Federal Health Matters

VA Begins IT Improvement Initiative

On July 17, the VA announced it would temporarily halt 45 problematic information technology (IT) projects—most of them related to health care—as part of a new initiative to promote IT success.

The department said the projects were halted because they were behind schedule or over budget; they will not be resumed until new project plans are created. These plans must be approved by Roger W. Baker, the VA's assistant secretary for information and technology, and conform to a new VA protocol called the Program Management Accountability System (PMAS). The PMAS requires that projects deliver systems and applications incrementally, that they meet milestones, and that they be halted if they miss three customer delivery milestones. All of the department's IT projects will be required to conform to the PMAS over the next year.

Baker told the web site informationweek.com that the initiative was inspired, in part, by the VA's failed project to develop a scheduling system for patient appointments. The new initiative is "all about forcing hard decisions by ensuring that there's a hard stop on failure," he said.

DoD Rejects IOM Call for Tobacco Ban

A DoD spokesperson said July 15 that the department has no intention of prohibiting service members' use of tobacco in war zones—despite a recent call by the Institute of Medicine (IOM) for a military-wide tobacco ban.

In a June 26 report commissioned by the DoD and the VA, the IOM's Committee on Smoking Cessation in the Military and Veteran Populations recommended a phased-in ban on tobacco use among all branches of the military. The DoD should ban tobacco use in officer academies and basic training within one year, prohibit army and air force commissaries from selling tobacco, and set a mandatory date for a tobacco-free military, the report suggested.

But according to DoD spokesperson Geoff Morrell, DoD Secretary Robert Gates believes that a ban on smoking and chewing tobacco among troops in Iraq and Afghanistan would take away "one of the few outlets they may have to relieve stress." Morrell added, however, that the DoD may have other options for discouraging tobacco use.

Among the IOM report's other recommendations were that the DoD and the VA both implement comprehensive, integrated tobacco-control programs and ensure that a trained tobacco-cessation counselor is available at all of their facilities. The report also encouraged Congress to repeal the Veterans Health Care Act of 1992, which mandates that VA facilities have both smoking and nonsmoking areas, so that these facilities can become completely tobacco free.

Service members who smoke are less fit, miss more work, have worse vision, and are more likely to drop out of the military within one year than those who do not, according to the report. It said that the DoD spends over $1.6 billion each year on medical care, increased hospitalizations, and lost days of work related to tobacco use, with the Military Health System having spent about $564 million on tobacco-related costs in 2006. The report also said that the VA spent $5 billion in 2008 to treat chronic obstructive pulmonary disease, which is attributed to smoking in over 80% of cases. It added that military sales of tobacco in 2005 amounted to $611 million—$88 million of which was spent on military morale, welfare, and recreation activities.

Senate Committee Addresses Women Veterans' Issues

The VA's strategies for improving care for female patients, privacy protections for these patients, and provision of women-centric mental health services were among the issues addressed at the Senate VA Committee's July 14 hearing, "Women Veterans: Bridging the Gaps in Care."

During the hearing, Patricia Hayes, the chief consultant of the VA's Women Veterans Health Strategic Care Group, gave an overview of women's health issues within the department. Randall B. Williamson, director of health care at the Government Accountability Office (GAO), reported on the GAO's audit of women's health services in nine VA medical centers (VAMCs), 10 community-based outpatient clinics (CBOCs), and 10 Vet Centers between July 2008 and July 2009. Other testimony came from Kayla Williams, an army veteran; Tia Christopher, a navy veteran who represented Swords to Plowshares; Jennifer Olds, an army veteran who represented Veterans of Foreign Wars; Genevieve Chase, an army reserve veteran and the founder and executive director of American Women Veterans; and Joy J. Ilem, deputy national legislative director of Disabled American Veterans.

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Hayes said that while the VA provides a level of quality care to women veterans that "exceeds the care many would receive in other settings," the department is nonetheless "aware of existing disparities between male and female veterans in our system." Some of these disparities are in the areas of high blood pressure, high cholesterol, diabetes, colon cancer screening, depression screening, and immunizations, she said.

Although the VA currently provides general primary care and gender-specific care to women veterans "through a multivisit, multiprovider model that may not achieve the continuity of care desired," Hayes said, it is working toward implementing a new model. In March 2008, Michael J. Kussman, then the VA's under secretary for health, charged a work group with ensuring that "every woman veteran has access to a VA primary care provider capable of meeting all her primary care needs, including gender-specific and metal health care, in the context of a continuous patient-clinician relationship." Hayes noted that all VA health care facilities have been asked to finalize analyses and action plans for addressing women's comprehensive primary care by August 1.

Williamson said the facilities audited by the GAO were at "various stages" of implementing the new model. Officials at six VAMCs and six CBOCs "had at least one provider who could deliver comprehensive primary care services to women veterans," he said, but officials at some facilities were unclear about the new model's requirements. For example, officials at one facility were unsure of whether the facility would meet the VA's comprehensive primary care standard if it used two different providers to offer primary care and basic gender-specific services (it would not).

None of the facilities visited by the GAO "were fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings," according to Williamson. He said that none of the visited VAMCs or CBOCs "ensured adequate visual and auditory privacy at check-in in all clinical settings" accessed by women, while only one of the VAMCs and two of the CBOCs complied fully with the requirement that examination tables face away from the door. Williamson added that in seven of the VAMCs and in all 10 of the CBOCs, none of the public restrooms offered sanitary napkins or tampons.

Mental health issues were a major topic throughout the hearing. Hayes said that "37% of women veterans who use VA health care have a mental health diagnosis" and that mental health needs involving "depression, posttraumatic stress disorder (PTSD), military sexual trauma (MST), and parenting and family issues" are common among these veterans. Christopher and Olds mentioned in their testimony that they had PTSD; in addition, Christopher said she had MST and Olds said she had been in situations involving sexual assault "numerous times."

Both Williams and Christopher stressed the importance of female-only counseling within the VA. Christopher added that the VA should develop "more female-only inpatient PTSD and MST programs" and enhance its outreach efforts to veterans with MST. Williamson said that both the VAMCs and the Vet Centers visited by the GAO offered a range of mental health services, with most of them offering at least one female-only counseling group.