. Directors monitored performances and reports were generated to show each network's performance. Some of these indicators included:

- chronic disease quality
- prevention performance
- patient satisfaction ratings
- utilization management

The reform also changed the procedure for allocating funds to the various VISNs. Historically, funds were distributed between hospitals based on historical costs. However, it was found that this method affected efficiency and quality of services. Therefore, funding for each VISN was distributed based on the number of veterans seen in each network, rather than on historical values.[37]

The New England Journal of Medicine conducted a study from 1994–2000 to evaluate the efficacy of the healthcare reform. They gathered the results of the evaluated key indicators from each of the networks and interpreted the results. There were noticeable improvements, compared with the same key indicators used for the Medicare fee for service system, as soon as two years after the reorganization. These improvements continued through year 2000. These results indicate that the changes made throughout the VA healthcare system, under the leadership of Kizer, did improve the efficiency and quality of care in VA healthcare system.[38]

Use of electronic records

VHA is especially praised for its efforts in developing a low cost open source electronic medical records system VistA[39] which can be accessed remotely (with secure passwords) by health care providers. With this system, patients and nurses are given bar-coded wristbands, and all medications are bar-coded as well. Nurses are given wands, which they use to scan themselves, the patient, and the medication bottle before dispensing drugs. This helps prevent four of the most common dispensing errors: wrong med, wrong dose, wrong time, and wrong patient. The system, which has been adopted by all veterans hospitals and clinics and continuously improved by users, has cut the number of dispensing errors in half at some facilities and saved thousands of lives.[40]

At some VHA medical facilities, doctors use wireless laptops, putting in information and getting electronic signatures for procedures. Doctors can call up patient records, order prescriptions, view X-rays or graph a chart of risk factors and medications to decide treatments. Patients have a home page that have boxes for allergies and medications, records every visit, call and note, and issues prompts reminding doctors to make routine checks. This technology has helped the VHA achieve cost controls and care quality that the majority of private providers cannot achieve.[41] The Veterans Health Administration Office of Research and Development's research into developing better-functioning prosthetic limbs, and treatment of PTSD are also heralded. The VHA has devoted many years of research into the health effects of the herbicide Agent Orange used by military forces in Vietnam.

In October 2012, the VHA announced a new goal "to care for and heal our wounded Veterans. In addition to repairing their damaged bodies and minds, VA has embarked on a unique campaign to repair their crumbling intimate relationships."[42][43]

Initiatives

The VHA has expanded its outreach efforts to include men and women veterans and homeless veterans.

The VHA, through its academic affiliations, has helped train thousands of physicians, dentists, and other health professionals. Several newer VA medical centers have been purposely located adjacent to medical schools.

The VHA support for research and residency/fellowship training programs has made the VA system a

leader in the fields of geriatrics,[44][45] spinal cord injuries,[46] Parkinson's disease [1] (http://www.parkinsons.va.gov/), and palliative care.

The VHA has initiatives in place to provide a "seamless transition" to newly discharged veterans transitioning from Department of Defense health care to VA care for conditions incurred in the Iraq War or war in Afghanistan.

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The VHA has also adopted Boston University's Project RED program,[47] designed to improve the discharge process for veterans in hopes that, by educating patients, the VHA will experience a reduced number of readmission among veterans and provide more information on telerehabilitation.[48]

Services

Mental health

Outpatent clinic in Petersburg, West Virginia

The percentage of patients with a mental illness was 15 percent in 2007. The percentage of veterans with mental illnesses has trended up. The VHA allocated an extra $1.4 billion per year to mental health program between 2005 and 2008. Mental health services in 2006 were evaluated as a part of the Mental Health Strategic Plan.[49][50] The report concluded:

> "Quality of care at the VA was shown to be better than the private sector. The VA had a higher level of performance then the private sector for 7 out of 9 indicators. In fact, they "exceeded private plan performance by large margins....Patients did not indicate improvement in their conditions. However, they had a very favorable opinions of their care.[49]

In 2009, the VA implemented an initiative called Suicide Assessment and Follow-Up Engagement: Veteran Emergency Treatment (SAFE VET) to identify and treat veterans at risk of suicide by providing care coordination for outpatient mental health services and community-based support.[51]

PTSD

Veteran Affairs utilization rates among Iraqi and Afghanistan-war veterans in the mid-Atlantic region

with PTSD diagnosis between 2002–2008 were tracked using ICD-9 codes of those newly diagnosed. When compared to veterans already being treated, veterans new to VA treatment program were less likely to complete follow up visits, and had fewer medication-possession days (74.9 days versus 34.9 days); also long wait times hindered VA medical utilization.[52] Limitations to this study included: type of treatment intervention was not delineated; only looked at PTSD treatment over a short period of time (180 days).

Another study found there was an increase in demand of the VA health system among veterans. Nearly 250,000 veterans were identified between 2001 and 2007; Iraq and Afghanistan war veterans had a 40 percent utilization rate, compared to only 10 percent of Vietnam veterans.[53] Veterans were categorized into three groups: non-mental health diagnosis, non-PTSD mental diagnosis, and PTSD mental diagnosis.[53] The most prevalent diagnosis was PTSD. The typical veteran affected by PTSD was male, from the Army or Marines, and a lower-ranked officer.[53] Veterans with PTSD had a high utilization of the VA system at over 91 percent.[53]

While this was a comprehensive study, there is more to be studied and understood about the effects of PTSD on returning veterans from active combat. A major limitation is that this study only captured the utilization of veterans within the VA health system. There was no data on veterans who sought medical services outside of the VA health system. We can have a better understanding of the mental health needs of veterans returning to civilian life. Moreover, it would be beneficial to explore and examine how utilization of mental health services is affected by the stigma that persists among veterans. Additional awareness of medical resources available to veterans can help to erase the stigma of seeking mental health treatment.

Women

With the population of women veterans projected to rise from 1.6 million in 2000 to 1.9 million in 2020, the VA has worked to integrate quality women's medical services into the VA system.[54] However, studies show that 66.9 percent of women who do not use the VA for women's services consider private practice physicians more convenient. Also, 48.5 percent of women do not use women's services at the VA due to a lack of knowledge of VA eligibility and services.[55]

Primary care

General care includes health evaluation and counseling, disease prevention, nutrition counseling, weight control, smoking cessation, and substance abuse counseling and treatment as well as gender-specific primary care, e.g., cervical cancer screens (Pap smears), breast cancer screens (mammograms), birth control, preconception counseling, Human Papillomavirus (HPV) vaccine and menopausal support (hormone replacement therapy).

Mental health includes evaluation and assistance for issues such as depression, mood, and anxiety disorders; intimate partner and domestic violence; elder abuse or neglect; parenting and anger management; marital, caregiver, or family-related stress; and post-deployment adjustment or post-traumatic stress disorder (PTSD).

Veterans may have experienced sexual harassment or sexual assault, known as military sexual trauma (MST) during their service. Health services are available to victims. VHA provides free, confidential counseling and treatment for MST-related mental and physical health conditions.

A 2017 study found that nearly one in five VHA women had experienced IPV in the preceding year, and research has shown that many military women reporting IPV experiences in the past year use VHA primary care as their main source of healthcare.[56][57] The VHA does not have an upper age limit for IPV screening, acknowledging that IPV is not limited by age.[57] However, it is believed that early detection is helpful towards allowing victims to access much needed resources earlier and thus the U.S. Preventive Services Task Force suggests providers especially regularly screen women of childbearing age for IPV.[58] The best care is provided when practitioners do not make assumptions about IPV on the basis of an individual's sexual orientation or other factors.[57]

No matter one's age, there are chronic health risks associated with IPV victimization, for both men and women.[59] Early detection is key to providing effective support systems to victims in the armed forces and reducing potential negative health consequences that are associated with such violence.[59]

Barriers to disclosure of IPV to providers in the VHA include lack of universal routine screening, patients not being comfortable about disclosure, and individual concerns over potential negative consequences on benefits or personal items, depending on how info is shared or used.[60] Barriers to providing the most effective responses to IPV cases include providers lacking time and information to help, and untrained personnel creating more harm than good.[60]

Specialty care

Management and screening of chronic conditions includes heart disease, diabetes, cancer, glandular disorders, osteoporosis and fibromyalgia as well as sexually transmitted diseases such as HIV/AIDS and hepatitis.

Reproductive health care includes maternity care, infertility evaluation and limited treatment; sexual problems, tubal ligation, urinary incontinence, and others. VHA is prohibited from providing either in-vitro fertilization or abortion services.

Rehabilitation, home care, and long-term care referrals are given to those in need of rehabilitation therapies such as physical therapy, occupational therapy, speech-language therapy, exercise therapy, recreational therapy, and vocational therapy.

Evaluations

"Patients routinely rank the veterans system above the alternatives", according to the American Customer Satisfaction Index. In 2008, the VHA got a satisfaction rating of 85 for inpatient treatment, compared with 77 for private hospitals. In the same report VHA outpatient care scored 3 points higher than for private hospitals.[41]

"As compared with the Medicare fee-for-service program, the VA performed significantly better on all 11 similar quality indicators for the period from 1997 through 1999. In 2000, the VA outperformed Medicare on 12 of 13 indicators."[61]

A study that compared VHA with commercial managed care systems in their treatment of diabetes patients found that in all seven measures of quality, the VHA provided better care.[62]

A RAND Corporation study in 2004 concluded that the VHA outperforms all other sectors of American health care in 294 measures of quality. Patients from the VHA scored significantly higher

for adjusted overall quality, chronic disease care, and preventive care, but not for acute care.[39]

A 2009 Congressional Budget Office report on the VHA found that "the care provided to VHA patients compares favorably with that provided to non-VHA patients in terms of compliance with widely recognized clinical guidelines — particularly those that VHA has emphasized in its internal performance measurement system. Such research is complicated by the fact that most users of VHA's services receive at least part of their care from outside providers."[22]

A Harvard Medical School-led study shows that cancer care provided by the Veterans Health Administration for men 65 years and older is at least as good as, and by some measures better than, Medicare-funded fee-for-service care obtained through the private sector.[63]

Physicians

Doctors who work in the VHA system are typically paid less in core compensation than their counterparts in private practice. However, VHA compensation includes benefits not generally available to doctors in private practice, such as lesser threat of malpractice lawsuits, freedom from billing and insurance company payment administration, and the availability of the government's open source electronic records system VistA.[41]

Currently the VHA is experiencing a physician shortage and as of 2018 10% of jobs in the VHA remain unfilled.[64] This shortage can be especially harmful to Veterans since a quarter of Veterans live in rural areas. These are the kind of areas that are most vulnerable to a shortage since they are already isolated and it can be hard to get access to the healthcare they need.[65]

Eligibility for VA health care benefits

A VA Veteran identification VIC card for Veterans eligible for VA health care benefits

To be eligible for VA health care benefit programs one must have served in the active military, naval or air service and separated under any condition other than dishonorable. Current and former members of the Reserves or National Guard who were called to active duty (other than for training only) by a federal order and completed the full period for which they were called or ordered to active duty also may be eligible for VA health care.[66]

The minimum duty requirements are that veterans who enlisted after September 7, 1980, or who entered active duty after October 16, 1981, must have served 24 continuous months or the full period for which they were called to active duty in order to be eligible. The minimum duty requirement may not apply to veterans who were discharged for a disability incurred in the line of duty, for a hardship or "early out." The VA determines the minimum requirements when the veteran enrolls for VA health care benefits.

To apply for entry into the VA health care system the veteran must complete VA Form 10-10EZ, Application for health care benefits.

Eligible veterans will receive a VA Veterans Health Identification Card (VHIC) formerly Veteran identification card (VIC) for use at all VA medical facilities.

By federal law, eligibility for benefits is determined by a system of eight priority groups. Retirees from military service, veterans with service-connected injuries or conditions rated by VA, and Purple Heart recipients are within the higher priority groups.

Current and former members of the Reserves and the National Guard who were called to active duty (other than for monthly drills and annual training) by a federal executive order may be eligible for VA health care benefits.[67]

Veterans without rated service-connected conditions may become eligible based on financial need, adjusted for local cost of living. Veterans who do not have service-connected disabilities totaling 50% or more may be subject to copayments for any care they received for nonservice-connected conditions.

The Goodwill Grant

If a veteran has a private health plan contract for medical insurance, the Goodwill Grant is the veteran's volunteered permission of the veteran's private health insurance granted for VA's direct cost recovery at VA facilities. 38 U.S. Code § 1729 - Recovery by the United States of the cost of certain care and services.[68]

Eligibility priority groups

Priority Groups	Group Description
Group 1	▪ Veterans with service-connected disabilities rated 50 percent or more disabling. ▪ Veterans determined by VA to be unemployable due to service-connected conditions. ▪ Veterans who have been awarded the Medal of Honor (MOH).
Group 2	▪ Veterans with service-connected disabilities rated 30 or 40 percent.
Group 3	▪ Veterans who are former Prisoners of War (POWs). ▪ Veterans awarded the Purple Heart Medal. ▪ Veterans whose discharge was for a disability incurred or aggravated in the line of duty. ▪ Veterans with VA service-connected disabilities rated 10 percent or 20 percent. ▪ Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation."
Group 4	▪ Veterans who receive aid and attendance or housebound benefits from VA. ▪ Veterans determined by VA to be catastrophically disabled.
Group 5	▪ •Veterans with a non-service-connected or non-compensable service-connected disability and Veterans rated by VA as 0% disabled and who have an annual income below the VA's geographically-adjusted income limit (based on your resident ZIP code). ▪ Veterans receiving VA Pension benefits. ▪ Veterans eligible for Medicaid benefits.
Group 6	▪ Compensable 0 percent Service-connected Veterans. ▪ Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki. ▪ Project 112/SHAD participants. ▪ Veterans of the Mexican border period or of World War I. ▪ Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975. ▪ Veterans who served in the Persian Gulf War in the Southwest Asia theater of operations from August 2, 1990, through November 11, 1998. ▪ Veterans who served on active duty at Camp Lejeune for not fewer than 30 days beginning January 1, 1957 and ending December 31, 1987. ▪ Veterans who served in a theater of combat operations after Nov.11, 1998, as follows: ▪ Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for 5 years post discharge.
Group 7	▪ Veterans with incomes below the geographic means test income thresholds and who agree to pay the applicable copayment.
Group 8	▪ Veterans with gross household incomes above the VA national income threshold and the geographically-adjusted income threshold for their resident location and who agrees to pay copayments. Veterans eligible for enrollment: Noncompensable 0-percent service-connected and: ▪ Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/ or placed in this subpriority due to changed eligibility status. ▪ Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10 percent or less

	■ Veterans eligible for enrollment: Nonservice-connected and Subpriority c: Enrolled as of January 16, 2003, and who remained enrolled since that date and/ or placed in this subpriority due to changed eligibility status ■ Subpriority d: Enrolled on or after June 15, 2009 whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10 percent or less ■ Veterans NOT eligible for enrollment: Veterans not meeting the criteria above: Subpriority e: Noncompensable 0 percent service-connected Subpriority f: Nonservice-connected

Covered services/acute care benefits

Standard benefits

Preventive Care Services

- Counseling on inheritance of genetically determined disease
- Immunization
- Nutrition Education
- Physical Examinations (Including eye and hearing examinations)
- Health Care Assessments
- Screening Test
- Health Education Programs

Ambulatory (Outpatient) and Hospital (Inpatient), Diagnostic and Treatment Services

- Medical
- Surgical (Including reconstructive/plastic surgery as a result of disease or trauma)
- Mental Health
- Dialysis
- Substance Abuse
- Prescription Drugs (when prescribed by a VA Physician)

Limited benefits

The following care services have limitations and may have special eligibility criteria:

- Ambulance Services
- Chiropractic Care[69] (at 47 VA hospitals (http://www.acatoday.org/pdf/government/VAOffrOnSte2013.pdf))
- Dental Care (see VA Dental Care)
- Durable Medical Equipment (walkers, crutches, canes, bathtub seats)
- Eyeglasses
- Hearing Aids
- Home Health Care
- Maternity and Parturition (Childbirth) Services Usually provided in non-VA contracted hospitals at

VA expense; care is usually limited to a mother. (VA may furnish health care services to a newborn child of a woman Veteran who is receiving maternity care furnished by VA for not more than seven days after the birth if the Veteran delivered the child in (1) a VA facility, or (2) another facility pursuant to a VA contract for services relating to such delivery)
- Non-VA Health Care Services

Long term benefits

Standard benefits

- Geriatric Evaluation. Geriatric evaluation is the comprehensive assessment of a Veteran's ability to care for him/herself physical health and social environment, which leads to a plan of care. The plan could include treatment, rehabilitation, health promotion and social services. These evaluations are performed by inpatient Geriatric Evaluation Management (GEM) Units, GEM clinics, geriatric primary care clinics and other outpatient settings.
- Adult Day Health Care. The adult day health care (ADHC) program is a therapeutic day care program, providing medical and rehabilitation services to disabled Veterans in a combined setting.
- Respite Care. Respite care provides supportive care to Veterans on a short-term basis to give the caregiver planned relief from the physical and emotional demands associated with providing care. Respite care can be provided in the home or other institutional settings.
- Home Care. Skilled home care is provided by VA and contract agencies to Veterans that are home bound with chronic diseases and includes nursing, physical/occupational therapy and social services.
- Hospice/Palliative Care. Hospice/Palliative care programs offers pain management, symptom control and other medical services to terminally ill Veterans or Veterans in the late stages of the chronic disease process. Services also include respite care as well as bereaverement counseling to family members.

Limited benefits

- Nursing Home Care. VA provides nursing home services to Veterans through three national programs: VA owned and operated Community Living Centers (CLC), State Veterans' Homes owned and operated by the states, and the community nursing home program. Each program has admission and eligibility criteria specific to the program. Nursing home care is available for enrolled Veterans who need nursing home care for a service-connected disability, or Veterans or who have a 70 percent or greater service-connected disability and Veterans with a rating of total disability based on individual unemployability. VA provided nursing home care for all other Veterans is based on available resources.
- Domiciliary Care. Domiciliary care provides rehabilitative and long-term, health maintenance care for Veterans who require some care, but who do not require all services provided in nursing homes. Domiciliary care emphasizes rehabilitation and return to the community. VA may provide domiciliary care to Veterans whose annual income does not exceed the maximum annual rate of VA pension or to Veterans who have no adequate means of support.

Financial Assessment for Long-Term Care Services

For Veterans who are not automatically exempt from making co-pays for long-term care services separates financial assessment (VA Form 10-10EC, APPLICATION FOR EXTENDED CARE SERVICES) must be completed to determine whether a Veteran qualifies for cost-free services or to what extent they are required to make long-care co-pays. Unlike co-pays for other VA health care services, which are based on fixed changes for all long-term care co-pay changes are individually adjusted based on each Veteran's financial status.

Home health care

Home health care includes VA's Skilled Home Health Care Services (SHHC) and Homemakers and Home Health Aide Services (H/HHA).

Skilled Home Health Care Services (SHHC)

- SHHC services are in-home services provided by specially trained personnel, including nurses, physical therapists, occupational therapists and social workers. Care includes clinical assessment, treatment planning and treatment provision, health status monitoring, patient and family education, reassessment, referral and follow-up.

Homemakers/Home Health Aide Services (H/HHA)

- H/HHA Services are personal care and related support services that enable frail or disabled Veterans to live at home.

Family Caregivers Program

- VA's Family Caregivers Program provides support and assistance to caregivers of post 9/11 Veterans and Servicemembers being medically discharged. Eligible primary Family Caregivers can receive a stipend, training, mental health services, travel and lodging reimbursement, and access to health insurance if they are not already under a health plan care. Each state has their own criteria and Board Members for approval, denial, and appeal.

Patient Aligned Care Team (PACT)

The Department of Veterans Affairs' Office of Patient Care Services has a Primary Care Program Office that has implemented a new patient-centered medical home (PCMH) model at VHA primary care sites. This PCMH model is referred to as Patient Aligned Care Teams (PACT). PAC Teams provide accessible, patient-centered care and are managed by primary care providers with the active involvement of other clinical and non-clinical staff. Veteran patients will be at the center of a "teamlet," which will include a primary care provider, RN care manager, LPN/health tech, and a medical support assistant (MSA). This teamlet is supported by a broader "team," which includes social workers, dieticians, pharmacists, and mental health specialists. Patient Aligned Care Teams (PACTs) are being implemented at all VA Primary Care Sites, including VA Community Based Outpatient Clinics (CBOC).

VA dental Care

For VA dental care a veteran must have a service-connected compensable dental disability or condition. Those who were prisoners of war (POWs) and those whose service-connected disabilities have been rated at 100 percent or who are receiving the 100 percent rate by reason of individual unemployability (IU) are eligible for any needed dental care, as are those veterans actively engaged in a 38 USC Chapter 31 vocational rehabilitation program and veterans enrolled who may be homeless and receiving care under VHA Directive 2007-039.

Transplant service

If the need arises, veterans are eligible for transplant service. The request will be coordinated by the Primary Care Team.

Vet Centers

The Vet Center Program was established by Congress in 1979 in response to the readjustment problems that a significant number of Vietnam-era veterans were continuing to experience after their return from combat. In subsequent years, Congress extended eligibility to all combat veterans who served on active duty from previous conflicts.

All community based Vet Centers provide readjustment counseling, outreach services and referral services to help veterans make a satisfying post-war readjustment to civilian life. Services are also available for their family members for military related issues. Vet Centers are staffed with small multidisciplinary teams some of whom are combat veterans themselves.

OEF/OIF/OND veterans

OEF/OIF/OND Care Management Team

The Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Care Management Team helps returning service members achieve a smooth transition of health care services. A specialized OEF/OIF/OND care management team provides case management and care coordination for all severely ill, injured and impaired combat veterans, including those suffering from:

- Mental illness
- Traumatic brain injury
- Spinal cord injury
- Blindness
- Burns
- Amputation
- Terminal Illness/Injury
- Polytrauma
- Other conditions not mentioned above that cause significant impairment to daily living

Domiciliary Care Program

The Domiciliary Care Program of the Department of Veterans Affairs provides residential rehabilitative and clinical care to veterans who have a wide range of problems, illnesses, or rehabilitative care needs which can be medical, psychiatric, substance use, homelessness, vocational, educational, or social. The Domiciliary Care Program provides a 24-hour therapeutic setting utilizing a peer and professional support environment. The programs provide a strong emphasis on psychosocial rehabilitation and recovery services that instill personal responsibility to achieve optimal levels of independence upon discharge to independent or supportive community living. The VA Domiciliary Care Program also provides rehabilitative care for homeless veterans.

- Eligibility: VA may provide domiciliary care to veterans whose annual gross household income does not exceed the maximum annual rate of VA pension or to veterans who the Secretary of Veterans Affairs determines have no adequate means of support. The copays for extended care services apply to domiciliary care.

VA travel reimbursement

Veterans may be eligible for mileage reimbursement or special mode transport in association with obtaining VA health care services if the veteran has a service-connected rating of 30 percent or more, or is traveling for treatment of a service-connected condition, receives a VA pension, the veteran's income does not exceed the maximum annual VA pension rate, the veteran is traveling for a scheduled compensation or pension examination, is in certain emergency situations. has a medical condition that requires a special mode of transportation and travel is pre-authorized, as are certain non-veterans when related to care of a veteran (caregivers, attendants and donors).

Federal benefits for veterans, dependents and survivors

Medical programs

- The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a health benefit program in which the Department of Veterans Affairs (VA) shares the cost of certain health care services and supplies with eligible beneficiaries. The program is available to spouses and children of veterans with permanent and total service-connected disability ineligible for the DoD TRICARE. The surviving spouse or child of a veteran who died from a VA service-connected disability, or who at the time of death was rated permanently and total disabled. Similarly to TRICARE, CHAMPVA beneficiaries are also accepted by TRICARE providers.
- The Spina Bifida Program (SB). Is a comprehensive health care benefits program administered by the Department of Veterans Affairs for birth children of certain Vietnam and Korea War veterans who have been diagnosed with spina bifida (except spina bifida occulta). The SB program provides reimbursement for inpatient and outpatient medical services, pharmacy, durable medical equipment, and supplies.
- The Children of Women Vietnam Veterans (CWVV) Health Care Program. Is a federal health benefits program administered by the Department of Veterans Affairs for children of women Vietnam War veterans born with certain birth defects. The CWVV Program provides reimbursement for medical care related to covered birth defects and conditions associated with the covered birth defect except for spina bifida.

Controversies

Coronavirus (COVID-19)

In the midst of the coronavirus disease 2019 (COVID-19) outbreak, 5,000,000 masks meant for hospitals of the Veterans Health Administration were seized by FEMA and redirected to the Strategic National Stockpile, stated Richard Stone, Executive in Charge, Veterans Health Administration.[70] After an appeal from Veterans Affairs Secretary Robert Wilkie to FEMA, the agency provided the VA with 500,000 masks.[70]

According to documents obtained by BuzzFeed News, at VA's Greater LA Healthcare System, medical personnel caring for patients who had tested positive for COVID-19 would receive only a single surgical mask per shift rather than the N95 respirators recommended by the Centers for Disease Control and Prevention. Those working in parts of the hospital without positive COVID-19 cases would be issued only a single surgical mask each week.[71] The American Federation of Government Employees (AFGE) has filed an Occupational Safety and Health Administration (OSHA) complaint with the Department of Labor regarding safety or health hazards at VA facilities.[72]

Veterans Affairs lists current statistics on confirmed infections and deaths due to COVID-19. As of May 5, 2020, VA has 9,771 confirmed cases and 771 deaths.[73]

See also

- Veterans benefits for post-traumatic stress disorder in the United States
- EBenefits
- Gerontology
- Rehabilitation Research and Development Service

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External links

- Veterans Health Administration (http://www.va.gov/health/)