

**VA'S EFFORTS TO PROVIDE HIGH
QUALITY HEALTH CARE TO
VETERANS IN RURAL COMMUNITIES**

HEARING

BEFORE THE

**COMMITTEE ON
VETERANS' AFFAIRS**

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH

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VA'S EFFORTS TO PROVIDE HIGH QUALITY HEALTH CARE TO VETERANS IN RURAL COMMUNITIES

TUESDAY, JUNE 27, 2006

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Henry E. Brown, Jr. [chairman of the subcommittee] presiding.

Present: Representatives Brown of South Carolina, Michaud, Moran.

MR. BROWN OF SOUTH CAROLINA. Good morning. The Subcommittee will come to order. This morning, we have assembled to take a close look at how the VA is providing for the care of our veterans who may live at a great distance from a VA medical center, a community-based outpatient clinic, or perhaps even a vet center.

This is not the first hearing that we have had on this subject, nor do I expect it will be the last. Due to the large number of service men and women we have returning from Iraq and Afghanistan and due to the numbers of those folks who may hail from rural areas, additional pressures are currently being placed at VA's doorsteps as more people desire to receive their care from VA.

This is probably a good problem to have in a sense it is a testament to the fine job that Dr. Perlin and his team are doing to provide or purchase care for our nation's veterans, not only in urban areas, but also in more remote areas of the country.

Having said that, we need to be able to effectively bridge the distance gap. And one thing is clear. The gap cannot and should not in my opinion be bridged by simply erecting new VA buildings on every street corner across the nation. Rather, we should seek to use new, emerging technologies to export the expertise that resides inside the VA's medical centers, CBOCs, or the vet centers.

The expanded use of telemedicine, while not a panacea, can go a considerable way towards alleviating some of the distance-based challenges in the area of primary care, mental health, and even long-term or home-based care. I suspect our VA witnesses will provide greater details on what can currently be accomplished in that area and what we can anticipate in the future.

Equally important to the use of new technologies, we should also seek to collaborate with local community providers wherever possible to ensure that the level of care and quality that VA provides can be expected of others if VA chooses to purchase those services in given areas.

I know the Department has taken steps towards doing that by moving forward on important initiatives like Project HERO, a multi-VISN demonstration project that will attempt to better coordinate and improve the purchased care that VA relies upon sometimes in very rural areas. As many of you probably recall, we had a hearing on Project HERO and are all anxious to see it rolled out later this year.

As I suggested, this will not be the last hearing we have on rural healthcare at VA. But equally important, we should also recall our last hearing on this important topic.

This Subcommittee had the distinct pleasure of traveling to Maine last summer to examine how the State handles its uniquely rural VA population. We had the opportunity to do that because the Ranking Member, my friend, Mike Michaud, invited us to this beautiful district.

Mr. Michaud and I share an interest in rural health, and I am privileged again today to examine VA's successes and challenges with my good friend from Maine. I also look forward to working with him on our upcoming health bill and incorporating some of his rural health provisions to that package.

With that, I would yield to the gentleman from Maine, Mr. Michaud, for an opening statement.

[The statement of Henry Brown appears on p. 32]

MR. MICHAUD. Thank you very much, Chairman Brown. I really appreciate your cooperation and your willingness to have a hearing in the great State of Maine, and I am hopeful we will be able to have a rural health bill that will reflect some of the issues we heard.

I greatly appreciate also, Mr. Chairman, you holding his hearing to explore VA's efforts to improve rural veterans' access to high-quality VA healthcare. I also want to thank all the witnesses on both panels for coming here today to testify.

And I am especially glad and pleased to see Dr. Hartley from Maine who is able to be here today as well. As a member of the Committee that wrote the 2005 ground-breaking Institute of Medicine report on the future of rural healthcare, he has a great deal of expertise on

the challenges facing rural communities and providing high- quality, state-of-the-art healthcare. So glad to have you here today, Doctor.

Next week, we will be celebrating our Nation's Independence Day along with picnics and parades in recognition and respect for the courage of farmers who took up arms to fight for freedom. The revolution that transformed colonies into a new nation happened because of rural citizen soldiers.

Since the Revolutionary War, rural communities, certainly Maine, have continued to answer their nation's call to service. Roughly 16 percent of Mainers are veterans, one of the highest percentages in the country. Across the nation, roughly one in five veterans enrolled in VA healthcare are from small towns and rural communities. In time, the percentage of rural veterans will likely increase because more than 44 percent of the recent U.S. military recruits are from rural areas.

It is important that we honor veterans with action, not just words. Doing so is all the more important, particularly while we are at war in Iraq and Afghanistan. Studies including the recent Institute of Medicine report on the future of rural health have repeatedly shown that rural communities, especially veterans, face unique challenges to access high-quality care such as distance and the availability of specialists.

While there are a number of efforts underway to improve access for rural veterans to VA's high-quality care, I am concerned that we are not adequately preparing and planning for the needs of elderly veterans, disabled veterans, and the younger generation of veterans returning from Iraq and Afghanistan to their home states in remote areas.

I have introduced House Resolution 5524, the Rural Veterans Health Care Act of 2006, which is a comprehensive approach to improving the quality of care available to rural veterans. Following the advice of the Institute of Medicine report, my bill aims to take a comprehensive and practical approach towards improving care for our rural veterans by increasing facilities and outreach, encouraging recruitment and training of healthcare professionals, focusing on research, and developing the IT infrastructure we need to enhance services in rural areas.

My legislation has support from veterans service organizations like the American Legion, Military Order of the Purple Heart, and Vietnam Veterans of America. The National Rural Health Association also supports House Resolution 5524.

So I want to thank you once again, Mr. Chairman, for holding this important hearing, and I request that my full comments be included in the record.

MR. BROWN OF SOUTH CAROLINA. Without objection.

[The statement of Michael Michaud appears on p. 39]

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Michaud. It was a great trip to Maine and to have a chance to visit with some of the veterans from your region. It was my first trip to Maine and I did not recognize how remote it really is and how far some of those people have to travel. But I applaud you for inviting us to come and enlighten us on some issues.

One of the things, Dr. Perlin, they said was, do not take away our VA care because it is the best in the world. And I know you would be interested to hear that, and that was a real compliment, I think, to the system up in Maine and also representative across the country.

Let us now turn to our first panel. The Subcommittee welcomes Dr. Jonathan Perlin, Under Secretary for Health, testifying on behalf of the Department of Veterans Affairs.

Dr. Perlin is accompanied by Patricia Vandenberg, Assistant Under Secretary for Health for Policy and Planning; and Dr. Adam Darks, Chief Consultant for Care Coordination; and Dr. Robert Petzel, Network Director, VISN 23.

Welcome, Dr. Perlin.

STATEMENTS OF HON. JONATHAN B. PERLIN, M.D., Ph.D., MSHA, FACP, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA VANDENBERG, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING; ADAM DARKS, CHIEF CONSULTANT, OFFICE OF CARE COORDINATION; ROBERT A. PETZEL, M.D., NETWORK DIRECTOR, VISN 23

STATEMENT OF HON. JONATHAN B. PERLIN

DR. PERLIN. Thank you, Mr. Chairman, and good morning to you and to Ranking Member Michaud. Thank you for the opportunity to be here before you today to talk about rural healthcare for veterans.

Thank you as well for your kind words because it really puts into context the story of VA's transformation. In fact, ten years ago, VHA faced a burning platform. We had to transform our care or we would have been obsolete and failed our mission.

We were a collection of hospitals serving only as a safety net for care, treating veterans only after they had a health catastrophe, like a heart attack or advanced cancer. We had to change.

Instead of being a safety net, we created a model of health promotion, disease prevention for our patients, and are now the benchmark in preventive services in disease managements, instead preventing heart attacks and treating illnesses like cancer and depression ear-

ly.

We built a true health system out of a portfolio of hospitals, integrating services not just between our hospitals, but across the entire continuum of care from the patient's home to the outpatient clinic and, of course, to the hospital.

We recognize the value of community-based outpatient clinics in establishing that continuum of care and in meeting the primary care and mental healthcare needs of rural veterans.

In 1995, VHA operated 102 CBOCs. Today we operate more than 700 including 234 that the CARES criteria identified as serving rural or highly rural areas. This number does not include 156 more clinics that are based at our medical centers for a grand total today of 876 outpatient clinics.

In fact, Secretary Nicholson announced his approval for 25 new or enhanced CBOCs on June 23rd, and we anticipate having some of these open by the end of this year with the remainder opening in 2007. And fully one-third are rural.

In 2004, the CARES Commission found that VA's existing protocols for prioritizing new CBOCs disadvantaged rural veterans. As a result, we have revised our national criteria to emphasize access to care for rural veterans. We also created a directive on rural access hospitals to assure quality services at those facilities.

And now according to satisfaction performance scores collected in 2005, 81 and a half percent of rural veterans rated their healthcare as very good or excellent; in fact, slightly exceeding urban veterans' ratings. In addition, clinical quality measures were up to 12.2 percent higher for rural veterans compared to their urban counterparts.

And data show that rural veterans are not necessarily under-represented in VA. As Ranking Member Michaud said, nearly one in five veterans live in rural areas. And, in fact, 32 percent of our enrolled veterans are rural and 34 percent of our patient population are comprised of rural veterans.

We work closely with Federal, state, and local healthcare agencies on rural healthcare issues. A Memorandum of Understanding with the Indian Health Service to enhance healthcare for American Indian, Alaskan Native veterans has resulted in new activities and programs and complements local initiatives.

And we are creating targeted partnerships with community health centers to meet specific locally-defined healthcare needs in rural locations.

Our 207 vet centers also address rural veterans' needs. Many are located in rural areas with staff traveling widely to reach veterans in remote locations. Some maintain stations staffed by one or two counselors that are connected to full-size vet centers. Many vet centers maintain partnerships with community providers such as state employment services and local substance abuse programs.

One of VA's top priorities is providing comprehensive and effective mental healthcare to all enrolled veterans who need it. We have invested \$300 million in new service improvements in the past two years. And of that, nearly \$17 million was used to add mental health professionals to CBOCs and another \$9 million expanded our telemental health programs.

In 1996, veterans who used our mental health services lived an average of 24 miles from the nearest VA clinic. That average is only 13.8 miles today.

We are increasingly relying on telehealth and telemedicine as an effective and efficient way to provide specialty care services to rural veterans and others. Our care coordination, Home Telehealth Program helps veteran patients manage their conditions and live independently in their own homes. By October 1st, more than 20,000 veterans will be enrolled in this program.

A national Teleretinal Imaging Program now assesses diabetics for eye disease. A 21-site polytrauma health network begins operations by September 30th and more than 14,000 veterans received telemental healthcare in the last fiscal year.

Within three years, VA expects to provide rural veteran specialty care unparalleled in any other healthcare organization in the nation. We, however, recognize limitations in our national telecommunications infrastructure and bandwidth requirements, and appreciate your support in improving this for rural veterans and all rural Americans.

Mr. Chairman, creation of new CBOCs, collaborations with other healthcare organizations, new approaches to providing healthcare services, advances in telehealth and telemedicine give me confidence that we are continually striving to provide not only the best care anywhere but the best care everywhere in our nation.

Thank you very much for the opportunity to testify. We would be pleased to respond to your questions and we request that the full statement be submitted for the record.

MR. BROWN OF SOUTH CAROLINA. Without objection. And thank you, Dr. Perlin, for your testimony and for your service to the veterans all over this country.

[The statement of Jonathan Perlin appears on p. 41]

MR. BROWN OF SOUTH CAROLINA. My first question is, what is the department currently doing to better understand where their user population lives and what type of strategic planning is being undertaken in the area of rural healthcare specifically?

I know you addressed that somewhat in your testimony, but do you have like a schematic map so you could readily see where the rural veterans are and how it continues to change with the new veterans coming back from the Operation Enduring Freedom and Operation

Iraqi Freedom?

DR. PERLIN. Thank you very much, Mr. Chairman, for this important question. I want to address it at two levels.

First you asked how we look at the nation and make sure we are meeting the needs geographically, understanding that the needs are not exactly the same in urban environments and suburban environments, somewhat rural environments, and highly remote and rural areas.

And, in fact, on a national level, a lot of that work goes on in Ms. Vandenberg's operation in terms of the modeling of the nation's population. I would ask her to first begin responding to how that process is achieved.

But I would also want to introduce Dr. Randy Petzel as not only the Director of VISN 23, the upper midwest network, but for him to respond subsequently to really describe how as network director with operational responsibility, he looks at an environment that ranges from the urban-ness of Minneapolis to the most remote regions of the Dakotas, and how he would actually plan to meet services in that area.

Ms. Vandenberg.

MS. VANDENBERG. Thank you.

When we do our annual actuarial model projections for the system, we start at the level of the veterans' population and then forecast the enrollment and then move down to unique patients.

You asked if we have a map that depicts the population. Yes, in fact, we do. Part of my office is responsible for geo coding and so we are in a constant update of the location of our veterans. We are looking at that from both the enrollee and the patients' perspective.

MR. BROWN OF SOUTH CAROLINA. I know I said that because demographically it is a real shift in this country. I know in my region of South Carolina, which represents Myrtle Beach and along the coast, a goodly number of those people are moving from Maine where it is so cold and some of the other parts down to sunny Myrtle Beach. And I just wanted to be sure that somehow or another demographically we were taking care of that shift so that—

MS. VANDENBERG. We are monitoring that, yes.

MR. BROWN OF SOUTH CAROLINA. —services would be moving with them. Thank you.

DR. PETZEL. In terms of how we might operate at the network level, again, as Ms. Vandenberg mentioned, we annually assess the needs in our network. And one of the ways we look at our service to rural veterans is to look at the veteran population, the proximity that they have to care at the present time, and also overlay the studies that are done about medically under-served communities, not just VA, but in general. And I think that allows us to identify the most critical areas in terms of rural-ness and in terms of a lack of healthcare.

And just as an example, during the CARES process, while there are not an overwhelming number of veterans there, we identified Williston and Dickinson, North Dakota as being very under-served areas medically as well as in terms of VA healthcare. And these became priorities for us to establish a couple of outreach clinics in that area.

And, again, we go through this annually.

MR. BROWN OF SOUTH CAROLINA. Just to follow up on that, we recently heard that 25 new CBOCs would be established. To what extent were the needs of rural veterans incorporated into the decision-making process?

DR. PERLIN. Well, let me answer your question, sir, in two ways. First, they are incorporated into the decision process by their being represented. Their presence in environments that we had not previously adequately served is really the hallmark of their representation. We identify that they are there, that they have a need for medical services, and we bring that service to them.

Increasingly, though, network directors such as Dr. Petzel, facility directors which have the direct purview over the community-based outpatient clinic meet with veterans to really learn what the needs are in the particular environment and really determine what would be most effective in terms of a specific location and try to work with serving the identified needs in the particular community.

MR. BROWN OF SOUTH CAROLINA. Before, Dr. Petzel, you respond, let me add this part of the dialogue, and maybe you can even expand on that too.

What is the department doing to explore existing rural health assets, for instance the rural health centers established by the U.S. Department of Health and Human Services, the State Department of Rural Community Health Centers and so forth?

While we are interested in providing for our rural veterans, we also have to be cognizant of those facilities and resources that already exist and not reinvent the wheel. After all, we are talking about valuable taxpayers' dollars.

How are you all interfacing with existing other agencies?

DR. PERLIN. There are a number of existing relationships that occur both at national levels, regional levels, and at local levels. Nationally we have Memorandums of Agreement with the Indian Health Service as an example for collaborating and serving our overlapping populations and increasing access for veterans.

I might in a moment ask Dr. Petzel to speak about how that occurs specifically in his network.

At a national level, we create a framework that creates a dialogue for the ability for us to target regionally, and locally to meet specific needs. Community health centers are important national assets. There are 3,600 of them. Not all of them are rural. Many are actually in urban and under-served environments. But we have partnerships

where we specifically target an opportunity to provide outreach.

Now, I should note that there is some difference in our patient population. Our focus, of course, is veterans. Community health centers traditionally or often is focused on maternal and children's issues in particular. So we need to make sure that our overlap really serves the constituencies as effectively as possible.

The second issue is that part of the ability for us to serve veterans well is the integrity, the continuity of the health information. And as we put clinics into the environments, we want to make sure that they are connected to our electronic health record.

And increasingly we will have dialogues about how we can not only have that continuity, be it whether it is within a direct sort of umbilical cord to our system or whether it is in the future with interoperability, with technologies that they would be introduced.

So at a very strategic and practical level, we say is there an overlapping need, is there an overlapping population, and at a technical level say, okay, can we carry this off and provide the right resources both to veterans and to the community health center population.

I would ask Dr. Petzel to speak about some of the collaborations that exist, for instance, either under the national aegis of the Indian Health Service memorandum or some of the local initiatives that exist with American Indians in VISN 23.

DR. PETZEL. Thank you, Mr. Chairman.

The Indian Health Service is probably the largest other Federal healthcare provider in our part of the country. And thanks in part to the Memorandum of Understanding that was signed several years ago, we have had a large number of collaborations with them on the reservations.

Just as some examples, we have contract clinics on four reservations in South Dakota. We have compensated work therapy programs on four reservations in South Dakota. And then in both North Dakota and South Dakota, we have telehealth, telepsychiatry, PTSD programs where a psychiatrist is remotely based and the facility is on the reservation, usually in the health center that the IHS establishes.

We do have plans in the very near future to establish an additional clinic in Wagner, South Dakota which is near the Yankton Sioux reservation. So we have got a large number, I think, of cooperative efforts going on with that Federal agency.

I would like to go back, though, just briefly to the previous question when you asked about how many of the new clinics were rural clinics.

We had three outreach clinics and four community-based outpatient clinics in that group of approvals and all of them were in highly rural areas.

MR. BROWN OF SOUTH CAROLINA. Are you allowing the neediest popu-

lation to use the VA clinics? I asked a question first whether you were taking advantage of the rural health clinics and some of the other available facilities based already there. I was just wondering if there is any reciprocal arrangements with the VA.

DR. PETZEL. Mr. Chairman, the only reciprocal relationships we have are in a few limited areas on reservations. We are cooperating with the Indian Health Service and non-veteran Native Americans, American Indians are using some of our services. But, otherwise, out in the communities, no. Our services are basically available to veterans right now.

DR. PERLIN. I would add, sir, that, of course, our biggest partner is the Department of Defense with the TRICARE coverage that extends and we accept in VA.

MR. BROWN OF SOUTH CAROLINA. Mr. Michaud, you had questions for the panel.

MR. MICHAUD. Thank you very much, Mr. Chairman.

Dr. Perlin, you mentioned that you recently announced plans to open 25 new CBOCs, some of which were never identified in the CARES process.

Can you explain in more detail how the VA has decided it can support new CBOCs not identified in the CARES process when we still have 156 priority CBOCs that were identified and that have not been implemented yet?

DR. PERLIN. Thank you, Mr. Michaud, for that question.

The CARES plan is a compass. It is not an absolute blueprint. I remember when Secretary Principi testified, he said that, you know, this was really the direction we were headed, but this would be evaluated in the context of circumstance, need, capacity, and access issues.

In fact, of that list of 25, depending on whether you use the CARES definition or the Census definition, either eight or nine are rural CBOCs. So we are really striving to make sure that we serve veterans' needs by improving access, by reducing capacity challenges, and in some instances relieving overstresses that occur in particular areas.

Our general trajectory is, in fact, to identify and meet the needs that are identified in the CARES report, and as I think is also understood in the CARES document that that is a plan that extends really over the better part of the next decade.

MR. MICHAUD. I guess my concern is that when you look at 156 priority CBOCs, they are priorities. And I know that some VISNs where there is only one CBOC proposed, they did not even submit a business plan because they do not have the money to do it.

So my concern is our going outside the CARES process. Out of the 25, how much was that decision made on political reasoning in some areas? That is a big concern that I have because there is a definite

need out there.

The next question is on the vet centers. I recently had a chance to meet with Blake Miller who is a rural veteran from Kentucky. He was nicknamed the "Marlboro Man" because of a picture taken after a firefight in Felujah. He has PTSD. Both he and his wife admitted that they need more counseling than what they are currently getting from the VA, and they have to travel over two hours to get the services that they need.

What are the VA's specific plans to expand the number of vet centers and vet centers' employees to the rural areas? Do you have a report that you can share with us to show what the VA plans on doing to fill that gap?

DR. PERLIN. First, let me identify a specific issue. If you are aware of a veteran who may need additional services from us, they are not getting it, I would be personally pleased to receive any information to meet any need.

Second, with respect to services and increased access to mental health service, I think this is one of the areas where I want to thank you, the Chairman for your support, exceptional.

As you know, the last two budgets have significantly increased the mental health initiatives, 100 million in 2005, 200 million in 2006. We put 339 in the 2007 and you saw fit to actually increase that further. And that is really allowing us to address some of the most fundamental priorities, the Mental Health Strategic Plan, our goal of improving access.

My priorities within that have been to increase access for specialty mental health services. And, in fact, whereas two years only 71 percent of clinics, CBOCs, had specialty mental health services, now it is approximately 90 percent. Increasingly the remaining ten percent, which may be very small CBOCs, very isolated outposts, in fact, have increased telemental health services, something that is both well received and extremely useful for remote veterans.

The third issue that you raise's the important issue of how we are getting to those individuals who are returning from combat who may disperse to very rural areas. And this is indeed an important and critical challenge, particularly since 62 percent of the veterans, combat veterans of OIF, OEF are reserve components.

And this is really an important role for the vet centers. Vet centers gave a lead in going out and doing transition assistance briefings to returning servicemembers at demobilization and at later training sessions and identifying services.

At each of the vet centers or throughout the country, we have Global War on Terrorism Outreach Counselors that are really peer counselors both to destigmatize the issue of identifying mental health needs as well to be able to speak on a peer-to-peer level. And that creates great entree.

In terms of staff, Al Batres, the Director of the Readjustment Counseling Service, provides me with needs associated with workload. And I am very proud to say that both as Deputy Under Secretary and as Under Secretary, every request he has brought for additional programmatic support, including the GWOT counselors and program expansion, including a new vet center, I have been able to support and put forward.

And so this is an area that we are dynamically following and appreciate any insights that might be forwarded from this Committee in terms of needs that exist in a particular locale.

MR. MICHAUD. I see my time has run out. But if you have a plan on how you plan to expand the vet centers, you should provide the Committee with a copy. Do you have one? Yes, no?

DR. PERLIN. I am not sure that there is necessarily a plan that is more specific than the operational plan for meeting the needs. I would not necessarily term it an expansion plan. It would be a needs-based, operational approach. And I am not sure that that is necessarily in a form that is—you know, a report that is ready to go out.

MR. MICHAUD. So you do not have an official plan then?

Dr. Perlin. There is an operations process, and I would be happy to share whatever documentation is available that associates workload with resource data.

MR. MICHAUD. Thank you.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Michaud.

MR. MORAN.

MR. MORAN. Mr. Chairman, thank you. Thank you and Mr. Michaud for holding this hearing. And, Dr. Perlin, thank you for joining us.

As I have indicated previously, I represent a district of approximately 60,000 square miles and no VA hospital within the district. And so the services that we provide rural veterans are the top priority of my service here on the Veterans' Affairs Committee.

Dr. Perlin, we will hear testimony—let me approach this a little bit differently. First, let me compliment the VA. I think the quality of healthcare that my veterans are receiving has improved dramatically over the last several years. Veterans are much more likely to be complimentary of the services they receive from the healthcare side of VA than they were when I began my career in Congress.

And we conduct veteran town hall forums on a regular basis and the compliments—the last one we had, the headline was about the compliments that the VA gets for the healthcare services that they are providing as compared to any negative.

So I think progress is being made, and I am very appreciative of that. We have a tremendous relationship and I think the right kind of attitude that comes from our VISN both in Denver and in Kansas

City, as well as the Cole Murray Hospital in Topeka and the Dole Hospital in Wichita. And I appreciate those services very much.

As always, there is more that can be done and there are still complaints about quality of healthcare that we need to address. Waiting lines are getting better, but they still exist. And most importantly, I still have an aging veteran population that have hours to go to access VA healthcare.

In that regard, we are going to hear testimony in the second panel as well as written testimony from the National Rural Health Association and from the National Organization of State Offices of Rural Health in which they again appeal for greater relationship between the VA and critical access hospitals. Those are hospitals that are very rural in nature and receive a different kind of reimbursement under Medicare as well as community hospitals.

And I know that the Chairman asked you a question about that, but my guess is that there is no community health clinic in Kansas and no critical access hospital in Kansas that has any relationship with the VA and that can provide services to Kansas veterans.

And so as you describe these collaborative efforts, my guess is that there is very little evidence on the ground that a veteran can go see their doctor or their local clinic in any place in my state. Would that be an unfair assessment on my part?

DR. PERLIN. First, Congressman, thank you very much for your kind appraisal of the improvements in quality. I think that is absolutely accurate. I have watched that transition in my career as well.

I looked in your part of Kansas and, in fact, today, if I count correctly, there are nine clinics that did not exist eight years ago, Abilene, Emporia, Junction City, Russell, Salina, Seneca, Dodge City, Hays, and Liberal. And I am very proud of that.

I do know that it is a challenge, though, to get to the inpatient hospital care. So our preferred goal, our desire is to make sure that we can provide really comprehensive, integrated, safe, effective, efficient, compassionate care for veterans. By having the health record and providing for the continuity of care, we can achieve better outcomes.

In fact, not just our belief, but the RAND organization would find that compared to all the care in the country, VA outperforms in 294 directly comparable measures in quality and prevention and disease treatment. That occurs with that coherence.

I would tell you that there are times where we have to purchase care at other hospitals. What happens then? Well, sometimes I want the veteran to go to that other hospital. Please understand if a veteran is having crushing chest pain and they have to go a long distance to a VA, I want them not to go to VA. I want them to go to the closest place.

On the other hand, if it is something elective, I want them to enjoy

the coherence of knowing what their whole past history is based on our electronic health record. I would also like them to do that because over the past two years alone, our purchased hospital services went from 600 to \$975 million. That is a pretty substantial increase, many, many times greater than the increase in the number of veterans we served.

And so our stewardship of the resources that you entrust to us also requires that we operate to provide not only the highest quality care, but do that most efficiently as well.

MR. MORAN. Well, Dr. Perlin, let me make sure I understand because what I think you are telling me is that for emergency care or traumatic injury, you would want the access to be immediate and if it is a private provider, that is satisfactory with the VA, but if it is routine care, your preference—when you talk about collaboration, the collaboration is not going to occur in a routine care kind of setting.

You are not looking for opportunities to associate the VA with a clinic, a private clinic, though publicly funded through community health clinics or through Medicare for that close relationship. Is that accurate?

DR. PERLIN. I would not draw the line quite that distinctly. For areas where we have access to service, there is less pressing need for the collaboration. In areas such as those that Dr. Petzel described, for example on the reservations, the opportunity to collaborate and partner is really exceptional.

You mentioned the community health centers. They are a terrific resource, but the opportunity to collaborate is really not best served where we have a veterans' community-based outpatient clinic proximate. But where we may not have the resources to meet the veterans' needs, that is an ideal opportunity for collaboration. I absolutely agree with you that that is both rational and efficient.

MR. MORAN. Mr. Chairman, would you allow me any leeway to follow-up and conclude?

MR. BROWN OF SOUTH CAROLINA. Yes.

MR. MORAN. Thank you, Mr. Chairman.

Just a couple other points. I do appreciate the CBOCs. We work very closely both at Wichita and Topeka. And we are hopeful that there are two others in the works. Anxious for the 2007 report to be made public so we can see where we are headed.

But even with those CBOCs that you describe, we still have 80-, 90-year-old veterans who are traveling two and three hours to get to the CBOC for routine care. So it is a geographic expanse that—as you describe all those locations, it sounds like it is a lot and it is going a long way in meeting our veterans' needs, but there is still a dramatic need for services closer to home.

And it also seems that there is a trend in the VA to bring those services, to require those veterans to travel to the Wichita or Topeka

hospital. My two examples.

A resident in my local hometown, Homer Schwartz, was receiving dental care from his hometown dentist through the VA. The VA changed the plan this year and decided he had to drive three hours to Wichita to receive routine dental care.

Same way, Hoxie veteran, Mr. Briary, Harv Briary, needed a new pair of glasses, always done through the VA with his local optometrist. But, again, the VA decided that under their new policy, got to come to Wichita to access those services.

So you have someone who lives four hours from the Wichita VA having to travel to Wichita to get a new pair of glasses. Those are the things that I would like to see the VA address. We are working with Wichita and Topeka on those issues, but much of what they—their answers to me often come from you here in Washington.

Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Moran.

We have sitting with us today, Ms. Hersheth from the great State of South Dakota. She is not a member of the panel, but with unanimous consent from the other members, we certainly would welcome you to entertain any questions you might have.

MS. HERSETH. Well, thank you very much, Chairman Brown. I want to thank you and Mr. Michaud for having this important hearing and for allowing me to participate in the Subcommittee activity today.

And I certainly am pleased that Dr. Petzel is here testifying. I appreciate his work in VISN 23 with so many of the folks in the State that I represent, South Dakota, which is perhaps not quite as rural, but almost as rural as Mr. Moran's district in western Kansas.

But if I could go back and explore just a little bit the service we are providing to rural Native American veterans. And I do greatly appreciate the efforts that the VA is taking to coordinate with IHS.

But I am concerned by the lack of healthcare providers in rural areas in general. And, Dr. Perlin, you talked about looking at sort of medically under-served areas, the overlay in terms of the population of veterans, and you referenced two communities in North Dakota.

Now, just on Sunday, I attended the graduation at the Oglala Lakota College in which over a dozen individuals received their degrees in nursing.

And so I am wondering what efforts, if any, VA is planning to work with tribal colleges or other programs to help educate and train rural Native American medical nursing and allied health professionals.

DR. PERLIN. Well, first, let me thank you for that question and your support in improving rural healthcare. That is a great opportunity to meet what is not only a rural shortage but a national shortage, that is competent, skilled nurses.

I do not have at hand the data on the particular relationship there,

but I am so interested in recruiting nurses not just in terms of VA need but as a national need. It is something that I will take back and be happy to provide additional information.

I do not know, Dr. Petzel, if you know anything specifically about this relationship.

DR. PETZEL. It is an interesting question, Congresswoman. First of all, I want to thank you for your support of veterans and veterans' issues in South Dakota. It is becoming a legend.

We have a relationship with several of the American Indian colleges in what we call the Gathering of Healers. It is a semi-annual event that we have where we bring healthcare providers into a remote setting, 30 of them, and they are taught about the culture of, in our cases, the Lakota and the Dakota. And it has gone a great way towards bridging this cultural gap.

I am going to go back and explore the possibilities that you have mentioned in your question. We have not talked directly with them about it, but it would be an excellent opportunity and I thank you for it.

MS. HERSETH. I very much appreciate both of your interest, and we would like to help you facilitate those meetings. I would commend the expertise of President Tom Shortbull of Oglala Lakota College, as well as President Lionel Bordeaux, President of the Sinte Gleska University on the Rosebud Reservation of the Sioux Tribe.

So thank you for your interest. I think it helps meet the needs in the IHS clinics as well as promoting the collaboration that we have undertaken to serve Native American veterans as well.

Now, I do understand that the VA is working on a special outreach program for returning OIF and OEF veterans who are Native Americans. And, Dr. Petzel, VISN 19 is participating. Will VISN 23 be implementing that program as well?

DR. PETZEL. Thank you. We will be participating and we have been participating. We have not called it a special outreach, but we visit each one of the reservations annually in conjunction with VBA and the State Veterans Commissioners to provide for an opportunity for American Indian veterans to avail themselves to our services.

And we will be folding into that a special attempt to try and reach out to the returning OIF, OEF veterans. We also do have on three of the reservations actual PTSD programs, an inpatient, if you will, or residential program on Pine Ridge, and then the PTSD telepsychiatry programs at Rosebud and Standing Rock.

MS. HERSETH. Thank you.

Let me turn to another topic that I know, Dr. Perlin, you are well aware of my interest in. That is the long-term care needs of veterans.

Now, most aging Americans who enter nursing homes or long-term care settings do so because they need assistance with daily living ac-

tivities. Now, for a rural veteran who has difficulties with daily living activities, telemedicine may not be the solution to help them remain independent. And, of course, we have other challenges in reaching those veterans in offering adult day care or geriatric foster homes.

So are we getting to the point where we have a comprehensive plan to address the long-term needs of aging rural veterans and are there plans either fiscal year 2006 or fiscal year 2007 for adult day care and geriatric foster homes again targeted toward rural aging veterans?

DR. PERLIN. Congresswoman, you present a challenge that has many layers. First, the challenge of an aging society. And we at the Department of the Affairs certainly are at the bow wave of this aging trend.

And I think you have heard certainly the Secretary's and all of our passion not only on providing the best institutional care when it is necessary but when there are other alternatives, providing the best support of noninstitutional care to maintain spousal relationships and community relationships and so forth.

I am pleased to note that the IG recently published a report that said that we made significant progress in really filling in some of the gaps in the noninstitutional care programs that a year ago the GAO had identified as opportunity for the department.

The challenge that you identify has the additional layer that in areas that are somewhat rural, there often are providers who will make home visits and offer the home services. In areas that are truly remote, it is a particular challenge and not just for VA, but it really comes down to whether you dislocate the patient from their home setting or whether you find something that is completely nontraditional.

And I would agree with you that telehealth and telemedicine is a wonderful adjunct up to a point, the point where the person has limitations either mentally (with limited cognitive function to be safe) or with the physical ability to care for themselves particularly if there are either no- -or also aged or frail caregivers.

And that is a challenge we are grappling with. Our approach has been to actually increase telehealth and telemedicine and extend the relationships with those entities that do exist in the community.

I might ask Dr. Darkins, who is particularly interested in this area, to provide additional comment as he runs the care coordination and telehealth programs.

DR. DARKINS. Thank you very much. I would absolutely agree that telehealth is not a panacea for everything, but it is something we are integrating with those other services. So it is a way in which a veteran can remain independent to self-manage their disease. And in collaboration with assistive services from long-term care, for example, medical foster home care.

We are also assessing these patients to really see exactly what the

mix of telehealth and other services is going to be in the future and based on this data. So as we evolve these programs, in how we are take them forward.

MS. HERSETH. Mr. Chairman, if I may go over time just to add one final comment.

MR. BROWN OF SOUTH CAROLINA. Yes.

MS. HERSETH. We have often on the Committee, a number of us have, you know, as we try to leverage most effectively the limited resources among different agencies, whether it is the VA, whether it is IHS, but also as we continue to grapple with Medicare reimbursement because we do face—we are at a disadvantage in rural America when it comes to home healthcare because we do not have some of the economies of scale. We have to travel farther distances.

And so I do think that any type of collaboration, while you are looking at and evaluating the mix of needs as some of our other healthcare providers and rural America are doing the same, that we look at this as perhaps the prime opportunity to leverage resources locally in the State and some of the Federal resources among different agencies to best meet that need and overcome the disparity that I believe exists in providing a very efficient form of healthcare and home healthcare to lower the costs in our more institution-based care.

So I thank you for your testimony.

Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you. We are glad to have you with us today.

And thank you, gentlemen, for your testimony, and we will proceed with the second panel.

DR. PERLIN. Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. From the great State of our Ranking Member, we welcome Dr. David Hartley. He is Director of the Maine Rural Health Research Center and a Professor of Health Policy and Management at the Muskie School of Public Service at the University of Southern Maine.

Dr. Hartley has and continues to focus on research on access to mental health and substance abuse prevention services in rural areas.

In 2003, his sustained research in rural mental health was recognized by the National Rural Health Association with their Distinguished Research Award.

And from my great State of South Carolina, we are pleased to welcome Dr. Graham Adams. He serves as the Executive Director of the South Carolina Office of Rural Health. Located in Lexington, South Carolina, this not-for-profit entity works to improve and enhance rural health delivery throughout South Carolina.

Dr. Adams has worked extensively in the areas of rural health, public health infrastructure development, community mental health,

and program development for under-served populations.

He has provided leadership to many public health and access improvement projects and currently serves on the advisory boards of many state, regional, and national initiatives. Dr. Adams currently serves as the President for the National Organization of State Offices of Rural Health.

And, gentlemen, welcome, and please proceed, Dr. Hartley, with testimony.

STATEMENTS OF DAVID HARTLEY, Ph.D., MHA, DIRECTOR, MAINE RURAL HEALTH RESEARCH CENTER, AND PROFESSOR OF HEALTH POLICY AND MANAGEMENT, MUSKIE SCHOOL OF PUBLIC SERVICE, UNIVERSITY OF SOUTHERN MAINE; AND GRAHAM L. ADAMS, Ph.D., EXECUTIVE DIRECTOR, SOUTH CAROLINA OFFICE OF RURAL HEALTH, AND PRESIDENT, NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH

STATEMENT OF DAVID HARTLEY

DR. HARTLEY. Well, thank you, Chairman Brown and Mr. Michaud and members of the Committee, for the opportunity to testify before this Committee.

I am speaking here today as a member of the Institute of Medicine's Committee on the Future of Rural Health which released its report in 2005: *Quality Through Collaboration; The Future of Rural Health*. Key recommendations of that rural IoM report are relevant to the quality of care that is available to rural veterans.

In *Quality Through Collaboration*, we brought the Institute of Medicine's quality chasm principles to bear on rural services and rural communities, and suggested that they can improve both the quality of personal care and the health of whole rural populations. Our report included twelve recommendations and four key findings.

Several of those recommendations are particularly relevant to rural veterans. With 44 percent of new recruits coming from rural places, we can expect an increase in veterans from Iraq and Afghanistan returning to rural America recovering from combat-related injuries both physical and emotional.

As a member of the IoM Committee, I see much common ground between the needs of rural veterans and the needs of rural populations more generally.

Three of our recommendations are especially relevant to the current issues facing rural veterans. First, an agenda to strengthen the rural workforce; second, health information technology, including a plan to convert to electronic health records; and, third, rural mental health and substance abuse services, a fragmented, under-funded,

non-system.

I believe we can make advances in three areas that will assure quality care to rural veterans and accelerate the agenda for providing quality care to all rural residents.

The Department of Veterans Affairs has the best integrated health information network in the nation with performance measures to assure that all patients receive high quality care. That system gets good outcomes for those who can receive and get to VA clinics.

The VA also has a residency program through affiliations with 107 medical schools. The IoM Committee struggled with the emphasis of graduate medical education on urban teaching hospitals.

In its 2005 report, the Advisory Committee on the VHA residency program recommended that the VA should maintain this training in areas of importance to the VA and to the nation, and that this might include geographic redistribution.

We know that physicians who grew up in rural areas and those who are trained in rural practices are more likely to locate in rural communities. I suggest that the needs of rural veterans warrant investment in rural sites in the VA residency program to assure that physicians are available to meet the needs of rural veterans.

The state-of-the-art information infrastructure that I just mentioned will help to assure that residents trained in VA sites are well-prepared to meet the high-quality standards set by the VA.

There are many rural areas of the United States where veterans do not have ready access to a VA clinic, but do have community health centers, rural health clinics, and critical access hospitals. If these types of providers partnered with the VA's information infrastructure, veterans living in such areas could receive high-quality care and these providers could establish 21st century information systems. Such collaborations would benefit veterans immediately and eventually other rural residents.

In much of my career, I have documented the lack of specialty mental health services in rural areas and explored models for delivering such services in the absence of psychiatrists and other mental health specialists.

Lacking mental health services, rural people with psychiatric problems have typically sought help from their primary care practitioners. Research tell us that such care has not always been of the highest quality.

Two conditions of veterans now returning from Afghanistan and Iraq may not be accurately diagnosed by primary care practitioners, posttraumatic stress disorder, PTSD, and traumatic brain injury, TBI. When such disorders are suspected, travel from a rural area to an urban area for VA specialty care might be the only way to get quality care.

In many of our most rural states, however, there is no VA TBI pro-

gram. And the symptoms of PTSD often affect the whole family and may lead to domestic violence, child abuse, divorce, substance abuse, and suicide. The lack of services in rural areas poses a significant barrier to effectively addressing these problems.

My research suggests that creative solutions are needed to address mental health and substance abuse problems in rural areas. To meet such needs for rural veterans, it might be necessary for the VA to establish its own rural behavioral health research center.

The Veterans Administration has an opportunity to build on the foundation established by the Institute of Medicine's rural report, to improve access to quality care for rural veterans, and to bring its unique resources for quality improvement and information management to rural providers. This looks to me like a win-win opportunity.

That concludes my testimony. I will be happy to answer any of your questions.

[The statement of David Hartley appears on p. 55]

MR. BROWN OF SOUTH CAROLINA. Dr. Adams.

STATEMENT OF GRAHAM L. ADAMS

DR. ADAMS. Thank you, Chairman Brown.

Good morning. I am Graham Adams, Executive Director of the South Carolina Office of Rural Health and 2006 President of the National Organization of State Offices of Rural Health or NOSORH.

All 50 State Offices of Rural Health serve rural communities by assisting rural providers, communities, and policy makers in improving access to quality healthcare. I appreciate the opportunity to speak before you to discuss this important matter this morning.

Veterans that live in rural communities face great challenges when trying to receive care. Lack of an adequate number of CBOCs, vet centers, or other approved sources of care make it difficult for rural veterans to receive timely, appropriate care.

According to the VA web site, my home State of South Carolina only has nine CBOCs and three vet centers. This is especially concerning given that South Carolina is one of the top 20 states in which veterans reside with 14.2 percent of the state's population being veterans.

Currently more than 44 percent of military recruits come from rural communities. A 2004 NPR report claimed that 44 percent of all soldiers killed during Operation Iraqi Freedom were from communities under 20,000 people.

Given this great commitment to service on behalf of rural communities, we need to do more to closely examine the healthcare barriers that face rural veterans. Developing solutions specific to rural veterans and their unique needs is the least we owe them.

First, develop a proactive policy of the VA contracting with Federally qualified health centers, rural health clinics, critical access hospitals, and other small, rural hospitals to provide care to rural veterans.

Approximately 20 percent of veterans who enroll to receive health-care through the VA live in rural communities. While CBOCs and vet centers provide essential points of access, there are not enough of these facilities in rural communities.

VA providers are known for providing good, quality care to those they serve. However, more providers are needed to serve the increasing number of rural veterans.

One immediate and logical solution to this dilemma would be to facilitate the VA contracting with existing rural healthcare facilities. Contracting with Federally qualified health centers and rural health clinics for primary care and critical access hospitals and other small, rural hospitals for inpatient services would allow more rural veterans to receive care in their home communities.

While Congress has adopted legislation encouraging VA collaboration in the Veterans Millennium Healthcare and Benefits Act, few examples of this collaboration exist in my home State of South Carolina today. More needs to be done to facilitate these VA partnerships and engage and adequately reimburse existing local providers in every state in rendering care to rural veterans.

Federally qualified health centers and rural health clinics receive cost-based reimbursement or enhanced reimbursement respectively for Medicare and Medicaid encounters. Both have been proven models for increasing access to under-served populations in isolated communities for decades.

Using evidence-based medicine and uniform standards of care, the VA needs to sharply focus on developing more access points through these partnerships with Federally qualified health centers, rural health clinics, and critical access hospitals.

Two, bolster rural mental health and family support services for veterans residing in small or rural communities. A lack of qualified mental health professionals, shortage of psychiatric hospital beds, and the negative stigma of mental illness often result in many rural residents not getting the care they so desperately need.

In addition to the normal stressors which drive individuals to seek mental healthcare, veterans can have the added challenges of dealing with service-related situations or mental illnesses. Problems derived from combat situations, readjustment to civilian life and work, and marital and family issues related to long absences from home often greet veterans as they return home from service.

Although vet centers provide these services, they are not consistently available at the local level. Due to the lack of rural mental health providers and a scarcity of psychiatric hospital beds, some in-

dividuals with mental illness end up being incarcerated in lieu of receiving proper treatment.

Our broken mental health system is not unique for veterans. However, given their service to our country and the unique needs that they often have, it is incumbent upon the VA and rural providers to do better.

However, in order to improve the situation, more resources must be made available in order to contract with local mental health providers, hire additional mental health providers, and contract with and adequately reimburse critical access hospitals and other small, rural hospitals to serve these patients.

Third, identify, fully fund, and replicate best practices in rendering healthcare, mental health, and family support services to veterans in rural communities.

Although veterans face many challenges in seeking and receiving care in rural communities, there are undoubtedly many communities where VA facilities, local healthcare providers, and advocates have worked together to develop models that work.

The VA needs to identify these models, study and analyze the data of where and when veterans currently interact with the system, and fund the replication of new and diverse efforts in rural communities.

This analysis of the unique needs of rural veterans, what is working and what is not, will educate and enrich the dialogue of providing care to those who have served our country.

The VA needs to collaborate with State Offices of Rural Health at the State level and HRSA's Federal Office of Rural Health Policy at the Federal level to coordinate these activities.

While many opportunities for improvement exist in providing care to veterans in rural communities, the VA is to be commended for the excellent service provided in many of its facilities.

Providing healthcare in rural communities requires unique solutions whether it is to veterans and their families or to the general population. Adopting some of these strategies referenced in this verbal testimony will aid in addressing these rural issues.

Thank you for the opportunity to speak today.

[The statement of Graham L. Adams appears on p. 61]

MR. BROWN OF SOUTH CAROLINA. Thank you, Dr. Adams, and thank you, Dr. Hartley, for your testimony.

We will now entertain a few questions and I will take the lead.

Dr. Hartley, in your opinion, is there a lack of contract providers who can meet VA's high standards of care in rural areas?

DR. HARTLEY. I think that your question has more to do with the high standards than whether the providers are actually there. And I cannot say that I can answer that definitively.

What I can say is that the IoM Committee recognized that par-

ticularly with respect to the role that information technology plays in meeting those high standards, the answer would be no. We need to improve the availability of information technology for our rural providers.

Now, I would add that from my personal experience, community health centers are doing a better job of getting up to speed certainly in my State than many other rural providers.

So I would say the first opportunity to contract with the VA would probably in many of these rural areas would be with the CHCs because they are rapidly catching up in terms of information technology. And once you have got that in place, I think that the sequence of events in terms of developing high-quality standards falls into place. But information technology is the key.

MR. BROWN OF SOUTH CAROLINA. Do you sense any problems with the electronic transfer of the veterans' records into those community centers? Is that a technical problem?

DR. HARTLEY. A technical problem? Well, I am not familiar enough with how VA contracts are structured to know whether that would raise any problems or not. My sense is there would have to be some flexibility on the part of the VA to make those contracts work. But I am not an expert on their contracting process.

MR. BROWN OF SOUTH CAROLINA. Let me just ask one further question. Many studies have shown that practice makes perfect. When it comes to medical procedures, wouldn't the low volume of patients in rural areas be an obstacle to training physicians and nurses in maintaining the necessary expertise required for teaching hospitals to be centers for technically sophisticated and innovative services?

DR. HARTLEY. I am sorry. I think I missed part of the question.

MR. BROWN OF SOUTH CAROLINA. Okay. In general, even with the consolidation of some of the services, is there enough volume to attract in the rural areas qualified physicians and nurses and how does that interface with the telemedicine part of it?

DR. HARTLEY. Well, that is part of the answer is that there is enough volume certainly to sustain a primary care system. When the needs go beyond the ability of the primary care system to meet them, one of the ways we meet those needs is through telehealth.

I was very pleased to hear the folks from the VA testifying earlier talking about telehealth, for example, outreach to treat PTSD which I was not aware of.

Certainly in the case of mental health, telehealth can do a great job because it does not involve hands on in many cases. And so it is an appropriate technology and it has been well received by some patients.

I think there are many questions, though, that are remaining unanswered in terms of what exactly we can expect to deliver at that level of quality in areas of very, very low population density. There

are always going to be limits and certainly we cannot expect to deliver everything out there.

MR. BROWN OF SOUTH CAROLINA. Okay. Thank you very much.

Dr. Adams, you suggested in your written statement that VA should do more to contract with critical access hospitals for specialty mental health services.

Do you believe that mental health providers exist in large enough numbers in those facilities to assist the VA?

DR. ADAMS. Well, sir, I know that mental health is a problem in all rural communities. And with the limited number of CBOCs and vet centers available, especially in some of our more rural states, using the critical access hospitals and other small, rural hospitals as a source of that care through contract, I think, could be a viable option.

There are more than a thousand critical access hospitals throughout the nation. And if you look at contracting and reimbursing adequately critical access hospitals and Federally qualified health centers and rural health clinics in meaningful partnerships, I believe that you can help to increase access for rural veterans without spending undo money and replicating some resources that might already be available in the community.

MR. BROWN OF SOUTH CAROLINA. In South Carolina, do you have a capacity problem as you try to deal with these special hospitals? Can they absorb the VA needs adequately?

DR. ADAMS. In South Carolina, specifically in rural communities, whether it is veterans or nonveterans, so often the mental health system is not in place, especially after hours and on weekends. And these folks show up at the ER of their small, local hospital. And oftentimes if they are decompensated, they are not doing well, they end up being carted off to jail and incarcerated because the local mental health system cannot deal with it. I think because of the lack of psychiatric beds, that is an additional problem that there are not even the beds available for them to be admitted into.

MR. BROWN OF SOUTH CAROLINA. Let me ask you a follow-up question. Do you personally believe that marriage and family therapists should be considered a valuable resource in curbing mental health related illnesses of veterans?

And the reason I ask is that we have provided MFT new authority to provide care for veterans in our legislative package that should be rolled over in the next few weeks.

DR. ADAMS. I do. I think that marriage and family therapists and other types of mental health counselors are vital, especially to the younger veterans that are coming back from service currently. All those issues that are involved with them being away from home, if they have posttraumatic stress disorder, so many of those issues could really—the family could benefit from a marriage and family

therapist. And in some cases, those kind of resources are available locally at a community health center.

So that is an opportunity where I believe the VA should look around, see what resources exist, and try and contract for those services instead of replicating the resource in the same community just because it has the VA name on it.

MR. BROWN OF SOUTH CAROLINA. Okay. Thank you very much.

Mr. Michaud.

MR. MICHAUD. Thank you very much, Mr. Chairman. I want to thank Dr. Adams, Dr. Hartley for your testimony this morning.

I also want to just comment briefly on Mr. Moran's question earlier to Dr. Perlin about the collaboration with Federally qualified health clinics or critical access hospitals, and Dr. Perlin said that they do try to collaborate.

I am not sure that message is getting out there in the different VISNs because I know one VISN in particular where you have a critical access hospital, you have a Federally qualified healthcare clinic, and you have the VA coming in and building a new clinic instead of working collaboratively.

I think when you look at rural healthcare, we have to work more in a collaborative effort to make sure that our veterans get the care that they need and deserve.

Dr. Hartley, in your testimony, you discussed a difficulty that rural veterans may face in receiving accurate and high-quality care for PTSD and TBI.

Is there a role that the VA can play in reaching out to these rural care providers to assist in awareness, diagnosis, and referral and treatment?

DR. HARTLEY. I am sure there is. In my experience, this is very similar to the problem that we have had with primary care practitioners not recognizing depression or recognizing it and not treating it according to protocol.

And there is quite a history of efforts to improve what we call guideline concordant care in the primary care setting. There has been a lot of research done on that and a lot of different things have been tried. And much of it is outreach of different sorts.

And it seems to me that the same kinds of expertise could be transferred to those same providers and it does seem to me that it is the VA who has the expertise. They are the folks in their VA centers who have the best skill in knowing how to recognize and how to deal with these cases.

It might be something new for them to do that kind of a collaboration with the primary care system that does not treat veterans, but I think they definitely have something to offer.

MR. MICHAUD. Could you elaborate on how the VA could build upon the Institute of Medicine recommendation for enhancing rural

healthcare?

DR. HARTLEY. Well, I have mentioned two particular areas that I think that they could have a huge impact. One of them is because they have so many training sites. If they were to make it a priority to have rural training sites and rural rotations, then we would have more physicians and other healthcare practitioners having experience practicing in rural areas which means from what we know that they would be more likely to end up practicing there. So that is one area.

The other one that I think is even more important, of course, is information technology. The VA, as I said, has a very good system. Both the technical aspects of it and the quality indicators of it, the performance measures, all of that, it is why we have such good care for our veterans.

That seems to me to be a great opportunity to transfer that technology and that expertise by way of these collaborative contracts to many aspects of our rural health infrastructure. It just seems to me like a great opportunity.

MR. MICHAUD. Thank you. And my last question, in rural and remote locations where there is no VA presence, community health centers, and rural clinics, maybe the default mental healthcare system for veterans, and this is for either one of you or both of you. What do you recommend VA do to reach out to these centers and clinics to help provide care for veterans?

DR. HARTLEY. Were you speaking specifically of mental health?

MR. MICHAUD. Yes.

DR. HARTLEY. Well, I think Graham had some specific statements on that in his—

DR. ADAMS. I might suggest developing some kind of a working group or a committee between the National Association of Community Health Centers, the National Association of Rural Health Clinics, the VA, and other interested parties to really sit down and discuss the issue because, to my knowledge, those discussions have not occurred at that level. They may have, but I am not aware of it.

Going on the VA web site, you do not have access to the other information about the 1,000 partnerships with community health centers that the VA staff referenced. When you go on my State, it shows the nine CBOCs, three vet centers, and the two VA MCs.

So I think if indeed those partnerships are out there, maybe we can do a better job of educating and marketing the fact that they are available to rural veterans and helping them to develop those linkages.

DR. HARTLEY. There is another opportunity. There is a provider type that we have not really mentioned at all today and that is the community mental health centers.

Now, community mental health centers, that is not an official, spe-

cific designation the way Federally qualified health center is. There is quite a bit of variability out there. And I would not make a blanket recommendation that we contract with all of them, but the VA does have a system for establishing qualifications before they will contract with someone.

It does occur to me that that is one of the few entities in rural areas that has an infrastructure for treating mental healthcare including in many cases marriage and family therapists and including sometimes psychiatrists, often psychologists. They are out there already.

And, again, it is this issue of we cannot afford to have duplicate systems. That is an opportunity that we should explore. And certainly the idea of having a cooperative committee to consider these options is a good starting place.

DR. ADAMS. I might offer that the National Rural Health Association might be the appropriate entity to facilitate that dialogue given that they are kind of the umbrella association for all rural health needs.

MR. MICHAUD. Once again, I want to thank both of you for your testimony. Thank you.

Thank you, Mr. Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Michaud.

Mr. Moran, do you have a question?

MR. MORAN. Yes, sir. Thank you, Mr. Chairman, and thank both our panelists for taking the time to prepare and be here today.

Dr. Adams, you heard Dr. Perlin respond to my question. I wanted to give you a chance to react. It appears to me that what Dr. Perlin was suggesting is that the opportunities for veterans to be cared for in their local communities in the absence of a VA CBOC or vet clinic or an actual hospital for routine services is pretty minimal, that the VA is interested in contracting with providers to meet the emergency needs, the traumatic needs of veterans in those rural settings.

And also as I understand, as we use the word collaborative here this morning, what I was interested in—obviously collaboration is a good thing. We all want to collaborate. But what I actually was most interested in is there ever an instance in which the veteran is seen by a hometown physician, admitted to a hometown hospital, treated at a community health clinic, treated at a mental health center, or when we talk about collaboration, is that something just very esoteric, that that never results in veterans being treated at home?

I am a proponent of CBOCs. I have worked hard to bring CBOCs to veterans in Kansas, but I always have seen that as an intermediate step for routine services ultimately being provided by the hometown physician. Actually, the physician does not have to be hometown. The physician of the veteran's choice, the clinic, the hospital of the veteran's choice. Again, distances to a CBOC can be two and three hours.

And so it appears to me that a couple of explanations by the VA why that is not at this point a good idea is technology, medical records. We have been through this issue with the VA on filling prescriptions. They want their own physician to write the script, not necessarily the hometown doc of the vet for purposes of quality care.

And then finally, is there any legislative authority that is lacking in trying to get the VA to move in this direction? Your thoughts to any and all of those things? You as well, Dr. Hartley, if you have an opinion.

DR. ADAMS. In preparation for my testimony, I spoke with two Executive Directors of Federally qualified health centers in my State, one of which is the St. James Santee Community Health Center, which is in Chairman Brown's area. And both of those facilities said that there is no formal collaboration. There is no formal partnership with the VA and their Federally qualified health center.

One Executive Director referenced that they do see TRICARE patients. They used to not see those patients. But when the War in Iraq really started to accelerate, they wanted to do that as service to the enlisted and veterans in their community. They see basic TRICARE. They do not see the upper tier of TRICARE because of the hassle associated with referrals and such.

So while some of these community health centers do voluntarily see veterans with TRICARE, none that I spoke to had any formal arrangements or any formal contracts nor had been approached.

I also in preparation for the testimony spoke with the Executive Director of our State primary healthcare association, which is the trade association for all of the Federally qualified health centers in South Carolina. And she also did not know of any formal arrangements, any dialogue between the VA and her association or any of her specific clinics.

So I think that while there may be the intent to go out and develop collaborations from my research and my years in the field, I have not seen any real tangible partnerships. I have read of certain circumstances in Utah and Missouri and Wisconsin where the VA does contract with community health centers and that seems to be working well, but I do not know too much about the specifics.

I feel that there is certainly an opportunity for the VA staff to sit down with specifically the National Association of Community Health Centers and talk about a meaningful way that the VA could contract with community health centers at either their Federally approved rate or a lower rate and provide some basic services.

But I would agree that it is not satisfactory to drive two, three hours for basic, routine care. And we all know that if it is a barrier—a lot of these folks do not have transportation—if it is a barrier, a lot of folks just do not seek care and then something that could have been taken care of earlier on that could have been routine care is go-

ing to escalate and cause that person to be hospitalized and cause the severity of the illness to be greater.

MR. MORAN. I recognize this issue is not without its whole set of issues in the sense that many of our veterans service organizations fear the diversion of resources from the VA system. That is obviously a legitimate concern.

And quality of care, the medical records that the VA has developed, their information technology system is becoming the premier information technology system in the healthcare delivery world.

So there are issues. But it does seem to me that for the care of the veteran that the VA has to go beyond the mindset that we are only going to provide emergency care for veterans, that we are also going to provide routine care, particularly in the setting when it is hours and miles away from access to a VA physician or clinic.

And it is also important, Mr. Chairman, you know, much of my time on healthcare issues in Congress have been associated with trying to keep access to healthcare available in rural communities. And just like a rural community needs every student in their school system, a hospital and a doctor needs every patient in the healthcare delivery system. That is about revenue, about keeping doors open.

And so as we divert our healthcare dollars away from local healthcare providers, we reduce the chances that rural healthcare is going to survive and be available to anyone in our smallest communities across the country.

And I appreciate the testimony of our witnesses. And, again, I want to be complimentary of the VA. This is an area, though, in which I look forward to working with them to see that we improve access to veterans and at the same time, strengthen our delivery system for all of rural America as we try to provide healthcare for every American.

I thank the Chairman.

MR. BROWN OF SOUTH CAROLINA. Thank you, Mr. Moran.

And thank you very much, Dr. Adams and Dr. Hartley, for coming and sharing this very informative testimony and as we continue to work towards more collaboration to do like Mr. Moran said, to try to keep as much of a practice within the rural communities as possible.

I recognize the innovation of telemedicine and some other innovative ways of working to meet the veterans healthcare needs. We hope that we can find enough joint effort within our provider system to make it a quality healthcare delivery system.

And we appreciate your testimony and appreciate your interest. And certainly as we move forward in this collaboration, if we need local legislation in order to make it an easier accommodation, we would certainly be willing to listen.

Thank you for coming.

Hold a minute. Members have five legislative days in order to submit an opening statement. Anyway, thank you all for coming.

And without any other business before the Committee, we stand adjourned.

[A statement for the record of Cathleen C. Wiblemo, Veterans Affairs and Rehabilitation Commission, American Legion, appears on p. 66]

[Whereupon, at 11:25 a.m., the Subcommittee was adjourned.]

APPENDIX

OPENING STATEMENT
HONORABLE HENRY E. BROWN, JR.
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS

Subcommittee on Health Oversight Hearing on to examine the Department of Veterans Affairs (VA) efforts to provide high quality health care to veterans in rural communities.

June 27, 2006

The Subcommittee will come to order.

Good Morning. This morning we have assembled to take a close look at how the VA is providing for the care of our veterans who may live at great distance from a VA medical center, a community based outpatient clinic, or perhaps even a vet center.

This is not the first hearing that we have had on this subject, nor do I expect it will be the last. Due to the large number of servicemen and women we have returning from Iraq and Afghanistan, and due to the number of those folks who may hail from rural areas, additional pressures are currently being placed at VA's doorstep as more people desire to receive their care from the VA.

This is probably a good problem to have in a sense as it is a testament to the fine job that Dr. Perlin and his team are doing to provide or purchase care for our nation's veterans not only in urban areas, but also in those more remote areas of the country.

Having said that, we need to be able to effectively bridge the distance gap. And one thing is clear: the gap cannot--and should not-- in my opinion, be bridged by simply erecting new VA buildings on every street corner across the nation.

Rather, we should seek to use new, emerging technologies to export the expertise that resides inside the VA medical centers, CBOCs or the vet centers.

The expanded use of telemedicine, while not a panacea, can go a considerable way toward alleviating some of the distance-based challenges in the areas of primary care, mental health and even long-term or home-based care. I suspect our VA witnesses will provide greater detail on what can currently be accomplished in that area and what we can anticipate in the future.

Equally important to the use of new technologies, we should also seek to collaborate with local community providers wherever possible to ensure that the level of care and quality that VA provides can be expected of others if VA chooses to purchase those services in a given area.

I know the department has taken steps toward doing that by moving forward on important initiatives like Project HERO—a multi-VISN demonstration project that will attempt to better coordinate and improve the purchased care that VA relies upon, sometimes in very rural areas.

As many of you probably recall, we had a hearing on Project HERO and are all anxious to see it rolled out later this year.

As I suggested, this will not be the last hearing we have on rural health care at VA. But equally important, we should also recall our last hearing on this important topic. This subcommittee had the distinct pleasure of traveling to Maine last summer to examine how the state handles its uniquely rural VA population. We had the opportunity to do that because the Ranking Member, and my friend, Mike Michaud, invited us to his beautiful district.

Mr. Michaud and I share an interest in rural health and I am privileged again today to examine VA's successes and challenges with my good friend from Maine. I also look forward to working with him on our upcoming health bill, and incorporating some of his rural health provisions into that package.

With that, I would yield to the gentleman from Maine for his opening statement....

Thank you, Mr. Michaud.

Let's now turn to our first panel. The Subcommittee welcomes **Dr. Jonathan Perlin**,  Under Secretary for Health, testifying on behalf of the Department of Veterans Affairs. Dr. Perlin is accompanied by **Patricia Vandenberg**, Assistant Deputy Under Secretary for Health for Policy and Planning, **Dr. Adam Darkins**, Chief Consultant for Care Coordination, and **Dr. Robert Petzel**, Network Director, VISN 23.

Welcome Dr. Perlin and please proceed.

Thank you Dr. Perlin for your testimony and participation at today's hearing.

The Subcommittee now asks the second panel to come forward.

From the great State of our Ranking Member, we welcome Dr. David Hartley. He is the Director of the Maine Rural Health Research Center and a Professor of Health Policy and Management at the Muskie School of Public Service, at the University of Southern Maine. Dr. Hartley has and continues to focus on research on access to mental health and substance abuse prevention services in rural areas. In 2003, his sustained research in rural mental health was recognized by the National Rural Health Association with their Distinguished Researcher Award.

From my State of South Carolina, we also are pleased to welcome Dr. Graham Adams. He serves as the Executive Director of the South Carolina Office of Rural Health. Located in Lexington, SC, this not-for-profit entity works to improve and enhance rural health delivery throughout South Carolina.

Dr. Adams has worked extensively in the areas of rural health, public health infrastructure development, community mental health and program development for underserved populations. He has provided leadership to many public health and access improvement projects and currently serves on the advisory boards of many state, regional and national initiatives. Dr. Adams currently serves as the President for the National Organization of State Offices of Rural Health.

Gentlemen, welcome and please proceed with your testimony.

Once again I thank all our witnesses, and our Subcommittee Members, for their participation and attendance today. This has been a very helpful and informative hearing. We thank you all for attending.

With nothing further, the hearing stands adjourned.

Opening Statement of Congressman Michael Michaud
Ranking Member of the House Veterans Affairs Health Subcommittee
June 27, 2006

Thank you, Chairman Brown. I greatly appreciate you holding this hearing to explore VA's efforts to improve rural veterans' access to high quality VA health care. I also want to thank all the witnesses for coming today.

I am glad that Dr. Hartley, from Maine, is able to be here. As a member of the committee that wrote the 2005 groundbreaking Institute of Medicine report on the Future of Rural Health, he has a great deal of expertise on the challenges facing rural communities in providing high quality state-of-the art health care.

Next week we will celebrate our nation's Independence Day. Along with the picnics and parades is the recognition and respect for the courage of farmers who took up arms to fight for freedom. The revolution that transformed colonies into a new nation happened because of rural citizen-soldiers.

Since that revolutionary war, rural communities – certainly Maine – have continued to answer their nation's call to service. Roughly, sixteen percent of Mainers are veterans: one of the highest in the country. Across the nation, roughly one in five veterans enrolled in VA health care are from small towns and rural communities. In time, the percentage of rural veterans will likely increase because more than 44% of the recent U.S. military recruits are from rural areas.

It is important that we honor veterans with action and not just words. Doing so is all the more important while we have service members in harm's way in Iraq and Afghanistan.

Studies, including the recent IoM report on the Future of Rural Health, have repeatedly shown that rural communities, especially veterans, face unique challenges to access high quality care, such as distance and availability of specialists.

While there are a number of efforts underway to improve access for rural veterans to VA's high quality care, I am concerned that we are not adequately preparing and planning for the needs of elderly veterans, disabled veterans, and the younger generation of veterans returning from Iraq and Afghanistan to their homes in rural and remote communities.

I have introduced legislation, H.R. 5524, the Rural Veterans Health Care Act of 2006, which is a comprehensive approach to improving the quality of care available to rural veterans.

Following the advice of the IOM report, my bill aims to create:

- An integrated, prioritized approach to addressing individual and community health needs;
- A strong “quality improvement” support structure to help health care providers acquire tools and knowledge necessary to improve quality of care;
- An increased capability to recruit, train and retain more highly dedicated health care professionals; and
- A secure IT infrastructure that will be so important to enhancing services and delivery of services to rural veterans.

My legislation takes a comprehensive and practical approach towards improving care for our rural veterans by increasing facilities and outreach; encouraging recruitment and training of health care professionals; focusing on research; and developing the IT infrastructure we need to enhance services in rural areas.

My legislation has support from veterans’ service organizations, like The American Legion, Military Order of the Purple Heart and Vietnam Veterans of America. The National Rural Health Association also supports H.R. 5524.

Thank you, again, Chairman Brown for holding this important hearing. I look forward to working with you to improve VA’s efforts to provide high quality care to rural veterans.

**STATEMENT OF
THE HONORABLE JONATHAN B. PERLIN, MD, PhD, MSHA, FACP
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS**

**BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS**

JUNE 27, 2006

Good Morning/Good Afternoon, Mr. Chairman and members of the Committee. Thank you for this opportunity to discuss ongoing efforts in the Veterans Health Administration (VHA) to provide safe, effective, efficient and compassionate health care to veterans residing in rural areas. Accompanying me today is Ms. Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning, Dr. Adam Darkins, Chief Consultant for Care Coordination, and Dr. Robert Petzel, Network Director, VISN 23.

VHA is committed to providing the highest quality of care to all veterans and understands that although veterans in rural areas face many of the same health concerns as veterans in urban areas, rural area veterans often face additional challenges such as limited finances and fewer specialists. These combined challenges have produced a situation where veterans in remote regions experience a reduced health-related quality of life. I share the Committee's concern for these veterans and would like to take a few minutes to discuss current programs and new initiatives within VA that significantly improve the quantity and quality of health care, while reducing costs and increasing access without the need for new legislation.

RURAL HEALTH INITIATIVES

VA has undertaken a number of efforts aimed at addressing delivery of health care services to rural veterans. Central to these efforts are several major initiatives now being implemented throughout the VA system: our Capital Asset

Realignment for Enhanced Services (CARES), which provided a framework for prioritizing new Community Based Outpatient Clinics (CBOCs), and fee-based service with private health care providers; and our telehealth and telemedicine programs, which are using new technology to bring doctors to their patients, rather than patients to their doctors. I will now discuss these efforts and others in greater detail while providing information on key health concerns facing many of our veterans.

CBOCs / CARES / CHCs

First, I'd like to tell you about our efforts with CBOCs, which are rooted in ambulatory and primary care and have provided VHA its preliminary foundation for enhancing rural access. Early on, VA recognized the value of CBOCs in meeting the primary care needs of rural veterans. In 1995, VA had 102 community based clinics and by 2000, VA had 600 CBOCs.¹ Because we recognize that CBOCs are an important component of the VA health care delivery system, we have continued to establish health care services in community settings where veterans are better able to gain access to health care services. Today, VA has over 700 CBOCs and operates or contracts for care at 100 outpatient clinics located in areas considered rural or highly rural. Between 2000 and 2003, VHA added 67 CBOCs, which brought VA health care to within thirty minutes of another 70,000 veterans. By the third quarter of Fiscal Year 2004, VA was operating or contracting for care at 76 CBOCs in rural or highly rural areas.

CBOCs have been the anchor for VHA's efforts to expand access to veterans in rural areas. Although VHA's CBOCs initially focused on the provision of only primary health care, more recently we have begun to include mental health services as part of the basic core services available to veterans. VHA's CBOCs

¹ Nomenclature clarification: In 1995, the term used for access points was community based or ambulatory clinic. In 2000, Community Based Outpatient Clinic or CBOC became the commonly used term.

are complemented by contracts in the community for physician specialty services or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area.

VA continues to review and implement selected CBOCs through a national approval process based upon the proposals from VA medical centers and the Veterans Integrated Service Networks (VISNs). This process allows decisions regarding needs and priorities to be made in the context of local market circumstances and veterans preferences; it creates uniform criteria and standards that must be met to ensure consistency nationwide.

This process has served VHA well throughout the years. But as demand for VHA health care continued to expand, VA recognized the need to assess the alignment of its capital assets relative to the demand for healthcare. In that context, VA, in June 2002, established the national CARES process. The goal of the CARES process is to assess veterans' health care needs in the VISNs, identify service delivery options to meet those needs for the future, and develop an associated capital asset realignment plan that assures the availability of high quality health care in the most accessible and cost effective manner, while minimizing impacts on staffing and communities and other VA missions. Through the CARES process, VISNs develop plans for capital asset infrastructure that are based on projected demand for services, evolving practices in health care delivery, demographics, and assessments of the existing as well as future capacity of physical plans to deliver accessible, high quality health care.

To further advance VA's efforts to provide quality health care for veterans and ensure an objective, external perspective to the CARES planning process, the CARES Commission was established in December 2003. For over one year, the 16-member Commission, comprised of experts in the health care industry, physicians, nurses, and veteran representatives, including former national and

state veterans service organization leaders, carefully evaluated data related to the demand for VA health care, types of services demanded, and demographics of the veteran population in geographical regions. Additionally, the Commission's analyses included views and concerns from Congressional members, individual veterans, veterans service organizations, medical school affiliates, and local government, community groups and partners and other interested stakeholders. The findings and recommendations of the Commission were submitted to VA in February 2004, and key to the Commission's findings was that it found VA's rationale for prioritizing the implementation of new CBOCs disproportionately disadvantaged rural veterans and was contrary to the goal of CARES. VA took this finding very seriously and in response, revised its national criteria for establishing CBOCs to include emphasis on the importance of access to care for rural veterans, use of CARES travel guidelines to assess access to care, and the availability of mental health services. In addition, VA also created a Directive on Rural Access Hospitals to assure quality services in rural hospitals.

VHA is now in the next phase of CARES. As part of the current CARES business studies in select market areas, Local Advisory Panels (LAP), which are, in part, comprised of representatives from veterans service organizations, governmental agencies, health care providers, planning agencies, academic affiliates, and community organization, which are ensuring that the full range of stakeholder concerns and interests are assembled, publicly articulated, and accurately documented. The needs of veterans residing in rural communities are always an important consideration in the LAP's evaluation. At this time, the Secretary is carefully reviewing the advice and requests from these panels and other interested stakeholders.

In addition to our efforts with CBOCs and CARES, VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of health care for rural veterans. We have strengthened partnerships with a number of

agencies providing health care in rural communities, including the Indian Health Service (IHS).

In the last two years, VHA and IHS have entered into a memorandum of understanding (MOU) to promote greater cooperation and sharing between the two health services to enhance health care provision for American Indian (AI) and Alaska Native (AN) veterans. In Fiscal Year 2005, more than 150 activities and programs to improve communication, expand access, ensure organizational support, and improve health promotion and disease prevention were developed and implemented under the auspices of this MOU.

Moreover, VA services are complemented by the services of community health centers (CHCs), which are local, non-profit, community-owned health care providers serving low income and medically underserved communities. For nearly forty years, this national network of health centers has provided primary care and preventive services to communities in need. Most centers try to arrange specialty care for clients with hospitals and individual health providers.

As of January 2006, more than 1,000 CHCs provide health care to community, migrant and homeless veterans and operate in more than 3,600 communities in every state and territory. Over 37,000 health care professionals work in areas designated as underserved or experiencing acute provider shortages. Three hundred sixty-one (361) CHCs are located greater than sixty minutes away from a VHA access point and are providing care to rural veterans.

As VA continues to look for ways to enhance access to health care for rural veterans, targeted partnerships with CHCs to meet specific, locally defined, health care needs in rural locations may provide an additional service delivery option to the array of practices already deployed by VA medical facilities. VHA will consider current policies and next steps that would assist VISNs and facilities to explore this option.

LTC / NURSING HOMES / DAY HEALTH CARE FACILITIES

The demand for Long-Term Care (LTC) in VA, whether in rural or urban settings, has greatly increased due to the aging of the veteran population. VA LTC has evolved from services delivered primarily in geriatric clinics and inpatient nursing home settings to a well-defined spectrum of care, including an array of home and community based care (HCBC) services.

VA believes that LTC services should be provided in the least restrictive setting where services are appropriate to a veteran's health status, functional status, and personal circumstances, and, whenever possible, in HCBC non-institutional settings. This philosophy honors veterans' preferences for care, which helps to sustain ties with their family, friends, and spiritual communities. With these other options, nursing home care can now be reserved for situations in which the veteran can no longer live safely and independently at home.

When nursing home care is needed, especially for a veteran residing in a rural area, VA identifies options for the patient from the broad spectrum of LTC venues available in the veteran's community, including, in many cases, the local State Veterans Home or contracted community nursing home care. VA makes every effort to identify options that maximize the veteran's ability to stay within his community for as long as possible. Newer options of VA geriatric healthcare, including adult day care, respite, hospice, and geriatric foster homes provide more opportunities for the veteran to stay close to home and close to family.

In a few minutes, I will also provide information on our telehealth and telemedicine initiatives and discuss how these advances provide even more options for the veteran population in need of healthcare. These newer telehealth and telemedicine options reinforce our focus on non-institutional health care options and bringing doctors to their patients, rather than patients to their doctors

MOBILE VET CENTERS:

The primary challenge in serving rural veterans is to effectively address access to care issues in areas where veteran populations are usually widely distributed over a large geographical area. Some Vet Centers are, by plan, established and maintained in rural areas, e.g., Grants Pass, Oregon; Caribou, Maine; Missoula, Montana; and Cheyenne, Wyoming, to ensure that rural veterans and families have access to readjustment counseling. Staff at rural Vet Centers engages in higher volumes of travel to reach veterans in outlying sections of their catchment areas. Travel is not solely for outreach to inform veterans about services available, but also to actually deliver readjustment counseling to veterans living at some distance from the Vet Center. This is done by establishing Vet Center outstations in rural areas such as Cedar Rapids, Iowa, the Michigan's Upper Peninsula, or Keams Canyon, Arizona on the Hopi Reservation. Outstations are administratively connected to a full sized Vet Center, utilize permanently leased space and are usually staffed by one or two counselors who provide full time services to area veterans on a regular weekly basis. Alternatively, some Vet Center counselors travel weekly to provide group and individual readjustment counseling on a once per week basis using donated space in the community. Such Vet Centers as the Hopi, Navajo, and Sioux/Rosebud Outstation also overcome cultural barriers to care by employing native peoples to staff the outstation. Also essential for Vet Centers serving the rural AI population is to participate in community ceremonies such as Pow Wows.

Other important aspects of the Vet Center for maintaining care for veterans in rural areas is to actively establish and maintain partnerships with other community providers such as state employment services, community substance abuse programs and health care providers such as IHS. Maintaining effective partnerships for referrals and supportive case coordination also may involve extensive travel to all communities within the Vet Centers' catchment area. The Vet Center program also maintains a contract program with over 300 private

sector providers under contract with VA to deliver readjustment counseling to veterans living at a distance from existing Vet Centers. Some Vet Centers in rural areas have telehealth linkages to their support VAMC which provides veterans in more remote areas access to VA mental health and primary care. The Vet Centers in Santa Fe, New Mexico, Logan, West Virginia and Chinle, Arizona on the Navajo reservation are examples of such sites with active telehealth programs. The Vet Centers also maintain some nontraditional hours keeping the Vet Center open after normal business hours or on weekends to accommodate veterans traveling in from greater distances.

MENTAL HEALTH SERVICES AND SPECIAL NEEDS

Comprehensive and effective mental health care is one of the top priorities for VA. The provision of mental health care in rural settings has historically been a challenge for all health systems and providers, including VA.

However, VA is making changes to address these needs. In Fiscal Year 2005, I began a massive investment to improve access to mental health services throughout the entire VA health care system, in both rural and urban settings. These targeted investments will come to almost \$300 million in just two years, and the intention is to continue supporting newly funded programs in Fiscal Year 2007. Of these funds, VHA has already provided over \$200 million to the VISNs for the expansion of mental health and substance abuse services and included an additional \$35 million through the Veterans Equitable Resource Allocation (VERA) process in Fiscal Year 2005 to enhance our overall mental health service capacity. Almost \$17 million has gone specifically to support adding Mental Health professional staff in CBOCs. Another \$9 million is being used to support expansion of Telemental Health programs to provide expert mental health care in rural areas. Other programs also support rural care, such as the development of Grant and Per Diem programs to serve homeless veterans in rural as well as in urban settings.

Some examples of VA's mental health program initiatives still under way for Fiscal Year 2006, or planned for Fiscal Year 2007, that will benefit rural veterans include:

- Integrating specialty mental health care into primary care and other medical settings
- Continuing to expand access to specialty mental health services at all CBOCs, either by direct staffing, local contracts, or telehealth;
- Developing and piloting a model for rural areas for implementation of the concepts of the Mental Health Intensive Case Management (MHICM) programs.
- Increasing inpatient psychiatry and substance abuse capacity in locations where ten-year forecasts estimate an increased demand for services;
- Providing timely access for homeless veterans to mental health/substance abuse assessments.

Data from 2006, reveal that we are achieving many of our goals, although some of our VISNs have more work to do. For example, Performance Measure data for the second quarter of Fiscal Year 2006, show that 87 percent of the CBOCs with over 1,500 enrolled veterans are now meeting the goal of having at least 10 percent of their visits represent delivery of mental health services. Data on wait times for established patients show that, in the second quarter, all VISNs met the Performance Measure regarding scheduling needed return mental health appointments for established patients within 30 days. We have other data indicating that as a result of our intensive efforts to expand services for rural veterans, veterans have access to service much nearer home. In 1996, VA users of mental health services lived an average of 24 miles from the nearest VA clinic; as of 2005, they now live only 13.8 miles away (just half as far).

These and other Performance Measures in Mental Health help to identify success related to the mental health initiatives and to identify areas for continued

improvement. In relation to the needs of veterans in rural areas, we are especially committed to expanding Telemental Health resources, to provide the most effective opportunity for enabling even the smallest and most rural of the CBOCs to improve the quantity of their basic mental health care and also to improve access to more specialized mental health services when clinically appropriate.

TELEHEALTH / TELEMEDICINE

Earlier in my statement, I mentioned the unique challenges veterans in rural areas face when accessing health care services, particularly in medically underserved areas. Telehealth provides a means whereby VHA can provide specialist care services to veteran patients, especially those who live in rural areas. Over the past three years, VHA has created the necessary infrastructure to enable routine clinical care services to transition onto telehealth platforms that are robust and sustainable. Robustness and sustainability in terms of telehealth networks means that they are safe, appropriate and effective and this requires the necessary clinical, technical, and business processes are instituted to this end.

VHA is currently implementing a care coordination/home telehealth program (CCHT) to help veteran patients with chronic conditions such as diabetes, chronic heart failure, chronic obstructive pulmonary disease, post-traumatic stress disorder, and depression, to self manage their condition and remain living independently in their own homes. The census of CCHT patients, as of June 21, 2006, is 15,003 veterans with chronic conditions. Enrollment in CCHT programs is currently growing at over 150 patients per week in anticipation of meeting a target of over 20,000 patients by the end of Fiscal Year 2006. Of the patients receiving care, 25 percent are in rural areas and 0.5 percent in highly rural areas. As experience is gained with this mode of service delivery, increasing numbers of veterans in rural and highly rural areas can receive care in this manner.

VHA is implementing a national teleretinal imaging program to assess veteran patients with diabetes for diabetic eye disease. Implementation to 92 sites is planned to be completed by mid Fiscal Year 2007. Of these sites, 29 are CBOCs of which eight are in medically underserved areas (MUA) as recognized by the Health Resources and Services Administration (HRSA). These 29 sites are expected to provide care to 5,335 veterans by the end of Fiscal Year 2008.

VHA will complete the development of a 21 site Polytrauma Telehealth Network by the end of Fiscal Year 2006. This state-of-the-art telehealth network will provide access for combat wounded veterans to specialist health care services that are closer to home. In creating such a national telehealth resource, VHA is establishing ground breaking quality of service standards to ensure that the telecommunications networks upon which this clinical care is provided are appropriately configured and engineered to the tolerances required to support mission critical clinical services.

In Fiscal Year 2005, 14,021 unique patients received care via telemental health in VHA; thus far in Fiscal Year 2006, 13,584 patients have received care. In the remainder of Fiscal Year 2006 and Fiscal Year 2007, VHA is implementing an expansion of telemental health to improve access to services in CBOCs for veterans with mental health conditions. Under the funding agreements with 21 VISNs, an additional 30,040 unique veteran patients will receive 130,450 new mental health encounters in CBOCs. Of 245 CBOCs that will provide these services 213 (87 percent) are in a HRSA designated MUA.

Thus, it can be seen how developments in telehealth within VHA are on a convergent path. Within three years VHA will be in a position to provide veterans in rural areas access to specialist care of a specificity that is unparalleled in any other health care organization in the nation. Achieving this promise requires intense, ongoing work to ensure the clinical, technical and business processes are re-engineered. The telecommunications bandwidth requirements and telecommunication technology infrastructure necessary to support this

undertaking are being assessed and may be a supplemental requirement in future budget requests.

It is vital to address the people processes in new health care developments. VHA's Office of Care Coordination, the office responsible for telehealth development within VHA, has been working closely with the VHA's Employee Education Service to implement national training programs for telehealth.

In January 2004, VHA established a telemedicine training center to develop care coordination/home telehealth services in Lake City, Florida. This center has trained over 2,700 VHA staff. In Fiscal Year 2005, VHA developed a training center for teleretinal imaging in Boston, Massachusetts. Also in Fiscal Year 2005, VHA established a Rocky Mountain Telehealth Training Center for general telehealth in VISN 19 with sites in Salt Lake City, Utah and Denver, Colorado. This center was designated to establish links with the University of Utah, University of Colorado and American Indian and Alaska Native Programs Center at the University of Colorado in Denver. VHA's Rocky Mountain Telehealth Training Center has a scope of operations that covers rural health care delivery.

In 2003, when VHA considered the needs for telehealth training, the particular importance of rural health needs were addressed and incorporated in a request for proposals in 2004. Instead of funding a designated rural telehealth training center, VHA incorporated rural telehealth and health informatics, as applied to telehealth, as a particular responsibility of the Rocky Mountain Telehealth Training Center. VHA's three telehealth training centers are linked through a common steering committee and this ensures that the rural focus is incorporated into the work of all the training centers.

EDUCATION / RESEARCH / TRAINING

Training and educating the next generation of medical professionals is central to VA's mission of providing exemplary health care to our nation's veterans. While

rural areas typically face shortages of health care professionals, VA is seeking to rectify this through several initiatives and in cooperation with other interested parties.

VA currently offers clinical training in centers devoted to geriatrics, mental health, multiple sclerosis, and other diseases. VA clinical care sites located in rural areas already provide clinical education in a variety of disciplines. Local schools of nursing, universities affiliated with a rural outreach clinic, and Area Health Education Centers provide graduate medical education for residents and trainees. A number of medical schools are considering increasing the size of their student bodies to address the pressing need for rural health care. On June 16, 2006, an article by Carrie Peyton Dahlberg entitled "UC Davis will target rural needs" appeared in the Sacramento Bee, and stated that 40 percent of U.S. medical schools reported a plan to increase their number of admitted students within the next five years to address the nationwide doctor shortage, which is particularly acute in rural areas.

CONCLUSION

Mr. Chairman, providing safe, effective, efficient and compassionate health care to our veterans, regardless of where they live, is the primary goal of the VHA. New technologies and better planning are allowing us to provide the same quality of care in any location. VHA recognizes the importance and the challenge of service in rural areas, and we believe that current and planned policies are addressing these concerns.

The right-sizing of our physical infrastructure as a result of the CARES program, the provision of new CBOCs, collaboration with Federal, State and local health care partners, and new approaches to health care services and advances in technology in telehealth and telemedicine, all combine to make VHA confident that we can provide the best care anywhere and everywhere.

This concludes my statement. Thank you for your time and I will be glad to respond to any questions that you or other members of the committee may have.

June 27, 2006

David Hartley

David Hartley, PhD, MHA
Maine Rural Health Research Center, University of Southern Maine

Written Statement accompanying testimony to US House Veterans' Affairs Subcommittee on Health. Cannon House Office Building. June 27, 2006

Thank you for the opportunity to testify before this committee. I was a member of the Institute of Medicine's Committee on the Future of Rural Health which met throughout 2004 and released its report early in 2005: *Quality through Collaboration: The Future of Rural Health* (IoM 2005). That committee continued work that began with *To Err is Human*, and *Crossing the Quality Chasm* and applied it to rural health. Key recommendations of the rural IoM report are relevant to the quality of care available to rural veterans. My career, for the past three decades, has included delivering mental health and substance abuse services and conducting research on such services in rural areas.

Throughout the Chasm series, the IoM has called for care that is safe, timely, effective, efficient, equitable and patient-centered (STEEEP). In *Quality through Collaboration*, we brought these principles to bear on rural services and rural communities, and suggested that they can improve both the quality of personal care and the health of whole rural populations. We suggested ways to modify quality indicators and processes to reflect the unique characteristics of rural communities, ways to address human resource issues, and especially ways to strengthen the health information infrastructure, which our national leaders have identified as an essential condition for quality improvement. Our report includes twelve recommendations and four key findings.

Several of those recommendations are particularly relevant to rural veterans. Since it is now estimated that 44% of new recruits come from rural places (Tyson 2005), we can expect an increase in the numbers of veterans from Iraq and Afghanistan who will be returning to rural

America recovering from complex combat-related injuries, both physical and emotional. As a member of the IoM committee, I see much common ground between the needs of rural veterans and the needs of rural populations more generally.

Among our recommendations, there are three areas that seem to me most relevant to the current issues facing rural veterans and those who are committed to their healing. First, we recommended an agenda to strengthen the rural workforce that included outreach programs to recruit young people into health professions, more rural-based educational programs, and rural training tracks and fellowships that emphasize rotations in rural sites. Second, we made several recommendations regarding health information technology, including a need to include a rural component in the National Health Information Infrastructure (NHII) strategic plan, and a specific plan for rural health providers to convert to electronic health records (EHRs) over the next five years, initially targeted to Indian Health Service provider sites, rural community health centers, rural health clinics and critical access hospitals. Third, we examined the delivery of mental health and substance abuse services in rural areas and found a fragmented, under-funded, non-system. We recommended a thorough assessment of the availability and quality of these services in rural America. As we seek to serve our rural veterans better, I believe we have an opportunity to make advances in these three areas that will assure STEEEP care to those veterans, and accelerate the agenda for providing STEEEP care to all rural residents.

The Department of Veterans' Affairs has arguably the best integrated health information network in the nation. It also has extensive, evidence-based, patient-centered performance measures and a monitoring system to assure that all patients receive high quality, guideline concordant care. That system gets good outcomes for those veterans who receive care from VA

clinics, and from Community-Based Outpatient Clinics and contract providers who can meet the VA's high standards of care.

The VA also offers training sites through an extensive residency program including affiliations with 107 medical schools, accounting for 9 percent of all residencies nationwide. The IoM committee struggled with the long-standing issue of graduate medical education (GME) with its emphasis on urban teaching hospitals. We have had minimal success in redirecting Medicare's GME payment structure to incentivize rural GME. In its 2005 Report to the Secretary of Veterans Affairs, the Advisory Committee on VHA Resident Education recommended that the VA should "...maintain training of a significant proportion of US residents in areas of importance to the VA and to the nation," and acknowledged that "geographic redistribution should be undertaken... only when an appropriate training environment and infrastructure are in place." (Advisory Committee on VHA Residencies 2005).

It is well-established that physicians who grew up in rural areas, and those who receive a major portion of their training in rural practices, are more likely to locate in rural communities when they begin their careers (Rabinowitz 2001). I suggest that the needs of 20% of VA's enrolled veterans and 44% of our recruits now serving in the military warrant investment in the VA residency training environment and infrastructure to assure that well trained physicians are available to meet the needs of rural veterans. The state-of-the-art information infrastructure I described above will help to assure that residents trained in VA sites are well-prepared to meet the high standards set by the VA.

The second highly relevant recommendation of the IoM Committee on the Future of Rural Health calls for a five-year demonstration program for information and communications technology (ICT) that would result in the establishment of a state-of-the-art ICT infrastructure

that is accessible to all providers and consumers. There are many rural areas of the United States where veterans do not have ready access to a VA clinic. However, many veterans may reside in rural areas that are served by HRSA-designated rural providers such as community health centers (CHCs), rural health clinics (RHCs) and critical access hospitals (CAHs). If the existing infrastructure of these types of providers were combined with the VA's information infrastructure, veterans living in such areas could receive high-quality care, and these providers could more rapidly establish 21st century information systems. Such collaborations would benefit veterans immediately, and, eventually, other rural residents.

As I mentioned earlier, my research emphasis has been in the area of rural behavioral health. A third very relevant issue from the IoM rural report addresses the quality and accessibility of mental health and substance abuse services. Much of my research has sought to document the lack of specialty mental health services in rural areas, and to discover alternative models for delivering such services in the absence of psychiatrists, psychologists and psychiatric facilities. The need for mental health services in rural America has been repeatedly identified as one of the topmost issues facing state-level officials and policymakers.

Evidence of the need for mental health services among veterans can be found in the high rates of combat zone suicide (Army News Service 2004), post-traumatic stress disorder, often not manifesting until a year or more after returning home, and in the VA's recently published studies of rural-urban disparities in health-related quality of life, both for veterans with psychiatric disorders (Wallace et al. 2006) and for veterans in general (Weeks 2004). Although rural veterans were found to have lower overall rates of psychiatric disorders than their urban counterparts, those with mental illness experienced a greater burden of disease and higher costs, and these disparities were associated with access to mental health care.

Lacking specialty mental health services, rural people with psychiatric problems have typically sought help from their primary care practitioner. Research tells us that such care has not always been of the highest quality, and often does not follow evidence-based guidelines for conditions such as depression, anxiety disorders and children's mental health issues (Rost et al. 2002). Two specific conditions of veterans now returning from Afghanistan and Iraq may not be accurately diagnosed by primary care practitioners who are not familiar with these conditions: post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). Once such disorders are suspected, it may be possible to refer vets to a VA specialist, and travel from a rural to an urban area for specialty care may simply be the only way to get quality care. In many of our most rural states, however, there is no VA TBI program. Moreover, the symptoms of PTSD typically affect the whole family, and may lead to domestic violence, child abuse, divorce, substance abuse and suicide. Here too, the lack of services in rural areas poses a significant barrier to effectively addressing these problems. My research suggests that creative solutions are needed to meet the need for mental health and substance abuse treatment in rural areas. Behavioral health research is dominated by well-funded precisely designed trials of various clinical interventions, many of which are unlikely to be implemented in rural areas. If creative solutions are to be found to meet the behavioral health needs of rural veterans, it may be necessary for the VA to establish its own rural behavioral health research center.

In summary, the Veterans Administration has an opportunity to build on the foundation established by the Institute of Medicine's rural report, to improve access to quality care for rural veterans, and to bring its unique resources for quality improvement and information management to rural providers. Clearly a win-win opportunity.

This concludes my testimony. I will be happy to answer any questions.

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Written Testimony

By

**Graham L. Adams, PhD
Executive Director, South Carolina Office of Rural Health
2006 President, National Organization of State Offices of Rural Health**

For the

**Health Subcommittee of the
House Committee on Veterans' Affairs**

**Oversight Hearing to Examine the VA Efforts to Provide
High Quality Health Care to Veterans in Rural Communities**

June 27, 2006

I am Graham Adams, Executive Director of the South Carolina Office of Rural Health and 2006 President of the National Organization of State Offices of Rural Health. All 50 State Offices of Rural Health serve rural communities by assisting rural providers, communities and policy makers in improving access to quality health care. I appreciate the opportunity to speak before you today to discuss this very important issue.

Rural Americans embody many wonderful traits from strong family values to numerous generations of military service. So often though, rural communities struggle with underfunded school systems, high unemployment rates and poor health status indicators. From a health care perspective, many rural communities suffer from aging health care facilities, a shortage of some key health care professionals, and a lack of specialty resources. Fortunately, rural health care providers and advocates have worked hard to address the disparity between urban and rural communities. While much progress has been made, much work still needs to be done.

Veterans that live in rural communities face even greater challenges when trying to receive care. Lack of an adequate number of Community Based Outpatient Clinics (CBOCs), Outreach Health Centers or other approved sources of care make it difficult for rural veterans to receive timely, appropriate care. According to the VA website, my home state of South Carolina only has 9 CBOCs, and 3 Vet Outreach Centers.¹ This is especially concerning given that South Carolina is one of the top twenty states in which veterans reside with 14.2% of the state's population being veterans. Scarcity of mental health and family counseling services is also a problem for rural veterans in need of these services.

Rural citizens have always heeded the call for military service. Currently, more than 44% of military recruits come from rural communities.² Sadly, recent statistics have also indicated that military personnel from rural communities are dying at twice the rate of their urban counterparts.³ A 2004 NPR report, claimed that 44% of all soldiers killed during Operation Iraqi Freedom were from communities under 20,000 people.³ Given this great commitment to service on behalf of rural communities, we need to do more to closely examine the health care barriers that face rural veterans. Developing solutions specific to rural veterans and their unique needs is the least we owe them.

Develop a proactive policy of the VA contracting with Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals and other small, rural hospitals to provide care to rural veterans.

Approximately 20% of veterans who enroll to receive health care through the VA live in rural communities.⁴ With an ever growing number of veterans returning home to their

¹ VA Website, June 24, 2006.

² Washington Post, November 4, 2005.

³ "Iraq War Takes Uneven Toll at Home," April 3, 2004: NPR All Things Considered.

⁴ American Journal of Public Health, October 2004.

rural communities after military service, these rural health care systems must be prepared to meet their needs. While CBOCs and Veteran Outreach Centers provide essential points of access, there are not enough of these facilities in rural communities. VA providers are known for providing good quality care to those they serve, however more providers are needed to serve the increasing number of rural veterans. One immediate and logical solution to this dilemma, would be to facilitate the VA contracting with existing rural health care facilities. Contracting with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for primary care and Critical Access Hospitals (CAHs) and other small rural hospitals for inpatient services would allow more rural veterans to receive care in their home communities. Inconvenience and transportation barriers caused by traveling considerable distances to receive care are often roadblocks for rural individuals seeking care. While Congress has adopted legislation encouraging VA collaborations (P.L.106-74 and P.L.106-117 § 102(e), The Veterans Millennium Health Care and Benefits Act), few examples exist today.

More needs to be done to facilitate these VA partnerships and engage and adequately reimburse existing local providers in rendering care to rural veterans. FQHCs and RHCs are the cornerstone of primary and preventive health care in many rural communities providing good quality care locally. Why reinvent the wheel by establishing new free-standing CBOCs or make rural veterans travel great distances? FQHCs and RHCs receive cost-based reimbursement or enhanced reimbursement, respectively, for Medicare and Medicaid encounters. Both have been proven models for increasing access to underserved populations in isolated communities for decades. Wisconsin, Missouri and Utah already have examples of these collaborations that are working well. Using evidenced-based medicine and uniform standards of care, the VA needs to sharply focus on developing more access points through these partnerships with FQHCs, RHCs, and CAHs.

Bolster rural mental health and family support services for veterans residing in small and rural communities.

Access to mental health services is a problem in many small rural communities. A lack of qualified mental health professionals, shortage of psychiatric hospital beds and the negative stigma of mental illness, often result in many rural residents not getting the care they so desperately need. These problems are exacerbated for veterans who live in rural communities given the variety of severe issues which often confront them. In addition to the normal stressors which drive individuals to seek mental health care, veterans can have the added challenges of dealing with service-related situations or mental illnesses. Problems derived from combat situations, re-adjustment to civilian life and work, and family and marital issues related to long absences from home, often greet veterans as they return home from service. More resources need to be made available at the local community level to assist veterans in dealing with these issues. Although Vet Centers provide these services, they are not consistently available at the local level. Due to the lack of rural mental health providers and the scarcity of psychiatric hospital beds, some

individuals with mental illness end up being incarcerated in lieu of receiving proper treatment. Our broken mental health system is not unique for veterans, however given their service to our country and the unique needs that they often have, it is incumbent upon the VA and rural providers to do better. However, in order to improve the situation, more resources must be made available in order to contract with local mental health providers, hire additional mental health providers and contract with and adequately reimburse Critical Access Hospitals (CAHs) and other small rural hospitals to serve these patients.

The families of veterans also struggle with issues related to their absence, return and readjustment to society. Some Vet Centers employ family therapists and other counseling professionals although not all do. Family therapists, specifically, provide much needed services to veterans, their spouses and children. Requiring Vet Centers to hire family therapists and fully funding them to do so would enable more veterans to access this vital service.

Identify, fully-fund and replicate best practices in rendering health care, mental health and family support services to veterans in rural communities.

Although veterans face many challenges in seeking and receiving care in rural communities, there are undoubtedly many communities where VA facilities, local health care providers and advocates have worked together to develop “models that work”. The VA needs to identify these models, study and analyze data of where and when veterans currently interact with the system and fund the replication of new and diverse efforts in rural communities. This analysis of the unique needs of rural veterans; what is working and what’s not; will educate and enrich the dialogue of providing care to those who’ve served our country. Examining the unique challenges inherent in providing health care in rural communities and crafting innovative solutions to meet the needs of rural veterans, is of the utmost importance. The VA needs to collaborate with State Offices of Rural Health at the state level and HRSA’s federal Office of Rural Health Policy at the federal level, to coordinate these activities. These state and federal entities, respectively, are the best suited to assist with this broad endeavor.

Conclusion

While many opportunities for improvement exist in providing care to veterans in rural communities, the VA is to be commended for the excellent service provided in many of its facilities. Providing health care in rural communities requires unique solutions, whether it is to veterans and their families or the general population. Adopting some of the strategies referenced in this written testimony would aid in addressing these rural needs.

While I am aware that this hearing is not designed to examine specific legislation, I recognize that H.R. 5524, the Rural Veterans Health Care Act of 2006, does encompass

many positive solutions to addressing the health care needs of rural veterans. I commend these strategies.

Thank you for the opportunity to speak with you today.

**STATEMENT OF
CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HEALTH
VETERANS' AFFAIRS COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VETERANS ACCESS TO QUALITY HEALTH CARE IN
RURAL COMMUNITIES**

JUNE 27, 2006

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the ongoing efforts of the Department of Veterans Affairs (VA) to provide high quality health care to veterans in rural communities. Research shows us that those veterans residing in rural areas are in poorer health than their urban counterparts. We also know that soldiers and Marines from rural areas are dying at twice the rate of military personnel from the cities and suburbs. According to a report published in April 2004, 44 percent of all soldiers killed during Operation Iraqi Freedom (OIF) were from communities under 20,000. Further, in October 2004, it was reported that nationwide, one in five veterans who enrolled to receive VA health care lives in rural areas.

Providing quality health care in a rural setting has proven to be very tough given factors such as limited availability of skilled care providers and inadequate access to care. VA's efforts need to be especially focused on this problem.

Rural Health Care Policies

On October 15, 2004, the VA Office of Inspector General (VAOIG) released the "*Evaluation of Department of Veterans Affairs Policies and Procedures Addressing the Location of New Offices and Other Facilities in Rural Areas*". This report examined VA's policies and procedures to give first priority to locating new offices and other facilities in rural areas, as outlined in the Rural Development Act (RDA) of 1972.

The report determined that despite not having formal policies in place, VA did make a significant effort to improve access to VA services for veterans living in rural areas. Mostly this was done through the placement of community based outpatient clinics and related health care services. The report went on to say that VA's actions to address health care needs of veterans in rural areas meets the intent of the RDA requirements.

The Capital Asset Realignment for Enhanced Services (CARES) Commission Report which found that the prioritization methodology used to identify new clinic locations in VA's Draft

The American Legion is pleased that VA is proposing to open 25 new CBOCs by the end of this year. However, of the 25, only ten appeared to be on the CARES CBOC priority list of 2004.

CBOCs are not the only avenue with which VA can provide access to quality health care to rural veterans. Enhancing existing partnerships with communities and other Federal agencies such as the Indian Health Service will help to alleviate some of the barriers that exist such as the high cost of contracting for care in the rural setting. Coordinating services with Medicare or with other healthcare systems that are based in rural areas is another way to help provide quality care.

The American Legion believes veterans should not be penalized or forced to travel long distances to access quality health care because of where they choose to live. We urge VA to improve access to quality primary and specialty health care services, using all available means at their disposal, for veterans living in rural and highly rural areas.

Again, thank you Mr. Chairman for giving the American Legion this opportunity to present its views on such an important issue. The hearing is very timely and we look forward to working with the subcommittee to bring an end to the disparities that exist in access to quality health care in rural areas.

Questions for the Record
The Honorable Michael H. Michaud
Ranking Democratic Member
Subcommittee on Health
House Veterans Affairs Committee,

June 27, 2006

**Oversight Hearing to Examine the Department of Veterans Affairs Efforts to
Provide High Quality Health Care to Veterans in Rural Communities**

Question 1: The CARES process identified gaps between veterans' demand for access to services and the location of VA's services. The Secretary identified 156 priority CBOCs and outreach centers to address those gaps by 2012, pending availability of resources. In FY 2005, because funds did not exist to support new CBOCs, the VA did not request any business plans from VA medical centers for opening new CBOCs. Clearly, it would not be prudent to try to open up all the CBOCs in 2012. Of the 156 priority CBOCs, how many will the VA open by the end of FY 2007? Please provide in detail how VA plans to ensure that the rest of the CARES priority CBOCs will open by 2012.

Response: It is the Department of Veterans Affairs' (VA) intention, depending on the availability of resources and validation of the current need for an outpatient clinic, to implement the priority clinics identified in the Secretary's Capital Asset Realignment for Enhanced Services (CARES) decision document by 2012. The CARES process identified 156 high priority community-based outpatient clinics (CBOCs) to address the identified gaps between veterans demand and access. Currently 10 of these priority CBOCs are operational. An additional twenty-one (21) priority CBOCs have recently been approved and are in the various stages of implementation.

Based on a recent validation of Veterans Integrated Service Networks (VISN) priorities for the planning and implementation of CBOCs, Office of Management and Budget has approved an additional 25 CBOCs, 22 of which are the high priority CBOCs identified in the Secretary's CARES Decision, to be opened by VA in fiscal year (FY) 2007, pending available resources.

VHA recently updated the veteran population, enrollment and workload data used in the CARES decision. Based on analyses using the new projection data such as enrollment, demographic and utilization, both at the national and local level, VHA is assessing the continued need and location for the high priority CARES CBOCs. It is VHA's intention to ensure that CBOCs are strategically located where access (with emphasis on veterans living in rural areas) and demand gaps still exist based on the most recent data available so that resources are used in the most efficient manner.

Question 2: I continue to be concerned by the delays in moving forward on the Lewiston-Auburn, Maine, CBOC. When do you expect your office to put out a call for

business plans for new CBOCs? What steps will you take to ensure that VISN 1 has sufficient resources to plan for the Lewiston-Auburn, Maine, CBOC?

Response: VHA has issued a call for new business plans for CBOCs. VISNs will submit plans for those CBOCs that they would like to activate in FY 2007. The due date for the new business plans is September 30, 2006.

The CARES plan recommends that a CBOC be opened in the Far North area of Maine, specifically the CARES decision identifies the CBOC location as Cumberland County. Since the Lewiston-Auburn location has received so much positive interest as a possible CBOC site, VISN 1 will undertake a review of the Cumberland County/Lewiston-Auburn area for the purpose of determining a CBOC location that best meets the needs of veterans in the northern area of Maine. VISN 1 is in the process of developing a proposal for submission to open a CBOC in Lewiston-Auburn in 2007 for review against National Criteria.

Question 3: In the CARES process, VA did not look at Vet Centers. Does VA have specific plans to expand the number of Vet Centers and Vet Center employees in rural areas, and if so, what are they?

Response: VA has approved and will be implementing a Vet Center program augmentation in FY 2007. The plan calls for two new Vet Centers in Phoenix, AZ and Atlanta, GA, which are areas with high veteran populations and high levels of demand for readjustment counseling. In each case, the new Vet Centers will be an addition to the already existing Vet Centers in both communities. The plan also calls for one-person staff augmentation in each of 11 existing Vet Centers. Some of the latter augmented sites serve a large rural veteran population such as Little Rock, AR; Ft. Wayne, IN; East St. Louis, IL; Johnson City, TN; and Sioux Falls, SD. The third component of this initiative is to convert to career employee status the second 50 of the total of 100 Global War on Terror (GWOT) outreach specialists hired in the previous two years to enhance outreach to the new veterans returning from combat in Afghanistan and Iraq. All of these positions will enhance outreach to rural veterans in the communities to which they are assigned. Additionally, outreach workers have been assigned to rural Vet Centers such as in White river Junction, VT; Lewiston, ME; Sioux Falls, SD; Springfield, IL; Wichita, KS; Fargo, ND; Madison, WI; San Juan, PR; Little Rock, AR; Cheyenne, WY; Santa Fe, NM; Redwood City, CA; Eugene, OR; and Hilo, HI.

Question 4: The VA has stated that it is monitoring the workload of Vet Centers and looking at gaps in the capacity of the Vet Center Program. What gaps in capacity in the Vet Center program have you identified in rural areas? Please describe how you will address those gaps in Vet Center capacity in rural areas and please state the time frame by which VA will address those gaps.

Response: The Vet Center augmentation sites identified above as serving rural populations, including Little Rock, AR; Ft. Wayne, IN; East St. Louis, IL; Johnson City,

TN; and Sioux Falls, SD, were selected based on unmet need in some designated rural areas. The criteria for assigning some of the GWOT outreach specialists prioritized underserved veterans in rural areas. A primary function of the GWOT outreach specialists is to initiate contact with returning National Guard and Reserve component troops, many of whom return to widely dispersed rural communities throughout the country following processing through military demobilization sites. All of the readjustment counseling service Vet Center augmentation initiatives have high priority and will be implemented as soon as feasible in FY 2007.

Question 5: How does VA gather input from experts and veterans on how to address the challenges of improving rural veterans' access to quality VA care? Would VA benefit from an advisory committee of rural health experts and rural veterans to help identify and plan to address the short-term and long-term issues and challenges in delivering high quality health care to rural veterans?

Response: VA obtains input from experts on a variety of clinical issues through our close partnership with 107 medical schools and dozens of universities and colleges, frequent collaborations and exchanges with non-profit health policy organizations, professional associations, and intergovernmental cooperation with Federal, State, and local entities. Examples of these contacts include Centers for Medicare and Medicaid Services (CMS), Health and Human Services (HHS), Public Health Service (PHS), Indian Health Service (IHS), State veterans' affairs departments, local mental health boards. In addition, VA regularly meets with veterans service organizations at the national, regional, and local levels. VA also receives input from its employees through clinical advisory groups. VA, also, receives input from several existing advisory committees, covering a breadth of issues including but not limited to homeless and minority veterans, readjustment care and long-term care. VA also receives feedback from individual veterans through customer satisfaction surveys and various focus groups.

In addition to these formal outreach and exchanges of views, there is regular informal outreach gathered at every level of the organization, through professional networking and comments received during public appearances. VA, as an organization, is acutely aware of the importance of receiving input and feedback from veterans of all demographic characteristics, and is open to and actively seeks out this information from all groups. VA does not believe that another advisory committee is necessary, based on the existing framework for receiving feedback and views.

Question 6: Health workforce shortages, and recruitment and retention of the health care workers are a key challenge to rural veterans' access to care and quality of care. The 2005 groundbreaking Institute of Medicine report on *The Future of Rural Health* recommended that the federal government must initiate a renewed, vigorous and comprehensive effort to enhance the supply of health professional working in the rural areas. VA should be at the forefront of the medical and nursing education of future rural providers.

Response: One of five strategies discussed in the Institute of Medicine report on *The Future of Rural Health* includes enhancing the human resource capacity of health care professionals in rural communities. VA has programs in place to assist in promoting recruitment and retention of hard to recruit healthcare professionals; facility managers use the programs to address local recruitment and retention issues, many of those being in rural areas based on upon the needs established by facilities in those areas. As an administration, VHA has one of the most substantial scholarship programs in government. While the intent of the programs are not specifically targeted toward expanding coverage of rural health, rural areas benefit due to the sheer volume of scholarships provided.

An example of a VHA program is the Employee Incentive Scholarship Program (EISP). The EISP was implemented in March 2000 and authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. At the conclusion of FY 2005, VA had awarded a total of 5,521 EISP scholarships to its employees, and 2,798 (50.7 percent) of these programs had been completed with 49.3 percent continuing to pursue completion. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this initiative include education and training programs in fields leading to appointments or retention in Title 38 or Hybrid Title 38 positions listed in 38 U. S. C. Section 7401.

While the available data for the scholarship programs isn't specifically recorded for rural and non-rural facilities, a hand tally of scholarships and funding offered through some of the smaller VA Medical Centers indicates over 1,200 employees in rural areas have benefited from scholarships through EISP. Facilities were included based on the populations identified in the 2000 census with populations lower than 95,000.

VA will continue its efforts to find ways to address the challenges raised by health workforce shortages in rural areas and looks forward to continued dialogue with the Subcommittee on how best to meet the health care needs of veterans in rural areas.

Question 7: What, if any, are VA's plans to establish additional rotations for medical residents in rural areas? What, if any, are VA's plans to expand programs to train, recruit and retain nurses in rural areas? What, if any, are VA's plans to expand programs to train, recruit and retain allied health professionals in rural areas?

Response: Within the Veterans Health Administration (VHA), the Office of Healthcare Recruitment and Retention (OHRR), the Office of Academic Affairs, and the Office of Nursing Services, work in collaboration to address recruitment and retention strategies that encompass all demographic areas of the United States. VHA is actively engaged in determining strategies best suited for enhancement of both the principles and practice of rural health care delivery, and in examining methods to enhance training efforts in rural sites. While preliminary efforts are underway, barriers have been acknowledged.

Trainees: There are two issues related to training in rural areas—the first is how to teach trainees the principles and practice of rural health care delivery (educational content) and the second is how to increase and enhance training efforts taking place at rural sites. In general, VA's academic partners have responsibility for the educational content of training programs, while VA provides sites of clinical care delivery. Education of health professionals, therefore, is conducted within the context of VA's clinical mission at sites that have an appropriate educational infrastructure. Educational infrastructure includes many components necessary to ensure a quality training experience, including supervisory staff, educational space, communication technologies including videoconferencing, and information resources. Barriers have been identified that prevent more widespread adoption of training at rural sites; for example, specifically disallows the provision of medically appropriated funds (privately owned conveyance, lodging and per diem) for trainees who travel to clinical sites.

For nursing and associated health trainees, there are often curriculum issues that make expansion of training to rural settings difficult. In nursing education programs, clinical experiences are well integrated with the didactic nursing courses; consequently, clinical sites must be located close to the affiliated educational sites. For example, nursing students may come to a VA site for one or two days per week over a semester while they are taking classroom courses. Therefore, it is not likely that the students will commute long distances to rural sites for the clinical experiences because doing so would interfere with their course work at the educational institution. VHA is engaged in determining potential strategies to overcome these challenges for both nursing and associated health trainees.

For medical residents, VA does have a new initiative, entitled "New Affiliations and New Sites of Care", which includes a focus on increasing and improving resident training at community based outpatient clinics (CBOC), many of which are located in rural areas. The initiative provides incentives for expanding residency training to these CBOC sites and VA anticipates awarding these additional resident positions this fall, for start-up in July 2007.

Retention: Also, in a continuing response to concerns about the anticipated national shortage of registered nurses, VA maintained its strong emphasis on the education and training of its nurses. The Employee Incentive Scholarship Program (EISP) received additional VA funding during FY 2004, to support tuition and expenses for employees seeking both associate and baccalaureate nursing degrees. As of September 30, 2005, participants who received awards to serve in registered nursing appointments upon completion of their education programs accounted for 93.2 percent of all EISP participants.

EISP was implemented in March 2000 and authorizes VA to award scholarships to employees pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel is difficult. At the conclusion of FY 2005, VA had awarded a total of 5,521 EISP scholarships to its employees, and 2,798 (50.7 percent) of these programs had been completed with 49.3 percent continuing to pursue

completion. EISP awards cover tuition and related expenses such as registration, fees, and books. The academic curricula covered under this initiative include education and training programs in fields leading to appointments or retention in Title 38 or Hybrid Title 38 positions listed in 38 U. S. C. Section 7401.

EISP Scholarships Awarded by Health Profession Category Through FY 2005

<u>Health Profession Category</u>	FY 2005	% of FY	Prior	Program	% of
	<u>Totals</u>	<u>Total</u>	<u>Years</u>	<u>Totals</u>	<u>Program</u>
Certified Registered Nurse Anesthetist	8	1.03%	11	19	0.34%
Certified Respiratory Therapy Technician	0	0.00%	2	2	0.04%
Dental Hygienist	0	0.00%	1	1	0.02%
Dentist	0	0.00%	1	1	0.02%
Licensed Practical/Vocational Nurse	20	2.57%	75	95	1.72%
Medical Technologist	1	0.13%	0	1	0.02%
Occupational Therapist	3	0.39%	5	8	0.14%
Pharmacist	27	3.47%	134	161	2.92%
Physical Therapist	2	0.26%	25	27	0.49%
Physician	0	0.00%	7	7	0.13%
Physician Assistant	4	0.51%	21	25	0.45%
Registered Nurse	712	91.40%	4,432	5,144	93.17%
Registered Respiratory Therapist	<u>2</u>	<u>0.26%</u>	<u>28</u>	<u>30</u>	<u>0.54%</u>
Column Totals:	779	100.00%	4,742	5,521	100.00%

While the available data for the scholarship programs isn't specifically recorded for rural and non-rural facilities, a hand tally of scholarships and funding offered through some of the smaller VA Medical Centers indicates over 1,200 employees in rural areas have benefited from scholarships through EISP. Facilities were included based on the populations identified in the 2000 census with populations lower than 95,000.

Question 8: Does VA have a comprehensive plan to address the long-term needs of aging rural veterans? If so, please provide the Committee with a copy of the plan.

Response: VA, as part of its strategic planning and budget formulation, does comprehensive projections of workload and demand. These are accomplished using a demand model that is modified for programs and benefits that are unique to VA.

Based on these analyses, VA plans to provide nursing home care for all veterans for whom such care is mandatory under the provisions of the Millennium Act who require such care and seek it from VA. VA also plans to expand access to non-institutional home and community-based long-term care services at a rate of approximately 18 per cent annually in order to meet the needs of aging veterans, including rural veterans. Many long-term care services are provided through contracts with local providers, and implementation of the plan requires local decision-making based on local demand for

services and on the availability of qualified providers in the community rather than a comprehensive national plan.

Question 9: Dr. Perlin, your written testimony, states that adult day care and geriatric foster homes can help a veteran stay close to home and close to family. How many adult day care and geriatric foster home programs does VA plan to open in rural areas in FY 2006 and FY 2007? Please identify the locations of the adult day care and geriatric foster home programs VA currently has in rural areas and plans to implement programs in FY 2006 and FY 2007.

Response: VA annually sets overall targets for the average daily census (ADC) of veterans to be provided access to non-institutional home and community-based services, including adult day health care. For FY 2006, VA has targeted an 18 percent increase in the number of veterans using non-institutional services. The target does not distinguish distribution by urban or rural location. The target for FY 2007 has not been set yet. These services are provided through contracts between VA Medical Centers and community providers. VA tracks the average daily census for these programs by Medical Centers, rather than the precise site of actual care delivery.

Question 10: Dr. Perlin, in your written testimony you state that partnerships with Community Health Centers could provide an additional delivery option to rural veterans. Please identify the locations where VA contracts with or collaborates with Community Health Centers or Community Mental Health Centers to provide care for veterans. What steps is VA taking to ensure that VA facilities consider such partnerships to ensure that veterans receive high quality care that is integrated with care from the VA?

Response: VHA works with other Federal, State and local agencies and State Rural Development Councils around the country that bring regional partners together to tackle economic development and other issues of importance in rural areas, including health care access. In terms of community health centers (CHC), there are currently few existing partnerships with VHA and CHCs. One example of a successful VA partnership with a community health center is the CBOC contract in Dover, Tennessee. The VA contracts for primary care with the Stewart County Community Health Center. This allows veterans to have not only VA services available to them, but also allows veterans to access CHC services onsite at the Stewart Community Health Center site. Although VHA facilities do consider such CHC partnerships, there are limitations to pursuing these agreements (under current law VHA can not assist CHC's in the contracting process, in any way favoring CHCs over other potential contractors). VHA has worked with HHS in the past to identify opportunities to overcome these barriers.

In specific reference to Mental Health care, VHA's Mental Health Strategic Plan has outlined an initiative to ensure that VISNs participate in State Mental Health Plan development. In this new effort the VISNs will work with their state(s) and the National Association of State Mental Health Program Directors to develop strategic plans and processes for collaboration to deliver mental health service. VA has just begun

expanding its CBOC services to provide mental health, locally, via staff, contract or sharing agreements. Already ongoing, is the collaboration that VAMC White River Junction has with the Community Mental Health Center located in St. Johnsbury, Vermont to share joint space. The VA provides mental health staff in the St. Johnsbury, Vermont CMC site to CBOC mental health patients. In addition Kirksville CBOC contracts with Preferred Family Health Center (CHC) for mental health counseling services in Missouri. Another example is the Cumberland Mountain Community Mental Health in Cedar Bluff, Virginia; Salem VAMC provides telepsychiatry equipment, connectivity resources, and psychiatry coverage, and the contracted service provider (the Cedar Bluff facility) provides, space, equipment, and nursing coverage to veterans who receive primary care at the nearby Tazewell CBOC. This approach extends mental health services to veterans in rural southwest Virginia in a manner that protects their privacy while increasing access to quality VA MH services. These collocations and contracts provide the VA patient with access to VA and CMHC services.

Opportunities to partner with community health and mental health centers will continue to be assessed by VISNs and facilities when planning for a CBOC services and locations.