RURAL HEALTH CARE

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 24, 2001
HEARING HELD IN WICHITA, KS

Printed for the use of the Committee on Veterans' Affairs

Serial No. 107–13

U.S. GOVERNMENT PRINTING OFFICE

78–242 PS WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMITTEE ON VETERANS' AFFAIRS

CHRISTOPHER H. SMITH, New Jersey, *Chairman*

BOB STUMP, Arizona
MICHAEL BILIRAKIS, Florida
TERRY EVERETT, Alabama
STEPHEN E. BUYER, Indiana
JACK QUINN, New York
CLIFF STEARNS, Florida
JERRY MORAN, Kansas
HOWARD P. (BUCK) McKEON, California
JIM GIBBONS, Nevada
MICHAEL K. SIMPSON, Idaho
RICHARD H. BAKER, Louisiana
ROB SIMMONS, Connecticut
ANDER CRENSHAW, Florida
HENRY E. BROWN, JR., South Carolina
JEFF MILLER, Florida
JOHN BOOZMAN, Arkansas

LANE EVANS, Illinois
BOB FILNER, California
LUIS V. GUTIERREZ, Illinois
CORRINE BROWN, Florida
JULIA CARSON, Indiana
SILVESTRE REYES, Texas
VIC SNYDER, Arkansas
CIRO D. RODRIGUEZ, Texas
RONNIE SHOWS, Mississippi
STEPHEN F. LYNCH, Massachusetts
SHELLEY BERKLEY, Nevada
BARON P. HILL, Indiana
TOM UDALL, New Mexico
SUSAN A. DAVIS, California

PATRICK E. RYAN, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON HEALTH

JERRY MORAN, Kansas, *Chairman*

CLIFF STEARNS, Florida,
HOWARD P. (BUCK) McKEON, California
JIM GIBBONS, Nevada
MICHAEL K. SIMPSON, Idaho
RICHARD H. BAKER, Louisiana
ROB SIMMONS, Connecticut
ANDER CRENSHAW, Florida
HENRY E. BROWN, JR., South Carolina
JEFF MILLER, Florida
JOHN BOOZMAN, Arkansas

BOB FILNER, California
RONNIE SHOWS, Mississippi
SHELLEY BERKLEY, Nevada
CIRO D. RODRIGUEZ, Texas
LUIS V. GUTIERREZ, Illinois
VIC SNYDER, Arkansas
STEPHEN F. LYNCH, Massachusetts

CONTENTS

September 24, 2001

	Page
Rural Health Care	1

OPENING STATEMENTS

Chairman Moran	1
Hon. Todd Tiahrt, a Representative in Congress from the State of Kansas	2
Hon. Bob Filner	4

WITNESSES

Almenoff, Peter, M.D., VISN 15 Network Medical Director, VA Heartland Network	28
Prepared statement of Dr. Almenoff	59
Franklin, James R., Vietnam veteran, Liberal, KS	5
Prepared statement of Mr. Franklin	45
Fromme, Tamina, Vietnam veteran, Dodge City, KS	10
Prepared statement of Ms. Fromme	49
Hill, Kent D., Director, VA Medical and Regional Office Center, Wichita, KS	22
Prepared statement of Mr. Hill	51
Mitchell, Olen, World War II veteran, Hutchinson, KS	7
Raju, L.S., M.D., VA Liberal Community Based Outpatient Clinic, Liberal, KS	25
Prepared statement of Dr. Raju	55
Ratzlaff, Scott, Desert Storm veteran, Colby, KS	8
Prepared statement of Mr. Ratzlaff	46
Zimmerman, Leann, Nurse Practitioner, Hays Community Based Outpatient Clinic, Hays, KS	27
Prepared statement of Ms. Zimmerman	57

OPEN MICROPHONE FOR QUESTIONING FROM THE AUDIENCE

Jim Bunker	34
Kim Crissler	35
Charlie Stephens	36
Master Sergeant Gifford McCargar	36
Charles Henley	38
David Cox	39
Robert Simpson	40
Moe Gividen	41

MATERIAL SUBMITTED FOR THE RECORD

Letter to Chairman Moran from Dr. L.S. Raju re post-hearing statement summary submitted for the record, September 26, 2001	56
Statement of Robert M. Malone, Jr., Director, VA Eastern Kansas Health Care System	63

RURAL HEALTH CARE

MONDAY, SEPTEMBER 24, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., at the VAMC Medical and Regional Office Center, Auditorium, 5500 East Kellogg, Wichita, KS, Hon. Jerry Moran (chairman of the subcommittee) presiding.

Present: Representatives Moran, Filner, and Tiahrt.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. Thank you very much. Usually when I pound the gavel in Washington it doesn't get as quiet. It's nice to know Kansans are respectful of the gavel.

I would like to call the subcommittee to order and to wish all a good morning. I am Jerry Moran. I am the chairman of the Health Subcommittee of the Veterans' Committee of the United States House of Representatives. I am a member of Congress from Kansas and delighted to be in Wichita.

I thought it would be appropriate before we start if we could all stand and have a moment of silence in respect for those who lost their lives and then we'll have the pledge of allegiance. If we could all stand for a moment of silence followed by the pledge of allegiance.

[At this time in the proceedings the pledge of allegiance
Was said and there was a moment of silence.]

Mr. MORAN. Our practice in Washington is for members of the committee to make opening remarks. I have always had some trouble with that because it always has seemed to me that the Members of Congress should be listening as much as they speak so I will try to summarize my opening remarks.

I want to welcome you, especially welcome my colleague, Bob Filner, congressman from San Diego, CA. He is the ranking member, meaning he's the most senior democratic member of this subcommittee. And it is very kind for Bob to join us here in Wichita today.

Mr. Filner and I share many of the same sentiments, many of your desires in what we do with veterans in particular, and what we do for veterans' health care. And we had several other members who had intended to join us today, but due to air travel it has been a bit for difficult for members to get from their homes or from Washington, DC to be in Wichita.

Following the acts of terror that occurred 13 days ago, the president asked the Nation to prepare for a long-term struggle against terror, but also for our country to return to a sense that we cannot be slowed down, we should not be detained, that we return to our normal way of life.

And I had some thoughts about canceling this hearing today as the result of what happened 13 days ago, but it occurred to me that this is an important part of what we face in the future. In fact, we had a former witness, a Miss America witness before our committee in Washington earlier this week and she quoted George Washington saying:

"The willingness of future generations to serve in our military will be directly dependent upon how we have treated those who have served in the past.".

It seemed very appropriate that we have this hearing, that we continue to look at the issue of health care as it relates to the veterans of our country, but also for purposes of preparing for the future. And so I am delighted that you could join us. We intend to have a good and informative hearing.

And let me use this opportunity to thank Congressman Tiahrt for joining us, allowing for us a subtle entry into the hearing. We are in the Fourth District of Kansas, Congressman Tiahrt's district, and Congressman Tiahrt is a member of the very important Appropriations Committee. Dollars are appropriated for many of the things veterans affairs authorizes, so Todd is very much a partner in our efforts in regard, not only to defense issues, but to veterans issues as well.

So, Todd, let me welcome you and, not let me welcome you in your own town, but thank you for the opportunity of joining us. If you have any remarks to make this morning I would be glad to hear from you.

OPENING STATEMENT OF HON. TODD TIAHRT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. TIAHRT. Good morning. It's nice to have you all here. And it's nice to have Mr. Filner from California, and Jerry here. This is very important work. And the worst part of working in Washington is getting blindsided. There are about 8,000 pieces of legislation, and there is so much going on it's hard to find out what affects individual Kansans.

So opportunities like this are a wonderful opportunity for you to tell us those things that we may be overlooking, make us aware of something that we didn't know before, that our staff has administered or we didn't see it in the needs that you have.

I have some of the numbers that Congress spends on veterans' benefits and veterans' health care and it's a lot of money. But that's not what is important here. What is important is your needs and how the veterans administration works with you and the influence that you have on the federal government.

So I am looking forward to the testimony, I am looking forward to seeing people who I have a great deal of respect for that served our country. And I want to welcome you and welcome Bob and Jerry and thank you for coming.

Mr. MORAN. Todd, thank you very much. Thanks for joining us and your hospitality. And it is good to work with you in Wichita on behalf of Kansas veterans.

Let me introduce a number of veterans here today who work on behalf of other veterans. We have a number of veterans' service organizations joining us. Richard Clutts; if you gentleman would stand, VFW Commander; Elgin Wahlborg, the commander of the American Legion; Kenneth Ketchum, Department Commander of Disabled Kansas Veterans; and Robert Cornsilk, President, Mid-American Paralyzed Veterans of America; and Bill Miller, Department of Veterans American Commander.

Thank you very much. I have always held great respect for veterans, and if you can have any more respect it's for those veterans who work on behalf of other veterans.

We also have with me today a number of members of my staff. Amy Theis, who works for me in my Hutchinson office and Lisa Dethloff, who works in my Hays office. They are here to help any Veterans with questions or comments in any way we can, do what we call case work on behalf of veterans. And also veterans service representatives, Jess Rodriguez and Ron Doucette.

Those who have individual issues that you would like to see Congress address, these are your own veteran service representatives who work on your behalf, and those people are here today. Lisa and Amy, they are standing in the back. You might raise your hands so they can know who you are.

Let me again indicate that I think we have made some progress and improvements in veterans' health care. We have a long way to go. We put initial dollars in VA needs. The focus is to see what we can do more to address the issue of veteran health care needs in rural America and particularly rural Kansas.

There needs to be a balance between the specialized services available here at the Wichita VA or Topeka or Leavenworth, as well as the services needed by many Veterans who are in an area that makes it difficult for them to travel to those communities and come to the VA Hospital for more routine services.

We worked hard with the VA. I appreciate Kent Hill and Bob Yuses (ph) for bringing CBOCs in Kansas. We hope to have a CBOC open in Salina later this year in which we can help provide additional health care assistance for those who happen to live long distances away from our hospitals.

Today we'll see a demonstration of tele-medicine and what it may mean to rural veterans, and how we can bring technology into the scene to make health care more deliverable to remote places across the country. We'll hear from witnesses who are veterans who are receiving benefits, as well as from health care VA professionals as to how we can help veterans.

One of the greatest issues our VA system faces is the lack of ability to attract and retain health care professionals, and we'll hear something about that today as to what we can do in Congress to make a difference.

I also want to acknowledge Jim Bunker and Dan Thimesch. Jim Bunker is the Kansas Chairman of the Gulf War Advisory Board, and Dan is the Kansas State representative. If those two gentlemen could stand.

They made an effort in our state as to the health care problems that arose from Persian Gulf War and related syndromes, and it's certainly an issue Mr. Filner and I are well aware. And Mr. Filner and I are strong advocates. Thank you, Dan and Jim, and I look forward to hearing from you.

I hope this can be done regularly and in an orderly fashion, so veterans who aren't representatives this morning can have an opportunity to address the committee. So again welcome, and thank you for your participation. I look forward to hearing your testimony and of our witnesses and ask my distinguished colleague from California, Mr. Filner, if he has any opening comments.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. Thank you for going through with this hearing.

Obviously, we have a new priority in this Nation, but if we stop dealing with other business then the terrorists would have won. So we need to deal with other parts of America's society as we are united behind the president in our new venture that we must undertake. Thank you for inviting me.

I did, I work very well and very closely with Chairman Moran in Washington. As a democrat I had some trepidation about coming to Kansas, but when I saw there are Liberal veterans and Liberal CBOCs, I felt very much at home, so thank you.

And I just want you to know as a member of the minority party you all here in Kansas have some great representatives who are real advocates for veterans. Jerry Moran, Chairman of the Health Care Subcommittee, is a real fighter in Washington. And Congressman Tiahrt joins our efforts and works very hard for the veterans of Kansas, and those in America.

I do want to just briefly touch upon some issues that deal with health care for rural America. That is the focus of this hearing. Clearly, our job, veterans committee in the United States Congress, is to make sure we have access, access to quality health care for every veteran in America, no matter where they live. Obviously there are some issues there.

We are trying, for example, to bring the VA closer to the veterans with our community-based outpatient clinics called CBOCs. And I know we are looking forward to the opening of one in Salina, hopefully this year. But we have to make sure that not only our facilities are close, but the quality care is received on a timely basis also. If you delay the benefits you really deny benefits.

And I know it must be enormously stressful to have tests taken only to find out they are outdated by the time an appointment by the specialist could be scheduled, which I think we'll hear examples of today. We need to find new ways to partner with other VA systems. We have looked at national community health care systems who want to work with the VA.

Transportation is an issue. Clearly it's a long drive to some places. As of now, the reimbursement rate for the VA to those who travel is 21 cents a mile and has not been changed for 23 years. And Chairman Moran, and others on the committee, have been trying to get the VA to adjust that. The federal employees now receive 34 and a half cents a mile. There is no reason why that should not

be the reimbursement rate for those who are coming to get health care.

So we are looking at those issues. We want to hear more about them and, as Congressman Tiahrt said, the best education we can get is from those who are dealing with the front line every day. So if you have problems we want to hear and we'll try to address them.

Again, I thank Chairman Moran. He is a real fighter for veterans, trying to make sure the rural concerns are at the top of our priority list as any other concern, and he will make sure that that occurs this morning. Thank you, sir.

Mr. MORAN. Thank you for your remarks. I should point out Mr. Filner has been working on this significantly longer than I have. He is a real expert on these issues. He indicated he was a junk-yard dog in his home district.

We had dinner last night and he was telling stories of how he is a junk-yard dog in San Diego, and he is a junk-yard dog in our committee. Occasionally he is a bit difficult to work with, but the reality is, Mr. Filner would be chairman of this committee if the democrats had control of Congress. So he is a very important player, very important figure in our efforts in regard to the VA benefits and taking care of veterans in our country.

It is very difficult to ask embers of Congress to give up time from their homes and families and in their districts. And I am so grateful that another Member of Congress is available to hear what Kansans have to say. So I thank him for his extra effort to getting here and joining us in Wichita.

With that, let's begin the hearing and ask the first panel to come forward. The panel consists of: Mr. James Franklin, a VA veteran from Liberal; Olen Mitchell, a World War II veteran from Hutchinson; and Mr. Scott Ratzlaff, a Desert Storm Veteran from Colby; and Tamina Fromme is a Vietnam Veteran from Dodge City.

And we have asked them to tell us, as Members of Congress, what they would like us to know about the delivery of health care in rural America. If you would be seated, we'll begin with Mr. Franklin.

STATEMENTS OF JAMES R. FRANKLIN, VIETNAM VETERAN, LIBERAL, KS; OLEN MITCHELL, WORLD WAR II VETERAN, HUTCHINSON, KS; SCOTT RATZLAFF, DESERT STORM VETERAN, COLBY, KS; AND TAMINA FROMME, VIETNAM VETERAN, DODGE CITY, KS

STATEMENT OF JAMES R. FRANKLIN

Mr. FRANKLIN. My name is James Franklin and I am from Liberal, KS. I would like to thank you for the opportunity to testify on veterans' health care in Kansas.

The Community Based Outpatient Clinics, or CBOCs, are wonderful for rural veterans and their eligible dependents when they work as planned. They bring VA services to the rural area without the need for the veteran to travel great distances. However, there are some bugs that need to be worked out of this system.

The Liberal CBOC is run by the Southwest Medical Center on contract by the Amarillo VAMC. They see veterans from three dif-

ferent VISNs which all—this is not entirely correct. The veterans coming from Colorado, as I understand, and are being signed up in either the Wichita or Amarillo VA of their choice.

All of these business have a little bit different way they like the veteran to be handled. Since Amarillo VAMC is not chosen the in-house Champ VA program, my wife has to drive 220 miles one way to this facility to receive health care. Yvette has deteriorated discs in her C5–C6 area of her neck causing her spinal cord sheath to be cut. Also she suffers from arthritis which is causing her great discomfort to the point she is not able to take care of the animals she used to raise.

On October 12th of 1999 she sought care from Dr. Zhuang, a primary care doctor of Wichita VAMC, and received it. She continued to receive care there on ten different occasions until April 16th of this year, making a 440-mile round trip each time. That is at our expense. There is no travel pay involved for the dependent.

When the CBOC at Fort Dodge, which is run by the Wichita VMAC, was open she tried seeing the doctor there, cutting the miles down to 160 miles round trip. After seeing Dr. Catherine Arroyo one time, the doctor refused to fill pain meds which she had been taking since the mid 1970s. Dr. Zhuang at the Wichita VAMC continued my wife on her meds.

The Dodge City CBOC did not pass on to her information about appointments and consults and she was in great pain. For over a year she hasn't been able to work. So on August 27th of this year she requested to have Dr. Zhuang at the Wichita VAMC be made her primary care doctor once again. This now means she faces the 440-mile round trip each time, but at least she's receiving the care that she needs.

There seems to be a lack of planning when it comes to scheduling tests. Test results should be received in timely manner in which the clinics can use them. There is a lot of money being spent on tests that are out of date by the time the patient is seen in a specialty clinic and appointments wasted in these clinics that could be used to someone else who has all of their needed info with them. The primary care doctor should be the one who sees that everything is done in a timely manner but this isn't happening.

The reason I am given for this is lack of adequate staffing to meet the caseload that the category 7 veterans are creating. The Iowa City, Iowa VAMC and it CBOC locations are turning away 500 to 600 veterans a week. That puts 3,600 men and women on a waiting list where they can expect to be left up to a year. I ask you not to let this happen in the State of Kansas.

There is only one vet center in the whole state. This is not serving the rural veteran with the same quality of treatment as received in the Wichita area.

I have more detailed facts about all the information I have given in this testimony and I am happy to answer any questions. I would like to thank you for your interest and the opportunity to testify on health care for rural veterans in the State of Kansas.

[The prepared statement of Mr. Franklin appears on p. 45.]

Mr. MORAN. Mr. Franklin, thank you very much. Mr. Mitchell.

STATEMENT OF OLEN MITCHELL

Mr. MITCHELL. Good morning. I am Olen Mitchell and I want to thank you for the introduction. I do appreciate it and I hope it will be beneficial and helpful in some way.

Let me take just a moment to introduce myself and give you a little bit of information on my background. I reside a 2405 Colorado, Hutchinson, KS, and have been a resident of Kansas for 60 some years. I served in the U.S. military from 1943 to 1946 with the 85th Infantry Division in Sicily and Italy. In the area in which I was wounded, there was two very well known ex-service men, Senators Daniel Inouye and Bob Dole of which they were of much help to me.

About 40 miles south of Rome I received a gunshot wound to my mouth and face. I returned stateside and spent 9 months in O'Reilly General Hospital at Springfield, MO, for dental work and plastic surgery. Upon discharge of service I worked for a local grain company for 15 years and purchased a Texaco wholesale distributorship from which I retired in 1982.

I am now 79 years of age. The nature of my service-connected disability of which I received 30 percent, requires me to need dentures every 5 to 7 years. The VA has made some of these and I purchased some on my own over the years.

In May of 2001 my primary doctor prescribed new medication for my high blood pressure called Mavik, two milligrams once a day, costing 87 cents per tablet. My original high blood pressure medication, Indapamide, only costs three and quarter cents per tablet.

The increase in cost prompted me to try to get some help with the cost through the VA. In order to receive this medication from or through the VA, it is my understanding that the VA doctor must agree with my family doctor that I do indeed need this.

On about the 17th of May, 2001, I called the VA in Wichita for an appointment with the doctor and my family doctor wrote a letter describing my case to the VA doctor. I was informed the first and earliest appointment would be the 20th of December 2001. This would be 7 months of waiting for an appointment.

My way of thinking is this is much too long to wait. There must be a better way. Veterans of my time, World War II, are at the age where they need more medical attention and medication at this time in their life. If we are going to help the program, we need to do it soon.

As you know, about 1200 World War II veterans are dying each day. Also, the cost of medication is at such a high price, veterans who are living on fixed incomes and some just on social security, cannot afford the medication they need. I am somewhat familiar with the cost of drugs since the prescription medications for my wife cost about 2,500 to $3,000 per year and almost without exception every third or fourth refill the prescription goes up from $1.00 to $5.00. We happen to have a good health insurance but no insurance for medications. The price of drugs is just another problem that needs attention.

Now, this is not a health issue but a concern of mine. What troubles me is the way some veterans are treated concerning medication, treatment and the purchase of goods. Some veterans receive all the above at McConnell Air Force Base. They deserve and are

entitled to these, but how about other veterans? Aren't we all veterans? I feel we are.

In some cases I think this would be a help to many. I would like some thought on this and perhaps a way could be found to correct it.

Again, let me thank you for this opportunity to appear and work with this panel to better the life of our veterans. And best of luck in your work ahead.

Mr. MORAN. Mr. Mitchell, thank you very much. Mr. Ratzlaff.

STATEMENT OF SCOTT RATZLAFF

Mr. RATZLAFF. I would like to begin by thanking Congressman Moran and distinguished members of the subcommittee on health.

In 1993 I was injured in a training exercise. This injury plagued me throughout the rest of my time in the Army. In 1995 I received surgery while still on active duty. This surgery was to my right knee. I completed my rehabilitation and was released from active duty with a 10 percent rating from the Veterans Administration.

My transition into civilian life went fairly smooth as I began working for a company based in Northwest Kansas. I worked and was productive until January of 2000. My right leg had always bothered me, but I started to notice something was terribly wrong. I decided it was time to get checked out by my local physician, who, in turn, directed me to an orthopedic specialist in Hays. It was this specialist who determined that my right knee was torn. Dr. Kass recommended that I have surgery done to repair the damage.

I contacted Mr. Jon Denton with the Kansas Commission on Veterans Affairs so that I might find out how long a wait was before surgery. I was displeased to learn it was a 6-month to 9-month wait for the surgery.

At this time I decided to use my medical services, civilian medical services because my goal was to repair the damaged knee and get back to work. On March of 2000 I received a surgery to my right knee. I began to rehabilitate and decided to contact the VFW to find out how to submit a claim to the VA.

On 5–16–2000, with the help of Mr. Denton, I began the first of my claims. I submitted all of my doctor's findings, along with a letter from my doctor, explaining diagnosis, treatment and prognosis as Mr. Denton said this would assist the VA in working my claim.

During this time my right leg condition began to deteriorate. I began to notice range of motion problems in physical therapy and discoloration to my right leg. By May of 2001 I was able to perform well enough. I was not able to return to work. I could not maintain my employment because of the time I missed from work. I resigned my position on 5–10 of 2000. I was not released by Dr. Kass to return to work.

You can imagine the terror my wife and I faced on wondering where the next dollar was going to come from. I began to call everyone I could think of to see what I could do about expediting my claim. I left no stone unturned, calling the Veterans Administration, Veterans of Foreign Wars, and the Kansas Commission on Veterans Affairs to see if I could qualify for a financial hardship.

I had my bank, which had my mortgage on my home and my vehicle notes, write a letter to the VA. My bank, knowing the situa-

tion, only asked that VA provide some kind of time line that my claim would take.

I then filed for a financial hardship on 6–9 of 2000. During the process of this first claim I learned that I would need another surgery. It was also during that time that the VA asked for an examination.

On 7 of 2000 I traveled to Grand Island, NE, to be examined by the VA. I could not understand why I was being examined after I submitted what I thought to be overwhelming medical evidence of an ongoing problem with my right knee and right leg. I submitted to an x ray and thorough examination by a nurse practitioner.

On July 27 of 2000 I had a second knee surgery and again was expected to heal but Dr. Kass would not release me to work because I continued to have difficulties. I submitted additional information to the VA from my doctors that showed I was unemployable at the time.

On 8–2000 I received a payment from the VA by way of direct deposit. This satisfied my bank for the time being but left my family doing a financial leapfrog. It was then that my bank and I decided that it would be better if I put my home on the market so that I would not foreclosure.

Again, all my bank requested was something in writing from the VA giving them a time line on my claim and this could have been avoided. That is to keep me from losing my home. The VA provided no time line.

After I did not recover from surgery, Dr. Kass recommended that I see Dr. Keith Green to see if I had reflex sympathetic dystrophy. I submitted to a spinal block in the operating room to determine if my pain was caused by RSD. Dr. Green did determine that I suffered from RSD and I sent the findings, along with a diagnosis/prognosis letter through Mr. Denton to the VA.

Dr. Green determined that spinal blocks were not working, so the decision was made to put in a dorsal column stimulator. This is a permanent device that is placed under my skin, and is connected to my spine.

During this time I also began to call the VA on almost a daily basis to check on my claim. I pleaded with the service representative to give me some indication of when my claim might be finalized. I explained each time that I was going to be foreclosed on if my bank did not get some kind of information. At one point I was told that I could be directed to the VA homeless program.

I understand that VA representatives are limited in what they can do. Like so many of us, they have policies and procedures they must follow. I asked if calling a congressman would help and I was told that calling my representative would only slow down the claims process as my file is pulled so the VA can respond appropriately to the inquiry.

I again contacted Lisa with Congressman Moran's office to see what might be holding up my claim. I think it is important to know that my condition was constantly changing. This created a paperwork nightmare as I always needed to send information to the VA.

In March 2001, our family home was sold. My hometown bank basically had no choice. They attempted to work with my wife and I as long as they could. In April of 2001 my family and I moved

to Colby, KS. I once again started to hit the phone and E-mail people to see what the status of my claim was.

In April of 2001, after numerous phone calls, I was asked to submit to another VA exam. This exam consisted of some flexibility determinations and some questions. The examining VA doctor admitted that she didn't know a whole lot about reflex sympathetic dystrophy. I explained how the implant worked and what it did for my pain. I also was asked by the VA doctor to sign a release so that she could get the results of my nerve conduction study by my private doctor, what he had done to aid in her findings.

I agreed to sign this release. I once again was waiting on all the paperwork to arrive at the right place so that the review board could look at my case and make a determination.

Finally, during the later part of May I began calling to check on my claim. By June of 2001, with the assistance of Congressman Moran's office, I received a determination for 60 percent disability with a temporary determination of 100 percent due to my unemployability status.

In reviewing my disability determination, it stated that the VA had no rating guidelines for Reflex Sympathetic Dystrophy and that I was rated under a different disorder. I should also point out that RSD has been a recognized disease with references that date back to 1953. I cannot understand why the VA doesn't have any rating criteria for this disorder.

I was assessed 100 percent disability temporarily for my footdrop, which leaves me without the use of my right foot. Because the VA states it to be temporary, they ask me to submit to a follow-up exam to further determine my employability status in about one year.

I can only hope by then the VA would be armed with more effective policies and procedures that could create a realistic time line for claim handling and realistic time lines for surgeries and medical care. I cannot imagine what uncertainties I would have weathered if I had to use the VA health care system.

I often wonder if I could have been diagnosed properly due to the information I received in hindsight by the VA not recognizing RSD. I would just ask that you look at the problems that I have had, with both the medical and claims handling departments of the VA. I feel that policy does dictate some of these difficulties, and that it would be worth your time to review them.

I can only hope that my testimony here today might help out the next veteran who might be attempting to use the VA medical care system. This was a trying experience for my family and I wouldn't want anybody else to go through it.

In closing, I would again like to thank Congressman Moran and the VA subcommittee for hearing my testimony, and hope that it can make a difference. Thank you.

[The prepared statement of Mr. Ratzlaff appears on p. 46.]

Mr. MORAN. Scott, thanks for your testimony. Miss Fromme.

STATEMENT OF TAMINA FROMME

Ms. FROMME. Congressman Moran, distinguished visitors and fellow veterans, I am both honored and humbled to be asked to participate in this field hearing. The quality and future of our heath

care is important to all of us, as is validated by our gathering here today.

There is much to be voiced about veterans health care. It is difficult to know where to begin. We all have different medical needs. Each individual has a statement to make about those needs that deserve to be heard. Unfortunately, those needs must be addressed by the four of us in a very limited time frame.

I have spoken with, and heard from many veterans over the last few weeks to try to ascertain a better understanding of how the process works. I am new to the problems that many of you face daily, or have dealt with in the continuing battle for quality and convenient health care, especially in the rural areas.

I was initiated into this struggle by needing a preemployment physical and no health insurance to help pay for it or income until my first paycheck, which will be the 25th of September, or tomorrow. A family member, who is a veteran, recommended that I go to Fort Dodge and sign up for veterans benefits. I could get my physical at Fort Dodge and it would be for half the price of local charges.

I drove 5 miles and saw Scott Dorsey, the Veterans' Service Representative. He was instrumental in helping me with the paperwork that was required. I was subsequently put into "the system", appointment for the physical was made, and my services began. I know now that I was fortunate that my application for services went smoothly and efficiently.

Kathy Wiley, the Advanced Registered Nurse Practitioner, serves at Fort Dodge. She is a marvelous professional. I was given the most thorough physical I have had in years. She has discussed my test results with me and has answered many questions. I have no complaints as to the health services and care I have thus far received. It is the future care that causes me worry and is really frightening.

As I stated before, since being asked to be here today, I have spoken with many other veterans, and Ms. Wiley, to see what my future health care will be like. I have learned what many of you already know firsthand. I must travel to Wichita for everything, except the basics that the outpatient clinic located in Fort Dodge, or other small outpatient centers, can provide.

Being a woman, over 50, family history of cancer, and not immune to the perils of aging and ailments of human suffering, I am hit with reality. This means that I must take a day of sick leave, travel almost 3 hours for a 30-minute mammogram, then the same trip home. A repeat trip is required for any dental, vision, hearing, cardiology, patient education, dietary education, CAT scans, bone density tests, or MRIs, if needed.

If I should require mental health care, I could possibly have one 45-minute appointment a month locally. The Vet Center does come to Fort Dodge for 1½ days every 2 weeks. If group or a major therapy is required, it would be yet more trips to Wichita for each session.

For dialysis, it is back to Wichita for each treatment, or my own private insurance to have services done locally. The cost of travel, possible and probable overnight stays, and lost days of work would

quickly overcome any savings by having these services completed in Wichita.

My research has revealed that many of the services I might need, and many of you already must have, are Fee Based Out. This means that these services are not provided here at this veterans facility, but are provided at some other facility here in Wichita, and then the Veteran's Administration pays that provider for those services.

Many of our veterans have no family close enough to give a helping hand, for whatever reasons, can't get to Wichita or have no private insurance. Some wait upwards of 6 months on the processing of their paperwork. These men and women who have faithfully served our country, in both peace time and war, are going without desperately needed health care. Sometimes these become life-and-death situations, to eat or have the medications needed, to have heat or travel to Wichita to see the doctor. Difficult choices many veterans make daily.

The fact that we live in rural areas compounds and complicates even the availability of the most routine and basic medical care.

Remedies I suggest would be, first, expedite all applications for veterans' medical benefits. Hire more clerical help, if that is the reason for the backlog and the processing procedure. Provide vouchers, contract for, or Fee Base Out to our existing local doctors, dentists, optometrists, cardiologists, medical health clinics, and medical clinics.

This would not only ease the strain on the existing facilities here in Wichita, but allow our veterans the opportunity for quality, as well as convenient health care that is closer to our homes, wherever they are.

We are thankful for the outpatient clinic located in Fort Dodge. Over 1,000 veterans were served there last year. These numbers are expected to increase as the news of this local service spreads. The need to have access to medical care is evidenced by these growing numbers.

Please, support what we do have, but continue to pursue and fight for the right to have medical care that covers all of our needs. We must have facilities or providers of health care more accessible to those of us who live in the rural areas, as well as those veterans who live in the more populated areas.

My son, his wife, and one son-in-law, who is currently in the Persian Gulf, are career Navy people. One of my grandsons took his first steps on the flight deck of the USS Kitty Hawk. A future Navy man, I am sure My children are active duty today. What will be available to them when they have chosen to retire and come home to rural Kansas?

Our futures and the futures of those individuals now serving depend on each of us working for a common goal. That goal is quality and convenient medical care for all veterans living in rural Kansas and rural America.

[The prepared statement of Ms. Fromme appears on p. 49.]

Mr. MORAN. Thank you very much. We wish your family a Godspeed in today's uncertain times. We wish them the very best. Mr. Franklin, the CBOC in Liberal is managed as part of the VA sys-

tem out in Amarillo. Are there specific difficulties that veterans in the Liberal area face as the result of that management situation?

Mr. FRANKLIN. In my situation, my wife, being an eligible dependent, is unable to be seen due to the fact that they are managed by Amarillo and Amarillo has opted out of the in-house dependent services. It is my understanding they have that option to determine whether or not the facilities they have meet the needs of their veterans that they are responsible to.

And if there are additional facilities that can be used, then the dependents get services. Dependents have these services available to them by law, but if they are opted out by the local VA clinic that is serving them, they can't receive them.

Mr. MORAN. That's the reason your wife could receive services at Fort Dodge, but not at Liberal, because they had opted out.

Mr. FRANKLIN. That is correct.

Mr. MORAN. Is there a compatibility with veterans? I assume when you are at Liberal the veteran may very well choose to come to Wichita for hospitalization versus Amarillo, and some might choose Amarillo. Do the hospitals talk to each other? The records that you have in Liberal, are they available to—if you travel to Wichita or Amarillo, is there a difference?

Mr. FRANKLIN. They are not available. They don't talk to each other, the VA in Amarillo and the VA in Wichita. I do understand that within the business that is possible, at least in some locations. But that is two different VISNs.

Mr. MORAN. Your wife has had the experience being in Fort Dodge and Wichita. Is there communications between Wichita and Fort Dodge?

Mr. FRANKLIN. I am not sure where the breakdown was, but the information was not being passed to her in a timely manner through Fort Dodge at that time. She would get to a specialty clinic, which an appointment would have been set months down the road for her, and when she would arrive the tests that she had received weren't current enough to satisfy the doctors at the specialty clinic.

So there would have to be a scheduling of another test for her and that would be months down the road before she could get into that test. And then it would have to be another rescheduling for the specialty clinic. It was a vicious circle.

Mr. MORAN. So tests from Liberal and Fort Dodge would have to be taken again, the same test again in Wichita?

Mr. FRANKLIN. The tests were not available in Fort Dodge or Liberal. You would have to come, in her case, here, to receive the tests necessary for the specialty clinics in Kansas City. She was having to drive to Kansas City. A 6½ hour drive, for a person with a bad back that is difficult.

Mr. MORAN. Miss Fromme, you talk about basic services being available at Fort Dodge, and your testimony has some suggestions. What do you see as the role that ought to be played with CBOC? What additional services would you see as being demanded by veterans living in the Dodge City area?

Ms. FROMME. We need to have more than going to the clinic for colds, flu, this type of thing, and from my own personal experience, for preemployment physical. I can't get a mammogram or could not

get one in Dodge. With my family history and my medical needs, I need to have one every 6 to 12 months, preferably every 6 months.

Dodge City has a certified mammogram machine but yet I can't get it there, I have to take a day off of work to come to Wichita for the exam. And it was 165 miles from my home here, one way, and that's outrageous.

Our local areas have quality health care providers. We should be able to use them here. If we come to Wichita and we have to have services done and they don't have some equipment here—it is my understanding I can't even have it done here at this facility. I would have to go a radiology department somewhere in Wichita to have those services. So why can't we have that done locally?

The clinic at Fort Dodge can't do dental care. I have to come to Wichita to go to the dentist. We have local dentists. We should be able to use those, and our local health care providers.

There was one individual that I know who had cataract surgery done locally in Garden City, yet they had to come to Wichita. Well, Wichita isn't where he ended up. He ended up in Newton to get glasses. He could have gotten glasses in Garden City or Dodge.

Mr. MORAN. When you talk about basic services in Fort Dodge, what most of us consider basic services, aren't available in Fort Dodge. It's a very narrow definition of basic services?

Ms. FROMME. Very narrow.

Mr. MORAN. Mr. Ratzlaff, what Ms. Fromme said reminded me of a question for you. Were you ever told by the VA to have an opportunity to have a surgery performed by a non-VA surgeon and VA would pay for that surgery?

Mr. RATZLAFF. No, it was my understanding that my choices were two, you know, just go through the 6- to 9-month wait or seek outside medicine.

Mr. MORAN. And the reason you were choosing civilian medicine was because of the wait?

Mr. RATZLAFF. The time line, right.

Mr. MORAN. And the financial difficulty was because of the medical bills?

Mr. RATZLAFF. Yes.

Mr. MORAN. You talked of financial hardship, what happens with that designation?

Mr. RATZLAFF. Basically my understanding is once I qualify for financial hardship then my claim would be expedited, go through the claims processing quicker.

Mr. MORAN. How long did it take from the first time you made a claim with the VA until you received assistance?

Mr. RATZLAFF. Over a year.

Mr. MORAN. And then, Mr. Mitchell, tell me a little bit more. Well, first of all, I would ask you, is it your experience that because of the increased cost of prescriptions we are seeing a lot more veterans who wish to access VA health care? Is that true of you? And that seemed to be the instigative factor of you seeking VA health care. And I assume that may be true of your friends and neighbors.

Mr. MITCHELL. I am sure that's true, because the price of medication is getting out of hand, and that was the primary reason that I did it. The same way with my dental. I have come over here for

dental work. But in the past, of course, I got out in 1946, so that was many years ago, and in those days my local dentist would take care of my needs and the VA would reimburse that. And that worked out for me. I am not sure about the VA, but that was a great setup. But now I have to come here.

I am close, 50 to 55 miles, but the thing that bothered me most about it was the long span between appointments, 7 months. And I will be fair about it, after contacting your office it was cut down to four. I came down in September and I am grateful and thank you for it, but that's entirely too long.

I could live with that because all mine was was a change in medication. But for someone that's really sick you have a problem. And I talked to several people over here and I got the same answer. Most of them were pretty nice in answering my questions. One or two was not. But they infer if President Bush called he would have to do the same thing. I really wasn't too concerned. I wasn't too concerned about President Bush getting medical attention. But that was the primary reason for me, was the cost of medication, and that's the only thing I take. At my age, tomorrow, I may add to that.

Mr. MORAN. Mr. Mitchell indicated that he is 55 miles from Wichita. Mr. Franklin and others, if you would, for the record, how far is it for you to come to the closest VA Hospital? State it out loud so the court reporter could place that in the record.

Mr. FRANKLIN. To Wichita, where my wife is to be seen, 220 miles one way. I can be seen in Amarillo, 167 miles from my house.

Mr. MORAN. Thank you.

Ms. FROMME. It's 165 miles one way for me.

Mr. RATZLAFF. It's 3½ to 4 hours. I am not sure of the mileage.

Mr. MORAN. Scott, did you start some place else besides Colby? When you made the claim were you living some place else?

Mr. RATZLAFF. Yes. Hill City, KS.

Mr. MORAN. Mr. Filner?

Mr. FILNER. Thank you, Mr. Chairman. Thank you for remitting your stories, and I know it's difficult to do that. And your stories pain me. This is not the way our veterans ought to be treated, from whatever war or whatever time you served.

Some of these problems are management deficiencies, et cetera, internal to the VA communicating to each other and your testimony will help us bore into those problems and try to solve them.

Most of them have to do with resources that the VA is given that they cannot handle. I know it won't be any comfort to you, I represent the urban district in San Diego, CA, and the waiting times are the same. It is not a question of rural/suburban, but is a question for the VA.

And the testimony in Hays CBOC who said they brought on one additional nurse practitioner and brought down the waiting times for certain appointments 6 months to 30 days, so we can see what is needed. And many of us in Washington are fighting for it, it used to be a flat line or declining level of resources. Given what we had, what you have all been told, we have this surplus and trillions of dollars years ahead so we ought to have reversed that trend for the VA.

And there were a bunch of proposals to add two or three billion dollars more per year, which would have begun to reverse some of these things. Those budget recommendations were not accepted by the Congress, unfortunately. So what that means is that these budget problems that you are addressing are really political problems.

And I use political not in the sense of party but political meaning it's the way a Nation decides its priorities. And in recent years we have not put veterans, as a Nation, at the top of our priorities. And I say as men and women of our communities, you don't have a surplus until you have paid your bills. And we haven't paid our bills to our Nation's veterans.

And this is an issue of politics, again, not party, not parties in politics, but it's an issue of involvement in the political system. We made a contract with veterans that should be fulfilled. You should not have to fight for these benefits. But the reality is a budget is determined by those who get involved in that political fight and veterans have to be at the table.

And I think the veterans who I deal very closely with in Washington, and in my own state and city, used to be able to deal with this. Going to the former chairman of the veterans' committee Sonny Montgomery, the needs would be presented to him and he would have a lot of power and would have gotten it taken care of. When we enter in deficit politics everybody had to fight for their share and that's when the benefits for veterans went down.

Interestingly enough, the one difference from congressman served elected in 1990 and those elected before is that we are about 75 percent of the congressional people have been in the military and 75 to 80 elected since have not. That's not to say they are evil. I am one of those, I did not serve in the military. But that means they don't know the problems veterans are facing and have to be educated.

So the veterans and advanced groups have to educate the Congress and these people do not know, they are not evil. Veterans have to be involved in that political process. I hate to say this to you because we owe this to you, but that means you have to deal with our Congress people, your senators, you have to make sure everybody is voting for increased budgets.

You have people at this table who are fighting for that but that's not necessarily the case in all cases. So it pains me to hear what you are saying. It will help. I fight, as I relate your stories into Congress. But it's a battle to increase the resources that you all have to be involved in to make our commitment on our contract to the full phase of that contract.

I thank you for allowing us to hear your stories and fight for more resources in Washington. It will help us.

Mr. MORAN. Mr. Filner, thank you very much. Mr. Tiahrt.

Mr. TIAHRT. Thank you. It seems like listening to you, what you experience sort of falls into two broad categories. One is trying to deal with distance that's involved and the other is the system. Amarillo opting out of dependent care, for example, is a system flaw. Not being able to get a local mammogram, having to come to Wichita to get a local mammogram, it seems like a system problem. And some of the problems are related to funding.

We do spend a lot of money as a Nation. Veterans' health care is 21 billion dollars, but it seems like that's not enough to fix the problems. And I think the system medical problems have come to distance. Colby is a wonderful spot on God's green earth, but it is a long ways from Wichita. It is hard to overcome that distance problem. But the system, waiting 7 months, seems like a long time. A lot changes in 7 months. Kids grow up, bills come overdue, time goes on.

And I think the systematic problems that you are bringing are a place where we could probably work a little harder to do better. We are not doing well and the system is not doing well. But I think we should accept that as a challenge and try to change these things.

Just a simple thing such as a mammogram is something I never thought was a problem, I guess, because I haven't had a lot of mammograms myself. But I think it's a systematic problem, something we ought to focus on. And I appreciate you all bringing them up.

Mr. Franklin, on dependent care, the distance seems to be the problem mostly. But there is also a time lag that you think that this dependent care versus the care you get, is it quicker for a veteran or longer for dependent care or about the same?

Mr. FRANKLIN. It is my experience it's been about the same for that care. There is a—somewhere in the system there is a breakdown in the scheduling in a timely manner. When you have three or four different specialty clinics involved, somebody has to coordinate that.

My understanding is it should be coordinated through the primary care doctor. For some reason that is not happening in the case of my wife. Now that she has changed back to the primary care doctor here in Wichita, we are hoping that that will correct that situation and everything will be done in a timely manner. Up until 2 weeks ago this was not happening until I rattled some cages pretty seriously.

Mr. TIAHRT. I want to compliment Jerry. I know he and his staff work very hard for the veterans and the First District in Kansas. And cutting the time down in half, I think, is a good indication when you do have a problem, I think, the interphase through your congressional office would be helpful. I think your point about no coordination, it seems there could be a better coordination or something, that it would be easier to get the people all arranged in a timely fashion.

Mr. Mitchell, you have friends over in Hutchinson, I assume, and have they talked to you about their form of health care or their VA problems? Are they similar to yours in nature? Is it mostly related to just medication at this point in their lives?

Mr. MITCHELL. Medication, I would say, would be the big problem. And I realize more and more people are getting medication for veterans, but that is a big item, it's a costly item. Time wise I haven't run into too many people in my home. In fact, some of them couldn't believe it about 7 months, 7 months for an appointment.

And in my estimation the technology like it is, in my case I think that we could handle it by a telephone call. My doctor wrote a let-

ter and sent it over here and all they had to do is get on the phone and talk that they agreed in the difference on medication. Maybe that would have taken care of it. But instead I had to wait all of this time.

But, like I say, I was okay. But if my neighbor would have been sick it would have been quite a problem. I am just concerned about it.

Another thing I brought up, I don't know if you understand it, but it is my opinion or have been told that a lot of veterans—and I think there are probably retired veterans—who go to the commissary at McConnell. That would be a big benefit. And I don't understand why one veteran can do it and another one can't. A veteran is a veteran to me. And it's not a health item, but it could be connected to it price wise. And that's the only reason I brought it up. But I will say, when I got in——

Mr. TIAHRT. Why wouldn't the two categories have access to commissaries, why would some do and some don't? Can you tell me?

Mr. MITCHELL. I really don't know. I can't answer those questions. The ones I know are retired from the military and so I really truthfully can't answer that. I know it is going on. I don't have access to that, and neither do a lot of my other veterans. But once I get over here, they take care of me very well. It's just getting over here.

Mr. TIAHRT. Well, I appreciate all of your service to the country. It means a lot to us. Thank you very much. Thank you, Mr. Chairman.

Mr. MORAN. Thank you. Todd, thank you very much. And I want the legislation to allow or require the VA to utilize a home-town physician and pharmacist prescription accepted by the VA. And that issue is being discussed at the time.

Mr. MITCHELL. Thank you.

Mr. MORAN. You are welcome. I appreciate your testimony and willingness to drive. I recognize you had to drive a long distance to be here. Thank you very much. You may step down.

We are going to take, not really a break, but have Dr. Kent Murray now, who is the chief of staff here at the Wichita VA, present a tele-medicine demonstration. So, Dr. Murray, we are here to see what you have to show us.

Dr. MURRAY. Actually we have had tele-medicine capability for several years. This is the unit that each facility currently has. And I am going to connect shortly with Kansas City. Wichita currently conducted with Kansas City a vascular clinic, and Dr. Subbarao, our surgeon, will tell how that works. And Mr. Brotten in Kansas City will demonstrate the capability to you in terms of what kinds of things can be done.

Obviously, this has great potential for communication between outlying facilities and Wichita facilities eliminating, hopefully, a need for a great deal of travel. So Dr. Subbarao would you like to come up and demonstrate the clinic.

This is actually a clinic that does occur here on a weekly basis with Kansas City. Dr. Subbarao and the surgeon from Kansas City will obviously keep the patient's identity confidential, but this is to show you how it works.

Dr. SUBBARAO. Good morning everybody. Thank you for the opportunity to demonstrate this tele-conference. I think it's very useful for care. Having been here 6 years, I found this one of the truly useful modalities to take care of some of the problems and issues you have.

I am a vascular surgeon and I used to conduct some of these operations here. But since we started having some of these operations in Kansas City VA there were several problems prior to this teleconference coming into force and patients had to make several visits to Kansas City.

And for some, as they have just mentioned, that was a lot of hardship traveling up and down. There had to be a better way and I think we did find a better way.

I am just going to demonstrate one patient, how we discuss this. We do this every Wednesday at 3 o'clock. My colleagues, I will introduce Dr. Cherian, he is a vascular surgeon in Kansas City. Good morning.

Dr. CHERIAN. Good morning. And on my right is Dr. Monaco. And you can see Bob McBee on the left side. Dr. Casini and the rest of the team are in the operating room and they will be here in a moment.

I think we probably could start to discuss patient number 3. That's the one that we have the x rays and films on.

Dr. SUBBARAO. Before we go to the patient, I want to introduce everybody here. Bob McBee, you can raise your hand. Bob has been extraordinary in coordinating this whole conference in tele-medicine. He not only communicates with vascular, but ENT and dermatology, and sees patients many miles away. We find this extraordinarily useful so patients' visits don't have to be that frequent.

And we decide on the care of the patient and then the patient makes one visit for definitive care. That has been the single most important thing in the process. We also cut the costs in having the veterans travel back and forth between these several institutions.

Dr. Cherian, can you hear me?

Dr. CHERIAN. I can hear you.

Dr. SUBBARAO. Patient three, we have talked about this gentleman before. This is 78-year-old who has had left internal carotid artery disease. That was less than 70 percent. Can you hear me?

Dr. CHERIAN. Yes, we can hear you.

Dr. SUBBARAO. We had an angiogram performed in July of this year and the patient is asymptomatic at this time. Do you have the films there?

Dr. CHERIAN. We have the films. And we are looking at the films on the screen right now. And we agree with your interpretation that he has bilateral high grade stenosis right at about 70 percent on each side.

Dr. SUBBARAO. Correct.

Dr. CHERIAN. I want to reconfirm that this person is talking asymptomatic.

Dr. SUBBARAO. I have had to do some work on his right lower extremity, but in the process of workup for them we had detected this carotid artery disease. He is asymptomatic.

Dr. CHERIAN. We have on the film, small aneurysm also.

Dr. SUBBARAO. Correct. And we are watching that CT scan, and we have been watching it for 6 months.

Dr. CHERIAN. Here is what we would like. I think we agree that he needs a bilateral carotid endarterectomy. Since he is asymptomatic on either side, we have to decide on which side we do the operation first. I have the screen. Can you see the picture there?

Dr. SUBBARAO. If you can focus the angiograms.

Dr. CHERIAN. Can you see them now?

Dr. SUBBARAO. I can't see them very clearly from here. Have the camera focus the angiograms on your screens.

Dr. CHERIAN. I will talk about the angiogram. The angiograms show slightly less stenosis on the right side, than the left side. But there are also changes on the ultrasound on the left side.

Dr. SUBBARAO. Left side.

Dr. CHERIAN. So it's a matter of deciding which side we do first. You are probably going to recommend that we do the left side because of the high velocity changes and also because the left would be more stenotic as seen on the angiogram. So we will improve the left side problems first, and in about 2 weeks we can do the right side, okay?

Dr. SUBBARAO. Okay.

Dr. CHERIAN. And I think we have all the information we need. All the other tests are accessible and the ejection fraction is 52 percent, correct.

What we will do in this case is Dr. Monaco will contact him, and we'll bring him in, within the next few weeks, the day before surgery, and watch him overnight, do the surgery the following day, and he could be back under your care the next day.

Dr. SUBBARAO. Yes. We'll have to do the follow-up duplex scans. We can follow up with the post-op duplex scans.

Dr. CHERIAN. Have you discussed the operation with the patient?

Dr. SUBBARAO. Yes, I did. And I told him he would probably get more from you first.

Dr. CHERIAN. I see from the notes he has stopped smoking.

Dr. SUBBARAO. Yes. That was significant on his part. And he understands the importance of stopping smoking.

Dr. CHERIAN. And his cholesterol is satisfactory. We will contact this patient and bring him in for more surgery and most likely do it on the left side, unless we have some evidence that may be significant on the right side. But most likely, we will do the left side and, as usual, we can follow up 2 weeks later on the other side.

Dr. SUBBARAO. Sounds good. Thanks a lot.

That is basically how we discuss patients. Prior to this we had to send the patient over and come back and make a visit with all of these tests. Now we have all the tests done here. And once we agree upon the plan, basically the Kansas City hospital unit gets in touch with the patient, gets to it a day at a time, patient gets the surgery done and I can follow up here with the duplex, or whatever tests necessary.

And I thank you for allowing me to present this case.

Dr. MURRAY. I think we should mention, the reason they have the films is we routinely transmit all of our x ray images to Kansas City and use tele-radiology for that. Most of our films, or a good many of our films, are read in Kansas City and will be sent with

all of our diagnostic information. So this is not just heads talking back and forth, this is a diagnostic.

Mr. McBee is the tele-coordinator in Kansas City and volunteered to show us some of the capability of what we can transmit back and forth on this piece of equipment. Mr. McBee.

Mr. MCBEE. Good morning. Thank you for letting us be a part of the conversation this morning. What we want to do at the VA is promote a program that will overcome the geographical boundaries inherent to the VA centers and the social needs to extend health care to rural areas, CBOC's government and not government facilities. Through the usage of this, and other tele-communication computers, we hope to bridge the gap between the health care providers and the remote location. Tele-medicine will allow us more immediate access to medical expertise providing better health care and hopefully eliminate some of the problems discussed this morning.

There are various aspects of this we can do. From this cabinet, we have various cameras. I will demonstrate those with the use of Dr. Cherian and he will demonstrate them. It will take me a few moments to switch between cameras and different mediums. And so bear with me and I will get started right now.

One of the first items we are going to demonstrate is a camera called ELMO. And what this will allow us to do is look at images. And we can put x rays on this and slides on this device. And can also be used in dermatology. I will get this focused for you a little bit better. And as you can see——

Mr. MITCHELL. We are not getting anything here, Bob.

Mr. MCBEE. You are not?

Dr. MURRAY. There you go. I guess what was happening is you were showing us the vascular case, but we have it now.

Mr. MCBEE. Sorry about that. As you can see, this is an image of my hand. And we would do something like this during a dermatological exam. We have conducted 170 dermatology visits over the last year with the Wichita VA, and it's been a very helpful tool for veterans to cut down the visits. This is just one use of this camera.

The camera's can go in and out. We can do regular black-and-white, positive/negative images. It's a really good multi-functional device. And this is what is called Elmo.

The next one is an exam here. This is a device that allows us to zoom in on various aspects of the body. I am going to show a signalization that there is a warning that the video—we are in danger of losing our video, but stand by. I am going to focus in on a couple of items of this camera.

This comes in and allows us to zoom in on various things. This clock is approximately ten feet away from me right now. And we can freeze these images, and the images will clear up somewhat. There is a small loss in the transmission of approximately 5 to 8 percent.

Are you hearing me all right?

Dr. MURRAY. Yes.

Mr. MCBEE. I will put another example of this camera.

Dr. MURRAY. Bob, we are going to need to move along. Can you just show us a quick example of other items? And we need to wrap this up.

Mr. MCBEE. All right.

Dr. MURRAY. How about an x ray?

Mr. MCBEE. All right. We will go to an x ray then.

Dr. MURRAY. They are going to show us an x ray that they would show us in the conference.

Mr. MCBEE. Are you able to see that now, sir?

Dr. CHERIAN. It is the showing the narrowing of the left side. That's the external carotid artery. And it shows narrowing of that also.

Dr. SUBBARAO. This is the common carotid artery. It is the internal and that's the external. And we need to have a good way of getting with each other in one set of the films.

Dr. MURRAY. Can you show us an aerial real quick?

Mr. MCBEE. Yes. Let me get it in focus.

Dr. MURRAY. We can actually get better focus than that, but I am getting multiple high signs right now we so better stop. Thank you. Thank you, Bob.

Mr. MORAN. Thank you very much. I do think technology presents lots of opportunity for those of us living in rural America and I am glad to see VA involved in advanced technology and working with you to bring it about to a greater extent.

We need to quickly bring the second panel to the table. If you would come to the stage, please, that would be great.

And we have Kent Hill, Director of the VA Medical and Regional Office Center; Dr. Raju, full-time physician in Liberal; Leann Zimmerman, nurse practitioner for the VA in Hays, KS; and Dr. Peter Almenoff, the VISN 15 Network Medical Director in VA Heartland Network in Kansas City.

And whoever sits down first, I think, gets to go first, Dr. Almenoff.

Mr. Hill, I thank you very much for your hospitality. I am grateful for all that you have done.

STATEMENTS OF KENT D. HILL, DIRECTOR, VA MEDICAL AND REGIONAL OFFICE CENTER, WICHITA, KS; L.S. RAJU, M.D., VA LIBERAL COMMUNITY BASED OUTPATIENT CLINIC, LIBERAL, KS; LEANN ZIMMERMAN, NURSE PRACTITIONER, HAYS COMMUNITY BASED OUTPATIENT CLINIC, HAYS, KS; AND PETER ALMENOFF, M.D., VISN 15 NETWORK MEDICAL DIRECTOR, VA HEARTLAND NETWORK

STATEMENT OF KENT D. HILL

Mr. HILL. Pleased to have you. Mr. Chairman, Representative Filner and Representative Tiahrt, distinguished veterans and guests.

Thank you for this opportunity to appear before you today to discuss the progress, challenges and future of health care provided to veterans in Kansas by the VA medical and regional office center here in Wichita.

Since 1997 we have dramatically changed the delivery of care in our service area. In keeping with national goals and the direction

of health care in general, we have promoted the development of outpatient versus inpatient care at our local facility. We have reduced inpatient days of care and reduced total cost to treat veterans. We have established four full-time outpatient clinics in Hays, Dodge City, Parsons and Liberal. And Liberal is one that we are managing with and the fifth is to go in this fall in Salina.

Coordination of care for each patient is the responsibility of a primary care provider, along with a team of other health care workers. Telephone care is now available 24 hours a day. We have promoted disease prevention.

VISN 15's aggressive development of the electronic medical record and a common patient database are the foundation upon which we are building a system for the immediate flow of medical information and images among facilities and community-based clinics. As a result of these strategies, the Wichita VA has been able to provide care to more than 20,000 unique veterans this fiscal year. This is double the number we served in 1997.

Three years ago the veterans and counties where CBOCs have been established traveled an average 130 miles for primary ambulatory care. Now, veterans in those same counties travel an average of 11 miles for VA health care.

Adequate professional and support staff are key to continued success. The number of physicians, nurses, pharmacists, and other professionals is low in Kansas compared to other states and our turnover and vacancy rates reflect this competitive market. Salaries for some professions, like pharmacists and ultrasound technicians are difficult to match.

The physician special pay and salaries makes recruiting for many specialists difficult. Another problem area is staff development involves foreign medical graduates. Even when excellent foreign medical graduates are available, the process regulating their employment is cumbersome, sometimes taking over a year to complete.

The rapid increase in number of veterans treated this year brought with it the demand for services and pharmaceuticals, the cost of which exceeded our expectations and capacity. VISN contingency funds ordinarily used to address such an unexpected shortfall were not available.

Consequently, we have delayed hiring some support staff needed to improve timeliness. Continued efforts to improve access will draw additional veterans and will inquire an increase in resources coupled with even greater efficiencies.

We realize that simply reducing the cost to provide services is meaningless unless we also maintain acceptable levels of quality, access and satisfaction. Our number one goal for 2001 and 2002 is to reduce waiting times for specialty care, a source of considerable patient dissatisfaction. We are working to improve the referral process for diagnostic services and specialty care by recruiting our own specialty staff (if recruitable) and promoting hospital competition for emergency hospital and outpatient services not available within the local VA.

For example, we are currently recruiting for a cardiologist, oncologist, and pulmonologist. Additional optometry and GI staff have already been added. High turnover rate among primary care

providers, coupled with the increased number of veterans accessing the system have caused unacceptable delays in obtaining appointments.

Recently, though, we have been able to hire additional primary care physicians and waiting time for new patient appointments have dropped from 4 months to less than 30 days.

Technological advances are making it possible to use relatively low cost equipment to conduct telepsychiatry between CBOC and facility. Patients willing to use the modality have been identified, and we will conduct the first session in Hays before the end of September.

The Wichita facility is a medical center and regional office. The primary service area for health care includes the 52 counties and south, central and western Kansas. The regional office is responsible for processing claims for the entire state of Kansas. Claims processing time is not what it should be. We have however, hired six additional rating veterans service representatives and nine additional veterans service representatives in the last year increasing by one-third the number of decision makers.

Even though these individuals have not been fully trained, yet production has risen steadily, and we are currently producing twice the number of decisions that we did even last November.

As previously noted, developing our workforce is the key to maintaining improvements and continuing progress for Kansas veterans. The focus of our Human Resource function will be the building of a candidate pool from which to draw the numbers and type of employees we want serving our veterans. This means paying more attention to employee satisfiers, enhancing the education program, making better use of employee retention and recruitment incentives, and streamlining the hiring process.

For example, Network 15 is pursuing OPM approval to establish a delegated examining unit that will reduce delays in hiring some hybrid Title and Title 5 positions. A VISN-wide mentoring program is in place to identify and develop candidates for key positions.

Patient satisfaction with outpatient services has steadily improved over the past 3 years. The 2000 data suggests that 90 percent rated services has steadily improved over the past 3 years. The 2000 data suggest that 90 percent rated services as good, very good or excellent. We are, however, working to beef up patient education and coordination of care.

In response to this, weekly surveys of both inpatient/outpatient areas are conducted and sorted by a team and provider. This information is used for feedback to staff and managers. This information is used for feedback to staff and managers. Local survey scores have dropped recently and the decline seems to be linked directly to the access issues.

In summary, Mr. Chairman, Wichita VAM&ROC has worked to improve services to veterans in Kansas. We are proud of our accomplishments but recognize the need to make further improvements. Our dedicated staff are up to the challenge and optimistic about the future for Kansas veterans.

Thank you for your continued support of our Nation's veterans. I, along with members of my staff, are available for any questions that you have.

[The prepared statement of Mr. Hill appears on p. 51.]

Mr. MORAN. Thank you very much. Dr. Raju.

STATEMENT OF L.S. RAJU, M.D.

Dr. RAJU. Good morning, Congressman Filner, Jerry Moran and Mr. Tiahrt and all the veterans. It is my great pleasure to be here this morning and I thank you again for asking me to be here.

I got involved just a couple of years ago when I was busy practicing in Liberal, KS, and had some instance of surgery and was looking for some way of not having to be on call over weekends. And the position of VA CBOC came up in the clinic, and I took it up not knowing exactly as to what I was able to be doing in a clinic without the facility of a VA hospital and so on and so forth. Since I have been there I have enjoyed the clinic very much and I do realize the quality of care that is provided there for veterans is very good that not many people can get outside of VA system. All of the care that is provided is streamlined and in a very complimentary fashion.

At the same time, I do realize there are a lot of things that could be done to improve this situation. CBOC clinics are very helpful to the local community, and it is hard to find people traveling 150 and 200 miles to come to the clinic and be able to obtain the good healthcare and medications. That seems to be a big relief when they find out that though they can't get all the medications that are available outside, but some substitutes, that they are still so gratified.

And the other reason they keep coming to the clinics, I sometimes ask them why they have to travel 150 and 200 miles, this being in the southeast corner of the state, people from, I think, even Colorado, Oklahoma, Texas and Kansas come over there. And it is difficult for them to go to another place, perhaps even going towards Denver. And they said they can't get to be seen by the same physician or practice each time they come in. And they seem to think that it matters a lot. They recognize the physician, your face, and know that you are interested in them, seems to be one of the factors that attracts them to the CBOC clinics as compared to a regional set up.

And like many have expressed, I think we want to see that the clinics, that they got prescriptions or for the clinical visit or clinical exam are appropriately and adequately equipped. For example, veterans around Wichita can get a lot of services for that matter, compared to the ones that come in to CBOC clinics. This offers a comparison to see what could be done to upgrade the CBOCs.

I think, in my opinion, for a starter, if we can try and work some way, (bearing in mind the costs that are involved) to try to give the veterans much needed care in a considerate way by arranging testing like radiology and x rays and examinations. And what Dr. Subbarao was talking about, such as barium enemas and IVPs (kidney and x rays), and so forth, if could be arranged locally, it would be a much appreciated service for the vets without having to travel to the tertiary centers each time.

If there is some way of not complicating the whole setup and bring up some way of doing things locally, thus helping them enormously. The vets express that they have to travel so much to have

the tests done and have them rescheduled and come back to get the opinions, results, and return again for any follow-up necessities, I think, in the long run, the whole system would have savings because they won't have to pay veterans so much to come back many times over and vets don't need to spend so much out of pocket.

And I think Wichita has been very good in their mission in the CPR system.

I would like to plead with you, please, also to try to see if there is something that you could do to treat the veterans as well as their families because they need good care, whether this is the dependent children. I think somewhere in the system they need the comprehensive care and this will encourage families to get enthusiastic and motivated, to look forward to getting into the military services, if there is an assurance that all the family will be taken care of.

And one of the other things that could be done to help them is provide the visual and hearing assistance without having to qualify (service connected) for the same. And this service will go a long way in helping them.

I am also saddened by the smoking and the consequences of emphysema, chronic bronchitis and heart disease, similar to what Dr. Subbarao was discussing—blood vessel disease. If there is some way that they can use the military service where right up front they were given some incentives not to start the habit in the first place, it will go a long way and save a lot of money and perhaps the lives and increase production for our country.

I would also like to add a little note about having a continuing medical education every 4 months, to every 6 months at least, for all the physicians, and practitioners, all the area doctors to come in and have an exchange of information and ideas which will help in many ways including learning from each other. I feel we have instances of duplication of investigative procedures (doing the same things over again) streamlined.

And coming to the prescriptions, some of us practitioners seem to take comfort in the fact that we can use a lot of medications available, (good ones, too) that should be used and could be used appropriately. But we tend to get away, sometimes using too many medications. I think these regular interactive meetings with colleagues will help us to get together and discuss how these could be handled best.

When it comes to narcotic medications, sleep medications, pain or arthritic medications, not unusual to find are person on many more than one medication. In their own mind the patients are convinced they need them all to keep comfortable and be healthy. We need to be educated about that, be able to have a common approach to deal with such situations.

Just forgot to add that I have been in Canada where I was taking care of people with cancer pain and such. And so, I don't talk about pain lightly at all, but I think there is a place for each medication and the benefit from the judicial use of the same.

I also want to add my thoughts to express that I think we need to have more physicians signed up because of the waiting times, for example, to make specialist appointment for a pulmonologist or cardiologist, et cetera, often having to wait too long. It is not they

don't want to see them, it's just they don't have time to see them. So the veterans are having to go see somebody else out of the VA system. If I have ten people how with near similar symptoms how best to deal with them. How can I say your angina is worse than somebody else's and so on. I am sure they will be left in the same dilemma in having to come up with who can go first and next, until they are all acutely ill. This we should preserve to avoid.

And before we get to that state of acute illness if we can do something to try to help them it will obviate many untoward waits/developments. One of the ways is to try to bring in medical students into the system. Since I have been in the CBOC clinic, I have had two or three medical students/residents to come spend time with clinic. Because teaching students, to spend time with them, perhaps more of them would decide to come back to work with the VA.

Mr. MORAN. Doctor, let me interrupt just a moment, let's come back and ask questions. I want to make time for Miss Zimmerman. I know how passionate you are and I appreciate it very much.

Dr. RAJU. Thank you.

[The prepared statement of Dr. Raju appears on p. 55.]

Mr. MORAN. Miss Zimmerman.

STATEMENT OF LEANN ZIMMERMAN

Ms. ZIMMERMAN. Mr. Chairman, members of the subcommittee, Representative Tiahrt, distinguished veterans and guests, thank you for this opportunity to appear before you today to discuss the progress, challenges and future of health care provided to veterans in Kansas by the VA Community Based Outpatient Clinic in Hays, KS.

I have had the privilege as a nurse practitioner to help implement the VA-staffed Community Based Outpatient Clinic in Hays beginning in October of 1999. In the past 2 years I have had the opportunity to provide primary care to more than 2,800 veterans. Thus, I view questions of access and quality of care through the lens of a provider facing these issues on a daily basis in the rural setting. There is no doubt that the CBOC is making a great difference for a numerous members that are veterans.

Though our CBOC is located in Hays, about a 3-hour drive from here, the new nurse practitioner we just recently hired decreased our wait time. In the past it was 6 months to get a new veteran in, now it is 3 months. So a new resource person helped out considerably.

Also, as of today we will have a new LPN and this will also help. We have only one clerk and this clerk has numerous tasks since the addition of the new staff. This has increased also her workload and thus her inability to do the eligibility enrollment forms. The enrollment process includes scheduling appointments for patients. This has to be done at Wichita at this time and this creates another wait time.

One of the problems we had at the Hays location in the past has been the parking and the small clinic. At the end of October we'll have a new space and new hospital building and it will be a much bigger clinic and better parking and I think this will be a great improvement. We'll also start with new telepsychiatry. That will be upcoming and we have this already.

Many veterans drive great distance just to get to the CBOC. Some drive as far as Colorado and Concordia. Often these veterans continue to be seen by their local physicians. Why would they do that? In the middle of the night they have an emergency, they go to the emergency room that's closest to them.

The problem that has been encountered is if the patient is seen in Hays and they need a prescription, they need it immediately. They have to use a VA-contracted pharmacy. And this helps provide medications through that way, for example, EMY. For instance, a veteran that's from Concordia, KS, has to wait 7 days to get it mailed. Contracting more pharmacies closer to the veteran's home would be a major benefit.

The provision of specialty services, already addressed, such as neurology and orthopedic surgery, all those waiting times seems to be an ongoing problem, and getting the veterans in sooner and get a resource problem in, getting the providers in there.

The preventative services practiced at the Hays CBOC are the same services that are provided here. We have the computer systems and the same documentation. Thus, if I see a patient he could come down for a specialty clinic and there is a continuity of care from one provider to a specialty. The problem is the traveling to that veteran and we need to make that easier for them.

In conclusion, I think the Hays CBOC has been a successful venture. I hear daily the expressions of veterans saying thank you so much for getting the medication for me and getting me in, and the things of utmost importance for these veterans. Probably one of the biggest challenges that we face is the resources, the things that we need to do to improve their services. Thank you.

[The prepared statement of Ms. Zimmerman appears on p. 57.]

Mr. MORAN. Thank you very much. Dr. Almenoff.

STATEMENT OF PETER ALMENOFF, M.D.

Dr. ALMENOFF. Mr. Chairman, members of the subcommittee, Representative Tiahrt, distinguished guests, thank you for this opportunity to discuss the progress we have made and challenges that we face in our ability to deliver high quality health care to the veterans we serve in the State of Kansas.

The VA Heartland Network's mission is simple: Maximum Veteran Benefits. We need to deliver comprehensive, high quality health care with the appropriate access. We provide high quality clinical services utilizing a hybrid delivery model.

When clinical services are not available within our network a make/buy decision is made. Our current model includes services based on-site, services based off-site through local contracts and network-wide contracts for health care delivery.

The VA Heartland Network is responsible for the health care of 38,773 veterans over 92 counties in the State of Kansas. Based on the 1998 Kansas medically underserved areas report, 44 percent of the counties in Kansas are critically underserved and 55 percent are underserved for primary care.

Care is delivered through a network of medical centers, community-based outpatient clinics and mobile outreach clinics located throughout Kansas and Western Missouri.

The Veterans Affairs Medical Centers providing primary and secondary domiciliary and long-term care are located in the cities of Wichita, Topeka and Leavenworth. Topeka also provides tertiary mental health care. The Kansas City Medical Center is a tertiary care facility that services the states of Kansas and Missouri.

In addition, all of these medical centers are associated with the University of Kansas School of Medicine and have active resident training and allied health professional training programs.

There are six community outpatient clinics and ten mobile outreach clinics all linked to one of the medical centers providing primary care services. In addition, many of the clinics have telemedicine capability that may provide some specialized services personally.

The Heartland Network has enjoyed considerable success in removing barriers to primary care in rural areas. With the addition of the community-based outpatient clinics and mobile outreach clinics, we have gone from an average distance veterans must travel for primary care in our network from more than 70 miles in 1996 to 15.9 miles in 2001.

In addition, we have increased the number of veterans served in the State of Kansas by 48 percent over the last 5 years.

In the area of preventative health care and evidence-based clinical practice guidelines, we have consistently outperformed the private sector. It is noteworthy that we require the same standard for these preventative measures at our CBOCs as we do at the parent facilities.

The addition of our Telephone Care Program in 1997 has significantly increased access to care for veterans in Kansas. The program is available during the WHEN hours (weekend, holidays, evenings, nights). Veterans reach the after-hours nurses usually by calling their VA or primary care team and then these calls are forwarded to Topeka via telephone technology.

The benefits for these veterans are that their needs are immediately assessed, advice is based on approved protocols and reference books, and care is individualized by accessing the caller's electronic medical record.

In many instances, when cost effective, we have been successful in partnering our CBOCs with local health care services to provide convenient services for veterans. Some examples include providing local ophthalmological services with our Parsons, KS CBOC or using the Heartland Network cardiac services contract that allows medical centers, or CBOCs, to access cardiac care in Wichita, Topeka and Kansas City.

We have successfully begun utilizing tele-medicine applications throughout Kansas to provide scarce clinical services. The telemedicine program has been used between medical centers or from medical centers to community-based outpatient clinics. We have several tele-medicine clinics available within the VA Heartland Network including dermatology, mental health, radiology, vascular surgery, geriatrics, orthopedic surgery, hematology/oncology and pain clinic.

In the Heartland Network, database integration (to be fully implemented the first of next month), will provide a seamless electronic medical record available at all sites across Kansas. The ulti-

mate goal of our project is to provide better health care to veterans in the Heartland Network. It will provide caregivers real-time electronic access to the patient's clinical and administrative information, improve the interfacility consult process, improve overall data consistency, increase coordination of care for veterans and allow interfacility scheduling for patient appointments and procedures. In addition, it will improve patient safety and help reduce duplication of services and resources.

The VA Heartland Network has done very well with our accreditations. All of our medical services in Kansas are accredited with an average JCAHO score of 96.5 percent. In addition, we were highly successful in our NCQA survey, being the only network in the Veterans Health Administration to achieve a 3-year accreditation with commendation.

Our compensation and pension examinations are completed on average within 26 days, well below the national standard.

The main challenges experienced in rural health care are related to recruitment and retention of professional staff. The issues involved here are multifactorial and include:

Inability to provide a salary that is competitive. This is especially true of specialty care physicians, but may also be true with primary care physicians, and nurse practitioners, particularly in the smaller towns with CBOCs.

We have found many providers are simply unwilling to live in a rural community with diminished cultural and entertainment opportunities without commensurate compensation.

When unable to recruit locally, parent medical centers must supply providers to these medical sites. In doing so, a great deal of patient care time is lost in traveling. In addition, provider morale is often diminished.

When unable to recruit U.S. citizens as providers, we frequently have highly qualified international medical graduate applicants who would be willing to serve in a rural area. Unfortunately, the visa process is remarkably cumbersome and can take a year or more to complete.

Obviously, this impairs our ability to respond to immediate staffing needs. Recent regulatory changes to speed the process have been only marginally effective.

We currently work with a very slow, outdated human resource process in the hiring of highly qualified health care providers. The health care job market is extremely competitive. By the time we are able to make a job offer, the candidate often has already been hired and is working elsewhere for months.

In conclusion, I would like to thank the subcommittee for providing me with the opportunity to discuss veterans' health care in the State of Kansas. We have worked very hard over the last 5 years to improve the quality of care, services and access. We still have work ahead of us, but I am confident our dedicated staff is up to the challenge.

[The prepared statement of Dr. Almenoff appears on p. 59.]

Mr. MORAN. Thank you very much. Panel, thank you. I am very much aware of the dedication all of you bring to your profession and job in your care and concern with the veterans as a doctor.

Doctor, I visited with you in your CBOC in Liberal; and, Mr. Hill, I am acutely aware of how much effort you all put in to make certain veterans of this area receive adequate health care. And we are grateful you care so much about that.

I will have plenty of opportunity to visit with you, more so than Mr. Filner will, so I will give Mr. Filner the first opportunity to ask questions. So, Bob.

Mr. FILNER. Thank you, Mr. Chairman, thank you again for your information today. In the earlier panel I referred to issues, I called them management versus resources, and I think Mr. Tiahrt used systematic as to what I called management.

And, Mr. Hill and Dr. Almenoff, from your perspective, from some of the stories we have heard earlier, I know some of those are resources and those are our problems. But I think I heard some systematic or management issues which I think you ought to be able to deal with. And I am wondering if you could respond.

Mr. Hill, payment for a primary care provider, as we heard from the earlier panel, there were some problems with that. Miss Zimmerman talked about the enrollment process which was centralized in Wichita as an impediment. Don't you have the ability to deal with that or decentralize that and solve the problems she referred to?

And, Dr. Almenoff, could you talk about your challenges, many of those are our problems. But somewhere the resource process, this is your situation, I don't know which ones are systemic and which ones are resource ones. And I would like you to respond as management as to what you can do about it. And I don't mean without us having to provide you with additional resources.

Mr. HILL. I don't think there is any doubt that we keep working to make the process better, and with the information like this, that we would be able to do that. We are always looking for ways to become more efficient.

And things have been brought up, for example, with the clerk problem, probably we haven't allowed the clerk there to be hired because we haven't had the money to hire an extra clerk right now. It's more efficient to have that done here in the unit that is charged with the responsibility.

The other things brought up by previous panel, payment for primary care provider, certainly that's our expectation. When it breaks down we worry about what happened.

Also, the development of a common database will help us with some of those issues. I currently have the rapid free-flow of information between the CBOCs and VAMROC, Wichita, and to have the same capability across the network would just be one more tool in identifying problems and making corrections.

Dr. ALMENOFF. With regard to the human resources problem, the human resource program is willing to make it better for employees and there has not been that in the system. In the past it was very desirable to go to the federal reserves in World War II, plus it created a lot of the process of these. Unfortunately, with health care changing and shortages of providers, that system is not changing with the changing environment, thus, we are still working with an eextremely old one and we don't have control.

Mr. FILNER. You can't change it?

Dr. ALMENOFF. We need to hire them.

Mr. FILNER. Again, I appreciate your testimony. I notice that the hearing process means that you talk in very general and bureaucratic kinds of terms. I have said this to you in Washington, folks, when they testified before us, and Mr. Moran has heard me say this, it makes me angry when I hear problems that our veterans are facing, whether it's someone lost their home, or people on the streets. We have not dealt with these problems. These are human issues, these are people who have served us, we need to be angry.

And I would like to see some anger and emotion and expression of concern from the administrative side. I know you all care about it or you wouldn't be in this field if you didn't. But when we hear some of the bureaucratic language, it sort of takes away from the human emotions.

This guy lost his house. I mean, that makes me horrendously angry. We ought to try everything to remedy that situation so nothing happens that that could happen again. This man's family, and we all care, we all know what a home means to the American citizen; or the fact that, you know, people have died on the waiting times situation, and we ought to be angry, and you ought to be angry and tell us what we need to do to help and respond to some of these concerns in a very, I don't know, I say emotional human way, to let them know that we care and we are going to do everything we can to change the situation for our veterans.

These are the folks that made us to have these hearings in a free society and we ought to provide them with every, every, every, benefit that we guaranteed, and make sure that it's done free of some of this bureaucratic services.

And again, I am venting my own self. I know you all care or you wouldn't be in the jobs you have, but sometimes I think we need to respond in a more emotional way in these situations.

Mr. HILL. I assure you I am very passionate about this. When I hear these issues come up, it does upset me. But I turn my anger and frustration to action and change it into something more positive and work to make things better. And in answer to, as to what you can do, I really think while there are deficiencies that need to be improved by us, I also think the system needs to have adequate resources.

Mr. MORAN. Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman. Mr. Hill, you have a tough job. The head of the American Airlines has a tough job today and yours is as tough as his is. And he may have more control involved in his company, more than the elements that you have over the veterans that you are overseeing here.

But I am wondering what structure is in place to find the problems and help improve them. If you look at some of these companies around the area here that I have had the honor of visiting, they have some—what do they call them, product team or quality teams—and they consist of people who are on the front line of the job, supervisors, engineers, sometimes in this case maybe physicians and nurses and claims workers, but they sit down with sometimes what they call their customers, people they provide services to and say, okay, how do we do this job better.

Miss Zimmerman has some good ideas about how to improve the system. I see several people, representatives of various organizations, I know they hear about it because they tell me. And just like this problem with the updated personnel process, some of those things I know need to be fixed outside of this area.

But is there a structure in place within the VA here in Wichita that sort of finds a problem and puts it on a board somewhere, tries to come up with solutions and work towards those solutions and have somebody in charge to see how it can be done?

Do you have any structure? I know you are trying to improve. Ninety percent, from good to excellent, is a pretty good customer satisfaction rate. But is there a structure in place where you have a continuing process, not just work in 6 months, but a continuing process?

Mr. HILL. Yes, and I think a very good one. Some of the issues today, some specific ones may not have been brought to my attention, but generally they are things I have heard of before.

Let me say this: The network has hearings two times every year, the network COO and travel east facility, they meet with all the contingents in that area and ask for directives at that time. And we also tell her what is going on.

We meet with her every month and tell her what is going on, director and chief of staff. I have a group called the Veterans Advisory board that meets monthly. And I have asked them to review the surveys that we do weekly with our veterans, both inpatient and outpatient, to review both their comments and the surveys we asked them to fill out, and give us a feedback, tell us how we are doing and give us a feedback. Tell us what we can work on now.

That is in addition to what we have done earlier. This is an ongoing process we have set up because we need direct feedback. We use them not only to identify problems, but to help us design improvements.

We also meet monthly with all the service officers in this area, we ask them to bring us their issues. Given the resources we have, priorities are determined. We have to decide which things are most important and those are the ones we concentrate on.

The rest of them are not forgotten, put on a list, and worked on as resources permit. Those of greatest concern are tracked and watched for opportunities to make improvements.

I also to make it possible for veterans to see me personally. I answer my own phone calls, and E-mail from employees, service officers, and volunteers. They have been told many times they are welcome to see me any time. And most of them, I think, are comfortable doing that.

We also have town hall meetings. For instance, opening the CBOCs, we travel every summer to rural Kansas and ask the veterans, how are we doing? And that has been widely attended. And we get good information from that and we try to process that.

Mr. TIAHRT. Thank you. I appreciate the work that you try to do.

Dr. ALMENOFF. May I add?

Mr. TIAHRT. Yes.

Dr. ALMENOFF. We also have a communicative level, the political leaders, the medical center meets twice a month by video to discuss all the clinical issues, to discuss the issues of moving patients be-

tween sites, to discuss increased waiting times, to discuss the driving times of 300 miles and to discuss all the problems of x rays being lost. And we do constantly discuss those areas and try to improve and care for everybody.

In addition, we have a clinical board which has a primary care provider, health provider, chief of staff, and they coordinate and discuss some of the logical issues that are involved.

And the last thing, we also have clinical symposiums. And what we do is based on a lot of feedback we get from our meetings. We go back to the, I guess it's nonmedical centers. Over a 2-week period we travel about 1500 miles and meet the veterans groups, we meet the employees, and we meet the medical staff and we have discussions.

And from that we develop clinical symposiums, ones that would be clinical staff where each center comes in, 50 of them, to work on areas that need significant improvement.

Two years ago we had a strategic planning meeting and a database was developed which should help now, I think, and will be on the line next month. But all nine medical centers, all 35 CBOCs, all outreach clinics, will be on one mainframe system. If I have an x ray in Wichita, KS, and go to Kansas City, it will be available.

So it's one medical record for all the patients, for all of our networks and all going in the CBOC. If they have a question regarding that patient for a surgery in Wichita, they could look in the medical record at the CBOC and see what is going on in the case. So that's very positive.

In addition, we have a cardiovascular meeting, and cardiology was a problem. And we worked on trying to develop our services and next month will look at primary care, look at how to make it a more efficient staffed clinic. People get together and try to figure out how to make these better.

Mr. TIAHRT. Those are good projects to be working on and I am sure the people using the services would be very pleased. Let me thank you for your help. You could be doing a lot of things, but you chose to serve our veterans, and I just want to say thank you.

Thank you, Mr. Chairman.

Mr. MORAN. I am very grateful for your testimony. Thank you for joining us today and you are dismissed.

I would like to take this opportunity now to hear from veterans who wish to address the subcommittee. If you could do us the favor by trying to summarize your comments in just a couple of minutes. We have about 15 minutes. We have a plane that we have to catch to be back in Washington in order to vote this evening. And if you could come to the microphone and identify yourself.

STATEMENT OF JIM BUNKER

Mr. BUNKER. Thanks for listening to some of these veterans about some of the problems. One of the things you heard a lot about was funding. And funding is a problem, grant and budget goes up and you give us 4 percent every year for the VA system.

But take a look at medical inflation. It's a double-digit inflation. Every 4 percent we are getting we are falling short. Every—I am just a Desert Storm veteran, I am not much of a number cruncher.

I do press for a lot of legislation, hammering on your door and Mr. Tiahrt, for more functions with the State of Kansas.

I have listened to some of the veterans in the State of Kansas and, especially for vets who were supposed to come for these exams, only about 29 percent ever did that. Most can't afford, A, the distance they have to drive or for getting time off of work.

A friend of mine who worked in 8100 Fort Riley, any time he gets off to come to the VA, which, when he comes is harassed by his boss, which created a lot of hardship for him so he finally quit his job. And doing so, he also lost his wife. There could be a lot more done.

If he had access to doctors out in small areas, small towns, Champ VA and TRICARE does a lot of fee-based programs where we can go off and see a private doctor and the government reimburses the doctor. The VA can do a lot more of that in offsetting the need and there should be more of that coming.

Just like the legislation for that private-doctor prescription can go through a VA prescription and get that prescription filled, that's important. But just as frustrating, I got a prescription at another place and had to wait for it to get filled so I could see a nurse practitioner to check my prescription. That's disgusting. So that needs to be done.

Moreover, I think a sense of trust needs to be given to the veterans. It's disheartening when I read about the secretary of veterans' affairs say we don't need to do presumptive services. He also said this, when you were going RHR 612 and 2540, well, the undiagnosed illness, he sat before your committee and said we don't need this legislation, we will take care of the veterans.

And a month after that, came out and tried to say how they aren't going to do presumptive services sent. So trust is something veterans want to see. But moreover, more funding, building VAs, but for medical system has, especially this last winter, when you saw the cost of medicine go up extraordinarily. So, please, increase the funding for the VAs.

Mr. MORAN. Jim, thank you very much. Let me go to the back microphone.

STATEMENT OF KIM CRISSLER

Mr. CRISSLER. Thank you. Kim Crissler, disabled American veteran. And I knew what you are basically hearing is that you can't do more with less. And that's what Congress has asked us to do for many, many years. I find it morally disturbing that Congress would pass $15 billion to bail out airlines and subsidized some of the holdings, and you can't come up with $2 billion to take care of veterans in this country. Where is the priority?

Mr. Moran, your office—I contacted your office a couple of times and was concerned with staffing. I think the Public Health Service and the VA to allow those individuals, doctors, nurse practitioners, nurse PAs, used to work at these CBOCs like they do health services would be helpful to the VA.

There is a memorandum of understanding between the Public Health Services and the VA for allowing the pharmacy to share resources, we could do the same thing with them for your staffing at the CBOCs.

One concern I have, Congressman Moran, is about your bill 2792 on the voucher program. I think it's a great idea to allow veterans access to the local care that they need.

I wonder if that may be abused as a selling of those vouchers to individuals like the food stamp program has been in the past. Obviously, there are concerns of fraud and abuse in all kinds of programs, and that concerns me that individuals may take advantage of those and sell those vouchers to the highest bidder on the street for care in the VA facility. I would like to see that that not happen if at all possible.

Right now, long-term care here in the VA, we have a nursing care here, we have a facility in Leavenworth, but in the year 2003, 2008 long-term care will be outrageous. I know the veterans, that you mandated that the VA take care of these individuals that are 76 percent more service connected, but we have no funds to do that. It's long past, obviously, that those retirees who have served their country faithfully for 20 years and end up with a disability be paying for their longevity and medical care.

And I do appreciate Congressman Moran being here. If you want to see a little passion and anger, you definitely came to the right place, we can do that for you.

My concern, too, is trying to find ways of cutting back. If we cut care to the categories 76 or even up to fives, you have eliminated almost a third of the revenue that's coming into the VA system, especially locally. They do a fantastic job in recovery cost here in this facility. And if we don't have those individuals coming in, we won't have the dollars we need to take care of the individuals in the coming year.

Thank you very much.

Mr. MORAN. Thank you very much. The gentleman in the front.

STATEMENT OF CHARLIE STEPHENS

Mr. STEPHENS. Congressman Moran and panel, Charlie Stephens from Salina. A two-part question regarding health care for your North Central Kansas veterans. Can you tell me if a location has been selected for the CBOC for the Salina contract, has it been decided for a certain facility for it yet?

Mr. MORAN. The question was about the CBOC in Salina. My understanding, no contract has been negotiated yet. We are trying to find out what the latest information is, but we don't know.

Mr. STEPHENS. Are we still programed for a possible opening date in November?

Mr. MORAN. I am told by the end of the year, first of the year. The date we had been given before was fall, and we don't know what that is. I am not sure what the distinction is, if it started yesterday or today. And I think we have 90 days before it's gone. We'll try to do our best to focus on this to get Salina a CBOC.

Mr. STEPHENS. Thank you very much.

Mr. MORAN. The gentleman in the back microphone.

STATEMENT OF MASTER SERGEANT GIFFORD McCARGAR

Mr. MCCARGAR. I am Master Sergeant McCargar from Salina, KS. I have a few things that I would like to read to you that I got

over the net from the military retired brass group nationwide. These are my thoughts:

A message from MSGT ret Floyd Sears MRGRG Mississippi and Tom Dooley's, These Are My Thoughts. "The military is currently in the limelight. This always happens during a crisis. When this current crisis ends nothing will have changed in reference to promises that are made.

"When it's all over people will forget the promises made. If we do not continue to apply the pressure, today's heroes (the military) will be tomorrow's bums.".

And Tom Dooley's answer:

"Floyd, your reasoning is precisely why we need HR 179/S 278 passed this year. More military retired will retire during the next 3 to 5 years and find out that the MTFs can't handle them and they can't find providers under TRICARE standard. They will also find thousands of MR 65 plus who can't find providers who take New Medicare Fee For Service (FFS) patients. What a reward for risking one's life!

"Regards, Tom Dooley.".

These are my thoughts:

I pray that our President, our Congress and our Department of Veterans Affairs does not forget about our veterans of this war, and takes care of these veterans' problems, be it by injury, war, illness or compensation as they have not done with veterans of our other wars.

We have these as our want list!

Here are the MRGRG want list:

H.R. 81—To amend the Internal Revenue Code of 1986 to allow a refundable credit to military retirees for premiums paid for coverage under Medicare part B.

H.R. 179—To restore health care coverage to retired members of the uniformed services.

H.R. 303—To amend title 10, United States Code, to permit retired members of the Armed Forces who have a service-connected disability to receive both military retired pay by reason of the years of military service and disability compensation from the Department of Veterans Affairs for their disability.

H.R. 548—To amend title 10, United States Code, to increase the minimum Survivor Benefit Plan basic annuity for surviving spouses age 62 and older, and for other purposes.

H.R. 612—To amend title 38, United States Code, to clarify the standards for compensation for Persian Gulf veterans suffering from certain undiagnosed illnesses, and for other purposes.

H.R. 699—To amend title 10, United States Code, to change the effective date for paid-up coverage under the military Survivor Benefit Plan from October 1, 2002 to October 1, 2008.

H.R. 1983—To amend title 10, United States Code, to revise the rules relating to the court-ordered apportionment of the retired pay of members of the Armed Forces to former spouses, and for other purposes.

H.R. 2073—To amend title XVIII of the Social Security Act to waive the part B late enrollment penalty for military retirees who enroll by December 31, 2002, and to provide a special part B enrollment period for such retirees.

H.R. 2125—To amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

H.R. 1232—To amend title 10, United States Code, to repeal the two-tier annuity computation system applicable to annuities for surviving spouses under the Survivor Benefit Plan for retired members of the Armed Forces so that there is no reduction in such an annuity when the beneficiary becomes 62 years of age.

When I signed up for SBP the rate then was at 55 percent. Now it is 35 percent or lower and tied to Social Security offset.

There are other desires. One is change of the Feres doctrine.

I have other things that I have a problem with. One of them is I am a member of the class A lawsuit for Florida and the president and attorney general. The appellate court decision that received was overturned.

Mr. MORAN. Thank you, Mr. McCargar. Let me limit to the remarks that are now standing or we'll run out of time.

Mr. THIMESCH. Thank you. We heard a lot of passion on the issues of health care back in 1997 when the state asked questions, do we have a problem with our Gulf War image. We do have a problem.

It shows a significant problem both with Gulf War illnesses. In the state of Kansas 34 percent are ill. We have accomplished much more than the federal government has been able to do. That's because we designed our project with private research directed towards that.

I am asking for more of a partnership with private research, Congress and VA, the veterans, all people interested in this, to try to develop better protocols. Protocols that, especially with Gulf War illness.

For the first 5 years of that after the Gulf War, that was treated with psychiatric drugs and that type of medication. That was improper. We know that because many of our veterans were ill with many other debilitating types of symptoms and problems and chronic things.

And now you ask how are we going to resolve this problem, yet bring the confidence back to the veterans that came to the VAs and were told for the first 5 years, and that was protocols from Washington DC, not VA in Wichita, saying you will treat these people with psychiatric drugs. That was wrong. We have to work towards changing protocols. Thank you.

Mr. MORAN. The gentleman at the back mike.

STATEMENT OF CHARLES HENLEY

Mr. HENLEY. Charles Henley of Winfield, KS. To me this meeting of a subcommittee hearing is a dream come true. I was injured 10 years ago and to have a congressional subcommittee, members of the VA, and group of veterans in one room together, to be able to express my opinion is quite remarkable.

I had a surgery done at the VA center in Milwaukee in 1994. And I before I start, I want to apologize if I sound too self-centered and I am not expressing—just expressing my views, but I think my views will express some of the opinions that some of the veterans

share here, and have waited 18 years to talk to this group of people.

And what I would like to say is that I find myself in a situation similar to—similar to Scott up here. When I had my surgery done in 1994 I experienced some temporary relief. I was able to go back to duty for a short period of time. But as things progressed, I found myself not being able to continue with my duties. I was dismissed from service because of that.

I continued in the private sector the best I could with what I had. And now I find myself not being able to practice in my profession any longer. I find myself unemployed for the last year.

I have had my surgery be done by a civilian doctor and I am recovering. It will probably be another year or so before I finish my recovery. But, in the meantime, my family and I survived on about $1,200 every 2 weeks that my wife makes on her job. But the State of Kansas has found me unemployable.

I receive a small weekly check from the State of Kansas. But when I do recover I will not be able to engage in my profession again. And to have a lifetime of education and training wiped out and to have come to the VA for a year ago and ask that my rating disability, my disability rating be changed or at least looked at to see if it could be changed to see if I could be entitled to some kind of benefit, and as of yet not received any word upon the change of disability, it is very discouraging and disheartening.

And, as I expressed to the congressman earlier, the letter that I received from him is the only good news I have received about my situation in the last 10 years. And that is the only thing that I have to show for is the piece of paper, and that was that. And I am very grateful for that.

I know that there are so many issues that need to be addressed, so many concerns that need to be heard that we—there is no way we can go through all of them now, all of us. But the one thing we can do is if we all do show a sense of community, a sense of togetherness, we can take care of business here.

We always have and we always will, but we need to show we can do this for each other. Thank you.

Mr. MORAN. Gentleman on the back microphone.

STATEMENT OF DAVID COX

Mr. COX. Good morning. My name is David Cox. I work for the government employees union, also United States Marine Corps veteran. I want to speak about a couple of things and throw some numbers out to you guys since you are going to be passing on these things.

I have been around the VA for way over 20 years and I have been involved in a positive way with the VA solving problems so on and so forth. Seven to 8 years ago, NDAV side, we had $2,500 employees. Right now we may be up to 60.

At the VA side, 5 or 8 years ago we had almost 900 employees, now we are down to 355. We are seeing more veterans, the complexities of the veterans we are seeing because of age is different. We have to take more time with them.

I heard someone mention just a couple of minutes ago we should have teams looking at the problems in the system, but we have em-

ployees that can't take a break. We have employees wanting to take a vacation. We have to go outside and hire agency help.

If you want to really look at things you need to look at the numbers of, what we are having to deal with. We have to do more on both sides of the House and we have less people. We went from 220 some people to a 55 on the DAV side. I don't know how people survive, but it's impossible to do what you guys are asking us to do. I hope you look at it.

The employee should be able to take vacation. That is not happening. We have to work around different things to get employees to take vacation. These veterans do not deserve this. When I want the time for me to use, I don't want it to be like this. You guys in Congress too often lock everybody together.

I know we have a downside on the government. I know there is a big push, but somebody up there needs to sit back and think. The VA cannot be dumped into this pot with everybody else because of the veterans. I am hoping you take us out of that downsizing part and start giving us people so we can do the work.

To lose that many people and have more work to do, I don't know how you expect us do to do that. 255 downsized to 55 benefits side and they are getting older, the claims, there are a lot more claims.

Mr. Hill said we are seeing twice as many veterans as we saw last year. Nine hundred employees to 355. Unless you address those problems, I don't know how we can do anything. Thank you.

Mr. MORAN. Thank you.

Mr. COX. I have one other thing. Our doctors, they do a great job. But right now somebody from Congress somewhere has got doctors doing computer work. Our doctors have to be computer experts as opposed to seeing veterans and I don't think that is fair.

I think you can hire a GS 4–5 clerk to input the information into the system for the doctors, and let them spend time with the older veterans because they need more time because they are getting older and it takes time to explain things. I don't know how that happened, but I hope you address that particular part of our doctors.

Mr. MORAN. Thank you. Mr. Simpson.

STATEMENT OF ROBERT SIMPSON

Mr. SIMPSON. Thank you. Robert Simpson, Master Sergeant Retired, Plainfield, KS. I want to discuss a point. I am a 100-percent disabled veteran. I received a heart transplant 8½ years ago in the Salt Lake City Hospital. I got a heart bypass 9 months ago at the Salt Lake City Hospital.

I have undergone 110 surgeries of the heart in the last 15 years. I am asked too many times how come you are still around? And I say, I am too mean to kill. I had $140,000 taken away from me. Why? Because I am a vet and 100-percent-disabled veteran.

Senator Bob Dole, a Kansas disabled vet and retired from Kansas draws both VA disability and senator's pension. How come? Isn't a senator a government job, wasn't it so in the United States Army?

My brother was 3 years in the United States Air Force, critically injured in a car accident in Hoisington, KS, went to work for the United States Army Civil Service, was 100 percent disabled and 19

years later, went from to VA from the civil service. But since he has air force time and his civil service time counted towards retirement, they retired him in the civil service and gave him 100 percent disability.

Why do I complain? He did 22 years of government service. I did 21 years of government service. He draws $3500 a month more than I do. What's the difference? I served my nation 21 years, 4 years in Vietnam. Why are we the only ones that have to put up with this? Why doesn't the Congress act? I have waited 13 years since I retired and I am still waiting. Thank you, sir.

Mr. MORAN. Thank you, sir. Our final spokesman.

STATEMENT OF MOE GIVIDEN

Mr. GIVIDEN. Yes, sir. Moe Gividen, National Service Officer Regional Director for VA vets.

Congressman Moran, Mr. Filner, Mr. Tiahrt, I appreciate you being here to give us an opportunity to tell you what is going on throughout the VA system throughout the country, not only here, but I represent 13 other states that I attend to. I hear everywhere I go, and it always goes back to the chronic saying of there is not enough money in the budget.

Every year the system is cut. Last year they come back and said we need an extra 300,000. It was designated for something special, not for the care of the veterans, not for the benefit side, for something else. And you know the VA got smoking years back and put veterans first, veterans come first.

I think it's time that the Congress and Senate did the same and put the veterans first. The veterans, if it wasn't for veterans, would we be here today, would we have this freedom to hold this meeting? No. Please, take us back to your colleagues and put the veterans first, put the budget up to where the system can work.

Twenty years ago, when I came in all you had to be was a veteran to get treated, medication without paying a dime, just you signed on the dotted line. Thank you.

Mr. MORAN. Thank you very much. Mr. Filner, any concluding remarks?

Mr. FILNER. Thank you, Mr. Moran, for sponsoring this hearing. We have learned a lot. When we go back to Washington we will be recommitted to the fight.

I think Mr. Simpson gave us an example of the strength of the system, with the kinds of surgery you have had and that you are here, as mean as you are, but it is showing the challenges we have to face to make it work for everybody.

We put into this next year's budget on the health care side when all the VSOs recommended a $3 point million increase the budget 20 to 300, $400 million, someone said it doesn't keep up with inflation with the cutbacks, and there are going to be more unfortunately. The concurrent receipt is absolutely disgraceful.

People that serve the Nation have an offset between the disability which, unfortunately, they earned, and the pension that they earned. And, as you pointed out, other people don't have that offset. I think all offsets are wrong. The offsets for the survivor benefit program ought to be taken away.

Do you know what it costs to deal with this concurrent receipt, it's called—it's both the disability and the full pension, the cost, it costs roughly a billion a year. We can afford to do this. We just voted, someone said, for a $15 billion bailout. Just, for the record, I voted against that, but we just voted $15 billion and this costs a billion. We can do it, we can afford it.

And I mean, I sit down with veterans like you, Mr. Simpson, and showed what they got out of 30 years of service for our Nation, two or 300 bucks a month. You cry when this is the way we are treating our folks. And we can do this.

And I said earlier, you guys persist to contact all of your representatives that we do this. We can afford to do this. I have been working—Mr. Moran and I talked about this—and I hope we have some progress on the Persian Gulf War illness. It's 11 years roughly since we were there and we don't have a treatment or a cause and we are about to send young women and men back. That's disgraceful.

The defense department, and unfortunately the VA, refuses to recognize us as something. They said it's all in your head for years and as Mr. Bunker said, they started treating with psychiatric drugs. This is a physical illness that many authorities have come up with theories for and we should look at every one of those and we need to have a hearing on that,.

Mr. Chairman, because we are doing the service 7 or 800,000 more, we, as a Nation, owe this. Especially since we are sending our young men and women, including Kansans, back to the same area and we haven't figured it out.

I have some theories, it's partially the shots. We didn't test them and we didn't test them and if we give those same shots again we will get the same results.

I appreciate hearing from you all. We have a—we have one of the best medical care systems in the world with the VA, as Mr. Simpson has proved that, but we have one that can do a hell of a lot better. And you all can respond because we owe it to you.

Mr. MORAN. Thank you, Mr. Filner. Mr. Tiahrt.

Mr. TIAHRT. Well, first of all, let me thank Mr. Moran and Mr. Filner for being here and giving us this opportunity for veterans, and also for the people who work here at the Veteran's Administration.

We have a long ways to go, as we said earlier. We know there are problems in the system and there is more than I, other ones that I heard of from the past, some of the systematic problems we need to deal with. But I appreciate you coming and letting us know. It's a good place to start and hopefully we can improve the system. I know we can do better. Thank you.

Mr. MORAN. Thank you very much, Todd, for allowing us to be in your district and Wichita. And we appreciate the attendance of the people who testified, as well as the other veterans and those interested in their VA health care system.

We would make a couple of introductions. Pat Crosetti, COE of Division 15, came from Kansas City. Our committee staff is here, and let me introduce those folks.

John Bradley is the House Veterans' Affairs Health Subcommittee staff director. John, come out.

Susan Edgerton is the democratic health subcommittee staff director for the House Veterans' Affairs Committee.

And Kimberly Cowins is with the committee in front.

And on my staff is Kim Rullman over here on the side. These folks do a lot to help you. So, thank you very much as well.

The record, will remain open for additional questions and comments. Any of you who would like to submit any comments in writing please do so within the next 5 days, if we could have your comments in writing.

And the committee stands adjourned.

[Whereupon, at 11:42 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF MR. JAMES FRANKLIN

My name is James R. Franklin and I live in Liberal, KS. I would like to thank you for the opportunity to testify on veterans' health care in Kansas.

The Community Based Outpatient Clinics or CBOCs are wonderful for rural veterans and their eligible dependents when they work as planned. They bring VA services to the rural area without the need for the veteran to travel great distances. However there are some bugs that need to be worked out of the system.

The Liberal CBOC is run by the Southwest Medical Center on contract by the Amarillo VAMC. They see veterans from three different VISNs which all have a little different way they want the patients handled. Since Amarillo VAMC has not chosen the in-house ChampVA program my wife has to drive 220 mi. one way to Wichita VAMC to receive health care. Yvette has deteriated disks in the C-5 and C-6 area of her neck causing her spinal cord sheath to be cut. Also she suffers from arthritis which is causing her great discomfort to the point she is unable to take care of the animals she used to raise. On 10/12/99 she sought care from Dr Zhuang, a primary care doctor at Wichita VAMC, and received it. She continued to receive care there on 10 different trips up till 4/16/01 making a 440 mi. round trip each time.

When the CBOC at FT. Dodge, which is run by the Wichita VAMC, was opened she tried seeing the doctor there cutting the mileage down to only 160 mi. round trip. After seeing Dr. Catherine Arroyo one time, the doctor refused to fill her pain meds which she had been taking since the mid 70's. Dr. Zhuang at the Wichita VAMC continued my wife on her meds. The Dodge City CBOC did not pass on to her information about appointments and consults and she was in great pain. For over a year, she hasn't been able to work. So on 8/27/01, she requested to have Dr. Zhuang at the Wichita VAMC be made her primary care Doctor once again. This now means she faces the 440 mi. round trip each time but at least she is receiving the care she needs.

There seems to be a lack of planning when it comes to scheduling tests. Test results should be received in a timely manner in which the clinics can use them. There is a lot of money being spent on tests that are out of date by the time the patient is seen in a specialty clinic and appointments wasted in these clinics that could be used by someone else who has all their needed info. The primary care doctor should be the one that sees that everything is done in a timely manner but this isn't happening.

The reason I am given for this is lack of adequate staffing to meet the case load that the category 7 veterans are creating. The Iowa City, Iowa VAMC and its CBOC locations are turning away 500 to 600 veterans a week. This puts 3,600 men and women on a waiting list where they can expect to be left up to a year. I ask you not to let this happen in the State of Kansas. There is only one Vet Center in the whole state. This is not serving the rural veteran with the same quality of treatment as received in the Wichita area. I have more detailed facts about all the information I have given in this testimony, and I am happy to answer any questions.

I thank you for your interest and the opportunity to testify on the health care for rural veterans in the state of Kansas.

Scott Ratzloff
Veterans Subcommittee on Health Field Hearing
Wichita, KS
September 24, 2001

In 1993, I was injured during a training exercise. This injury plagued me throughout the rest of my time in the Army. In 1995, I received surgery while still on active duty. This surgery was to my right knee. I completed my rehabilitation and was released from active duty with a ten percent rating from the Veterans Administration.

My transition into civilian life went fairly smooth as I began working for a company based in Northwest Kansas. I worked and was productive until January 2000. My right leg had always bothered me, but I started to notice something was terribly wrong. I decided it was time to get checked out by my local physician who in turn directed me to an Orthopedic Specialist in Hays. It was this Specialist that determined that my right knee was torn. Dr. Kass recommended that I have a surgery done to repair the damage. I contacted Mr. Jon Denton with the Kansas Commission on Veteran's Affairs so that I might find out how long a wait was for surgery. I was displeased to learn that it was a 6-9 month wait for the surgery.

At this time, I decided to use civilian medical services because my goal was to repair the damaged knee and get back to work. On 03/00 I received a surgery to my right knee. I began to rehabilitate and decided to contact the VFW to find out how to submit a claim to the VA. On 5/16/00, with the help of Mr. Denton, I began the first of my claims. I submitted all of my doctor's findings along with a letter from my doctor explaining diagnosis, treatment, and prognosis as Mr. Denton said that this would assist the VA in working my claim.

During this time, my right leg condition began to deteriorate. I began to notice range of motion problems in physical therapy with discoloration to my right leg. By 05/01, I was unable to perform well enough to return to work. I could not maintain my employment because of the time I had missed from work. I resigned my position on 05/10/00. I was not released by Dr. Kass to return to work.

You can imagine the terror my wife and I faced on wondering where the next dollar was going to come from. I began to call everyone I could think of to see what I could do about expediting my claim. I left no stone unturned, calling the Veterans Administration, Veterans of Foreign Wars, and The Kansas Commission on Veterans Affairs to see if I could qualify for a financial hardship. I had my bank, which had the mortgage on my home and my vehicle notes, write a letter to the VA. My bank knowing the situation only asked that VA provide them with some kind of time line that my claim would take.

I then filed for a financial hardship on 06/09/00. During the process of this first claim, I learned that I would need another surgery. It was also during this time that the

VA asked for an examination. On 07/00, I traveled to Grand Island, NE to be examined by the VA. I could not understand why I was being examined after I had submitted what I thought to be overwhelming medical evidence of an ongoing problem with my right knee and right leg. I submitted to an x-ray and a thorough examination by a nurse practitioner.

On July 27th 2000, I had a second knee surgery and again was expected to heal but Dr. Kass would not release me to work because I continued to have difficulties. I submitted additional information to the VA from my doctors that showed I was unemployable at that time. On 08/00, I received a payment from the VA by way of direct deposit. This satisfied my bank for the time being but left my family doing a financial leapfrog. It was then that my bank and I decided that it would be better if I put my home on the market so that I would not risk foreclosure. Again, all my bank requested was something in writing from the VA giving them a time line on my claim and this could have been avoided. VA provided no time line.

After I did not recover from surgery, Dr. Kass recommended that I see Dr. Keith Green to see if I had Reflex Sympathetic Dystrophy. I submitted to a spinal block in the operating room to determine if my pain was caused by RSD. Dr. Green did determine that I suffered from RSD and I sent the findings along with a Diagnosis/Prognosis letter through Mr. Denton to the VA. Dr. Green determined that spinal blocks were not working, so a decision to put in a dorsal column stimulator was made. This is a permanent device that is placed under the skin and is connected to my spine.

During this time, I also began to call the VA on almost a daily basis to check on my claim. I pleaded with the service representative to give me some indication of when my claim might be finalized. I explained each time that I was going to be foreclosed on if my bank did not get some kind of information. At one point, I was told that I could be directed to the VA Homeless program. I understand that the VA representatives are limited in what they can do. Like so many of us they have policy and procedures they must follow. I asked if calling a congressman would help and I was told that calling my representative would only slow down the claims process as my file is pulled to review so that the VA can respond appropriately to the inquiry. I again contacted Lisa with Congressman Moran's office to see what the hold up might be on my claim. I think that it is important to note that my condition was constantly changing. This created a paperwork nightmare, as I needed to send information to the VA.

In March 2001, our family home was sold. My hometown bank basically had no choice. They attempted to work with my wife and I as long as they could. In April of 2001, my family and I moved to Colby, KS. I once again started to hit the phone lines and e-mail people to see what the status of my claim was.

In April 2001, after numerous phone calls, I was asked to submit to another VA exam. This exam consisted of some flexibility determinations and some questions. The examining VA doctor admitted that she did not know a whole lot about Reflex Sympathetic Dystrophy. I explained to her how my implant worked and what it did for

my pain. I also was asked by the VA doctor to sign a release so that she could get the results of my nerve conduction study my private doctor had done to aid in her findings. I agreed to sign this release. I once again was waiting on all the paperwork to arrive at the right place so that the review board could look at my case and make a determination.

Finally, during the later part of May, I began calling to check on my claim. By June 2001, with the assistance of Congressman Moran's office, I received a determination for 60% disability with a temporary determination of 100% due to my unemployability status. In reviewing my disability determination, it stated that the VA had no rating guidelines for Reflex Sympathetic Dystrophy and that I was rated under a different disorder. I should also point out that RSD has been a recognized disease with references that date back to 1953. I cannot understand why the VA does not have any rating criteria for this disorder. I was assessed 100% disability temporarily for my foot drop, which leaves me without the use of my right foot. Because VA states this to be temporary, they will ask me to submit to a follow-up exam to further determine my employability status in about a year.

I can only hope that by then the VA would be armed with more effective policies and procedures that could create a realistic time line for claim handling and a realistic time line for surgeries and medical care. I cannot imagine what uncertainties I would have weathered if I had used the VA health care system. I often wonder if I would have been diagnosed properly due to the information I received in hindsight about the VA not recognizing RSD. I would just ask that you look at the problems that I have had with both the medical and claims handling departments of the VA. I feel that policy does dictate some of these difficulties and that it would be worth your time to review them. I can only hope that my testimony here today might help out the next Veteran who might be filing a claim or attempting to use the VA medical care system. This was a trying experience for my family and I would not want anyone else to go through it.

In closing, I would again like to thank Congressman Moran and the VA Subcommittee on Health for hearing my testimony and hope that it can make a difference.

Tamina S. Fromme
2006 Hart
Dodge City, Kansas 67801

US Army, Specialist 4
1973 -1975

Congressman Moran, distinguished visitors, and fellow veterans. I am both honored and humbled to be asked to participate in this field hearing. The quality and future of our health care is important to all of us as is validated by our gathering here today.

There is much that needs to be voiced about veterans health care. It is difficult to know where to begin. We all have different medical needs. Each individual has a statement to make about those needs that deserve to be heard. Unfortunately, those needs must be addressed by the four of us in a very limited time frame. I have spoken with and heard from many veterans over the last few weeks to try to ascertain a better understanding of how the process works. I am new to the problems that many of you face daily or have dealt with in the continuing battle for quality and convenient health care, especially in the rural areas.

I was initiated into this struggle by needing a pre employment physical and no health insurance to help pay for it, or income until my first pay check, which will be the 25th of September, or tomorrow. A family member, who is a veteran, recommended that I go to Fort Dodge and sign up for Veterans Benefits. I could get my physical at Fort Dodge and for half the price of local charges! I drove five miles and saw Scott Dorsey, the Veterans Service Representative. He was instrumental in helping me with the paper work that was required. I was subsequently put into "the system", appointment for the physical was made, and my services began. I know now that I was fortunate that my application for services went smoothly and efficiently.

Kathy Wiley, the Advanced Registered Nurse Practitioner, serves at Fort Dodge. She is a marvelous professional I was given the most thorough physical I have had in years. She has discussed my test results with me and has answered many questions. I have no complaints as to the health services and care I have thus far received. It is the future care that causes me worry and is really frightening.

As I stated before, since being asked to be here today, I have spoken with many other veterans and with Ms Wiley to see what my future health care will be like. I have learned what many of you already know first hand. I must travel to Wichita for everything except the basics that the outpatient clinic located in Fort Dodge, or the other small outpatient centers, can provide.

Being a woman, over 50, family history of cancer, and not immune to the perils of aging and ailments of human suffering, I am hit with reality. This means that I must take a day of sick leave, travel almost 3 hours for a 30 minute mammogram, then the same trip home. A repeat trip is required for any dental, vision, hearing, cardiology, patient education, dietary education, CAT scans, bone density tests, or MRI's if needed. If I should require mental health care, I could

possibly, have one 45 minute appointment a month locally. The Vet Center does come to Fort Dodge for 1 ½ days every two weeks. If group or major therapy is required, it would be yet more trips to Wichita for each session. For dialysis, it is back to Wichita for each treatment, or have my own private insurance to have services done locally. The cost of travel, possible and probable over night stays, and lost days of work would quickly overcome any savings by having these services completed in Wichita.

My research has revealed that many of the services I might need, and many of you already must have, are "Fee Based Out." This means that these services are not provided here, at this Veterans Facility, but are provided at some other facility here in Wichita, and then the Veterans Administration pays that provider for those services.

Many of our veterans have no family close enough to give a helping hand, for whatever reasons can't get to Wichita, or have no private insurance. Some wait upwards of 6 months on the processing of their "paper work." These men and women, who have faithfully served our country in both peace time and war, are going without desperately needed health care. Sometimes these become life and death situations - to eat or have the medications that are needed; to have heat or travel to Wichita to see the doctor - difficult choices many veterans make daily.

The fact that we live in rural areas compounds and complicates even the availability of the most routine and basic medical needs.

Remedies I suggest would be first, expedite all applications for Veterans medical benefits. Hire more clerical help if that is the reason for the back log of the processing procedure. Provide vouchers, contract for, or Fee Base Out to our existing local doctors, dentists, optometrists, cardiologists, mental health clinics, and medical clinics. This would not only ease the strain on the existing facilities here in Wichita, but allow our veterans the opportunity for quality as well as convenient health care that is closer to our homes, wherever they are.

We are thankful for the outpatient clinic that is located in Fort Dodge. Over 1,000 veterans were served there last year. These numbers are expected to increase as the news of this "local service" spreads. The need to have access to medical care is evidenced by these growing numbers.

Please, support what we do have, but continue to pursue and fight for the right to have medical care that covers all of our needs. We must have facilities or providers of health care more accessible to those of us who live in the rural areas as well as those veterans who live in the more populated areas.

My son, his wife, and one son-in-law are career Navy people. One of my grandsons took his first steps on the flight deck of the USS Kitty Hawk. A future Navy man I am sure. My children are active duty today. What will be available to them when they have chosen to retire and come home to rural Kansas?

Our futures, and the futures of those individuals now serving, depend on each of us working for a common goal. That goal is quality and convenient medical care for all veterans living in rural Kansas and rural America.

Thank you .

Statement of
Kent D. Hill, Director
VA Medical and Regional Office Center, Wichita, Kansas
Before the
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Congressman Jerry Moran, Chairman
Field Hearing
VA Medical and Regional Office Center, Wichita, Kansas
September 24, 2001

Mr. Chairman, members of the subcommittee, Representative Tiahrt, distinguished veterans, and guests:

Thank you for this opportunity to appear before you today to discuss the progress, challenges and future of health care provided to veterans in Kansas by the VA Medical and Regional Office Center in Wichita.

OVERVIEW

Since 1997, we have dramatically changed the delivery of care in our service area. In keeping with national goals and the direction of health care in general, we have promoted the development of outpatient versus inpatient care at our local facility. We have reduced inpatient days of care and reduced total cost to treat veterans. We have established four full-time community based outpatient clinics (Hays, Dodge City, Parsons, Liberal) with a fifth (Salina) to be opened this fall. Coordination of care for each patient is the responsibility of a primary care provider along with a team of other health care workers. Telephone care is now available 24 hours a day. We have promoted disease prevention. VISN 15's aggressive development of the electronic medical record and a common patient database are the foundation on which we are building a system for the immediate flow of medical information and images among facilities and community based clinics. As a result of these strategies, the Wichita VA has been able to provide care to more than 20,000 unique veterans this fiscal year. This is almost double the number served in 1997. Three years ago, veterans in the counties where CBOCs have been established traveled an average of 130 miles for primary ambulatory care. Now, veterans in those same counties travel an average of 11 miles for VA health care.[1]

STAFFING AND RESOURCE ISSUES

Before discussing patient satisfaction and our 2002 goals, I would like to comment on some of our challenges.

Adequate professional and support staff are key to continued success. The number of physicians, nurses, pharmacists, and other professionals is low in Kansas compared to other states[2] and our turnover and vacancy rates reflect this competitive market. Salaries

for some professions, like pharmacists and ultrasound technicians are difficult to match. The physician special pay and salaries makes recruiting for many specialists difficult. Another problem area in staff development involves foreign medical graduates. Even when excellent foreign medical graduates are available, the process regulating their employment is cumbersome, sometimes taking over a year to complete.

The rapid increase in number of veterans treated this year brought with it the demand for services and pharmaceuticals, the cost of which exceeded our expectations. VISN contingency funds ordinarily used to address such an unexpected shortfall were not available. Consequently, we have delayed hiring some support staff needed to improve timeliness. Continued efforts to improve access will draw additional veterans and will require an increase in resources coupled with even greater efficiencies.

REDUCE WAITING TIMES

We realize that simply reducing the cost to provide services is meaningless unless we also maintain acceptable levels of quality, access and satisfaction. Our number one goal for 2001 and 2002 is to reduce waiting times for specialty care, a source of considerable patient dissatisfaction. We are working to improve the referral process for diagnostic services and specialty care by recruiting our own specialty staff (if recruitable) and promoting competition for emergency hospital and outpatient services not available within the local VA. For example, we are currently recruiting for a cardiologist, oncologist, and pulmonologist. Additional optometry and GI staff have already been added. High turnover rate among primary care providers, coupled with the increased number of veterans accessing the system have caused unacceptable delays in obtaining appointments. Recently though, we have been able to hire additional Primary Care physicians and waiting time for new patient appointments have dropped from four months to thirty days.

BEHAVIORAL HEALTH SERVICES

Technological advances are making it possible to use relatively low cost equipment to conduct telepsychiatry between CBOC and facility. Patients willing to use the modality have been identified, and we will conduct the first session in Hays before the end of September.

CLAIMS PROCESSING

The Wichita facility is a Medical Center and Regional Office. The primary service area for health care includes the fifty-two counties in south, central and western Kansas. The Regional Office is responsible for processing claims for the entire State of Kansas. Claims processing time is not what it should be. We have however, hired six Rating Veterans Service Representatives and nine Veterans Service Representatives in the last year increasing by one-third our number of decision makers. Even though these individuals have not been fully trained, production has risen steadily, and we are currently producing twice the number of decisions that we did even last November.

STAFF DEVELOPMENT

As previously noted, developing our workforce is the key to maintaining improvements and continuing progress for Kansas veterans. The focus of our Human Resources function will be the building of a candidate pool from which to draw the numbers and type of employees we want serving our veterans. This means paying more attention to employee satisfiers, enhancing the education program, making better use of employee retention and recruitment incentives, and streamlining the hiring process. For example, Network 15 is pursuing OPM approval to establish a delegated examining unit that will reduce delays in hiring some hybrid Title 38 and Title 5 positions. A VISN-wide mentoring program is in place to identify and develop candidates for key positions.

PATIENT SATISFACTION

Patient satisfaction with outpatient services has steadily improved over the past three years. The 2000 data suggest that 90% rated services as good, very good or excellent. We are working to beef up patient education and coordination of care.[3] In response to this, weekly surveys of both inpatient/outpatient areas are conducted, and sorted by team and provider. This information is used for feedback to staff and managers. Local survey scores have dropped recently and the decline seems to be linked directly to the access issues.

CONCLUSION

In summary, Mr. Chairman, Wichita VAM&ROC has worked to improve services to veterans in Kansas. We are proud of our accomplishments but recognize the need to make improvements. Our dedicated staff are up to the challenge and optimistic about the future for Kansas veterans. Thank you for your continued support of our Nation's veterans. I, along with members of my staff, am available to address any questions you may have at this time.

[1] VHA Planning Systems Support Group (PSSG), Geographic Access Reports Page. Prior to opening the CBOCs, veterans residing in Ford County would travel an average distance of 107 miles to obtain VA medical care. Likewise, veterans in Ellis County would travel 121 miles; Seward County, where the Liberal CBOC is located, 160 miles and Labette County, 130 miles. Now after opening those CBOCs, veterans average travel distance for these counties is 11 miles.

Improve Access
(travel distance to care - one way)

	Prior to CBOC	After CBOC
Ford County Ft. Dodge	107	14
Ellis County Hays	121	18
Seward County Liberal	100	8
Labette County Parsons	130	13
Average	130	11

[2] HRSA State Health Workforce Profiler, Bureau of Health Professions National Center for Health Workforce Information and Analysis, U.S. Department of Health and Human Services, www.hrsa.gov/healthworkforce/profiles.

[3] National Performance Data Feedback Center Outpatient Satisfaction 2000 Wave 2.

Statement of
L. S. Raju, M.D.
Liberal Community Based Outpatient Clinic
Liberal, Kansas
Before the
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Congressman Jerry Moran, Chairman
Field Hearing
VA Medical and Regional Office Center, Wichita, Kansas
September 24, 2001

Mr. Chairman, members of the subcommittee, Representative Tiahrt, distinguished veterans, and guests:

Thank you for offering me this opportunity to appear before you to share some of my thoughts with regards to the Liberal, Kansas VA Community Based Outpatient Clinic (CBOC).

I have been a practicing physician for about thirty years now, initially in India and later in the United Kingdom, Canada and for the last several years in the U.S.A. I have been privileged to be associated with the VA CBOC (outreach) clinic at Liberal, Kansas for almost two years. This clinic has been steadily growing since I have been there.

With the wholehearted and well coordinated efforts of both the Amarillo and Wichita VA Medical Centers and that of the concerned veterans themselves, this clinic has been a great help in providing quality health care to the area veterans. Initially, when I accepted this physician position, I was not very sure as to how well I could take care of the needs of the veterans as patients. Since having been there, I have realized that the VA system does indeed offer the veterans a comprehensive continuum of health care including the much needed health promotion and preventative care.

I feel that there still is room for improvement in providing some of the care in a more convenient and timely manner. I have found that there are veterans traveling anywhere up to about 150 miles one way to come to the Liberal CBOC for their care and obtaining medications. It would very much help these veterans if some of the radiological procedures such as sonograms, IVPs (kidney x-rays), some of the blood tests other than the routine ones could be done locally or a little closer to the veteran's home than having to travel several tens of miles for the tests initially and having to return for follow-up on these tests.

The coordination of care and access to specialist services such as urology, orthopedics, etc. could be improved. The quality of care is good, however, the system could benefit from better case management and a system that promotes easy referrals for consultation. I wish to emphasize that the staff have always been very forthcoming and willing to help anytime.

Thank you for the opportunity of being here on behalf of the Liberal CBOC.

Department of Veteran's Affairs
Liberal Primary Care Clinic
2130 N. Kansas
Liberal, Kansas 67901
620-626-5574

Honorable Mr. Jerry Moran,
U.S.Congress,
Washington, DC

Sept 26th, 2001.

Dear Hon. Mr.Moran,

Thank you for the opportunity of presenting some thoughts at the recent Congressional Committee Hearings at Wichita on the 24th September regarding the VA Medical services.

Like myself many of my colleagues and friends in the audience at that meeting were very impressed about your dedicated desire and striving to help the veterans and their families, especially realizing that you are so very busy with a lot of other business with you being on so many different committees.

In continuation of the VA Medical services, if I may please be allowed to briefly summarize a few salient points as hereunder:

There is a need to broaden the scope of the CBOC set ups to include providing some more expanded investegational services at the primary care site such as ultrasound and IVPs Etc.
This would add to enhance the quality of care provide locally.

The provision of available medications ought to be expanded to make the system more uniform.

Periodic specialist clinics may be conducted at the CBOCs for the convenience of the veterans, as for eg. an orthopaedic clinic every 4 month, or so, a vision/hearing assessment clinic about twice a year, a mental health clinic every 4 monts or so, and so on.

The participation of Medical students and residents in the "Rotations" through the CBOCs may be a reasonable way of encouraging some of the young graduates to seek careers in the VA.

A more realistic compensation for attracting and retaining the medical professionals in the system to minimize the rapid "Turn over" of these needed individuals.

I hope these few thoughts are worth some consideration.

Ms.Kim Rullman has been specially helpful in coordinating a lot of the happenings before and during the hearings and would like to thank her very much for all the help she extended to me.
I would like to wish you and your dedicated staff the very best in your endeavors at the house.

Again I wish to thank you immensely for this opportunity,

Sincerely,

L.S.Raju, M.D.

Statement of
Leann Zimmerman, Nurse Practitioner
Hays Community Based Outpatient Clinic
Hays, Kansas
Before the
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Congressman Jerry Moran, Chairman
Field Hearing
VA Medical and Regional Office Center, Wichita, Kansas
September 24, 2001

Mr. Chairman, members of the subcommittee, Representative Tiahrt, distinguished veterans, and guests:

Thank you for this opportunity to appear before you today to discuss the progress, challenges and future of health care provided to veterans in Kansas by the VA Community Based Outpatient Clinic in Hays, Kansas.

OVERVIEW

I have had the privilege as a Nurse Practitioner to help implement the VA-staffed Community Based Outpatient Clinic in Hays beginning in October 1999. In the past two years, I have had the opportunity to provide primary care to more than 2,800 veterans. Thus, I view questions of access and quality of care through the lens of a provider facing these issues on a daily basis in the rural setting. There is no doubt that the CBOC provides a major service to those veterans living a great distance from a VA Medical Center.

WAITING TIMES

Though located more conveniently, the CBOC has experienced problems with providing timely initial appointments for veterans. The waiting time has been as high as six months. The recent hiring of an additional nurse practitioner has decreased the waiting time to 30 days. The anticipated addition of another LPN should enhance efficiency and lead to further reduction in waiting times. At present, a single clerk handles numerous clerical tasks. These tasks have increased with the addition of the new Nurse Practitioner. The enrollment process constitutes another barrier to timely initial appointments since this is accomplished on-site at the Wichita VAMC, rather than locally, and must be completed before the patient is seen.

Adequate clinical space has been another problem, but I am happy to report to you that our CBOC will be moving in October to a new location with additional clinical space and parking area with room for expansion when we implement new programs such as telepsychiatry.

MEDICATION

Many veterans drive a great distance to access the Hays CBOC. Many travel from Colorado as well as remote locations in western Kansas. Often these veterans continue to be seen by their local physician. This is certainly the case when contact with a local provider is desirable for emergencies or acute hospitalization. In these cases, the motivation for enrollment with us would seem to be for the prescription benefit rather than for primary care. These patients are naturally quite concerned about the level of co-pay required.

Medications needed immediately are provided through a local pharmacy in Hays via a VA contract. Routine medications are mailed from the VA. Additional contracted pharmacies would be useful for any acutely needed over-the-phone prescriptions in other outlying areas.

ACCESS

The provision of specialty services can be problematic in the CBOC setting. There are often significant waiting times for such specialties as neurology and orthopedic surgery. More frequently needed services such as audiology, optometry/ophthalmology and dental are also difficult to obtain in timely fashion.

Preventative services are practiced at the Hays CBOC and are equivalent to those practiced at the main VA Medical Center. The lack of cost to the veteran for these services is obviously a major factor in our exceptional compliance.

CONCLUSION

In summary, the Hays CBOC can be viewed as a successful venture. I hear expressions of gratitude from veterans on a daily basis. It is my hope that the CBOC concept will be supported sufficiently to maintain adequate staff and services to continually improve access and quality for our veterans.

Statement of
Peter Almenoff, M.D., VISN 15 Network Medical Director
VA Heartland Network (VISN 15)
Before the
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
Congressman Jerry Moran, Chairman
Field Hearing
VA Medical and Regional Office Center, Wichita, Kansas

September 24, 2001

Mr. Chairman, members of the subcommittee, Representative Tiahart, distinguished veterans, and guests.

Thank you for this opportunity to discuss the progress we have made and challenges that we face in our ability to deliver high quality health care to the veterans we serve in the state of Kansas.

The VA Heartland Network (VISN 15) mission is simple: Maximum Veteran Benefits. We need to deliver comprehensive, high quality health care with appropriate patient access. We provide high quality clinical services utilizing a hybrid delivery model. When clinical services are not available within our network a make/buy decision is made. Our current model includes services based on-site, services based off-site through local contracts, and network wide contracts for health care delivery.

OVERVIEW

The VA Heartland Network is responsible for the health care of 38,773 veterans over 92 counties in the state of Kansas. Based on the 1998 Kansas medically underserved areas report, 44% of the counties in Kansas are critically underserved and 55% are underserved for primary care.

Care is delivered through a network of medical centers, community based outpatient clinics (CBOC), and mobile outreach clinics (MOC) located throughout Kansas and western Missouri.

The Veterans Affairs Medical Centers providing primary and secondary, domiciliary, and long-term care are located in the cities of Wichita, Topeka, and

Leavenworth. Topeka also provides tertiary mental health care. The Kansas City medical center is a tertiary care facility that services the states of Kansas and Missouri. In addition, all these medical centers are associated with the University of Kansas School of Medicine and have active resident training and allied health professional training programs.

There are 6 community outpatient clinics and 10 mobile outreach clinics all linked to one of the medical centers providing primary care services. In addition, many of the clinics have telemedicine capability that can provide some specialized services.

SUCCESSES

The Heartland Network has enjoyed considerable success in removing barriers to primary care in rural areas. With the addition of the community based outpatient clinics and mobile out reach clinics, we have gone from an average distance that veterans must travel for primary care in our Network from more than 70 miles in 1996 to 15.9 miles in 2001.

In addition, we have increased the number of veterans served in Kansas by over 48% over the last five years.

In the area of preventative health care and evidence based clinical practice guidelines, we have consistently outperformed the private sector. It is noteworthy that we require the same standard for these preventive measures at our CBOC's as we do at the parent facilities.

The addition of our Telephone Care Program in 1997 has significantly increased access to care for our veterans in Kansas. The program is available during the WHEN hours (Weekend, Holidays, Evenings, Nights). Veterans reach the after-hours nurses by calling their usual VA or PC team and then the calls are forwarded to Topeka via telephone technology. The benefits for the veterans are that their needs are immediately assessed, advice is based on approved protocols and reference books, and care is individualized by accessing the callers' electronic medical record.

In many instances, when cost effective, we have been successful in partnering our CBOCs with local health care services to provide convenient service for veterans. Some examples include providing local opthalmalogical services with our Parsons, Kansas

CBOC or using the Heartland Network cardiac services contract that allows medical centers or CBOCs to access cardiac care in Wichita, Topeka, and Kansas City.

We have successfully begun utilizing telemedicine applications throughout Kansas to provide scarce clinical services. The telemedicine program has been used between medical centers or from medical centers to community based outpatient clinics. We have several telemedicine clinics available within the VA Heartland Network including dermatology, mental health, radiology, vascular surgery, geriatrics, orthopedic surgery, hematology/oncology, and pain clinic.

In the Heartland Network, database integration (to be fully implemented the first of next month) will provide a seamless electronic medical record available at all sites across Kansas. The ultimate goal of the project is to provide better health care to veterans in the Heartland Network. It will provide caregivers real-time electronic access to a patient's clinical and administrative information, improve the inter-facility consult process, improve overall data consistency, increase coordination of care for veterans and allow inter-facility scheduling for patient appointments and procedures. In addition, it will improve patient safety and help reduce duplication of services/resources.

The VA Heartland Network has done very well with our accrediting processes. All of our medical centers in Kansas are accredited with our average JCAHO score of 96.5 %. In addition, we were highly successful in our NCQA survey, being the only Network in the Veterans Health Administration to achieve a three-year accreditation with commendation.

Our compensation and pension examinations are completed on average within 26 days, well below the national standard.

CHALLENGES

The main challenge experienced in rural health care has related to recruitment and retention of professional staff. The issues involved here are multifactoral and include:

1. Inability to provide a salary that is competitive. This is especially true of specialty care physicians, but may also be true with primary care physicians, and nurse practitioners, particularly in the smaller towns with community based outpatient clinics. We have found many providers are

simply unwilling to live in a rural community with diminished cultural and entertainment opportunities without commensurate compensation.

2. When unable to recruit locally, parent medical centers must supply providers to these medical sites. In doing so, a great deal of patient care time is lost to traveling. In addition, provider morale is often diminished.
3. When unable to recruit U.S. citizens as providers, we frequently have highly qualified international medical graduate applicants who would be willing to serve in a rural area. Unfortunately, the visa process is remarkably cumbersome and can take a year or more to complete. Obviously, this impairs our ability to respond to immediate staffing needs. Recent regulatory changes to speed the process have been only marginally effective.
4. We currently work with a slow, outdated human resource process in the hiring of highly qualified health care providers. The health care job market is extremely competitive. By the time we are able to make a job offer, the candidate often has already been hired and working elsewhere for months.

CONCLUSION

I would like to thank the subcommittee for providing me with the opportunity to discuss veteran's health in the state of Kansas. We have worked hard over the last 5 years to improve the quality of care, services, and access. We still have work ahead of us, but I am confident our dedicated staff are up to the challenge.

STATEMENT
OF
ROBERT M. MALONE, JR.
DIRECTOR, VA EASTERN KANSAS HEALTH CARE SYSTEM
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
SEPTEMBER 24, 2001

Mr. Chairman, members of the committee, distinguished veterans and guests:

It is an honor to have the opportunity to discuss with you today how VA Eastern Kansas Health Care System, is working to provide the veterans of rural Northeastern Kansas with a comprehensive, quality healthcare plan which offers excellent access.

The VA Eastern Kansas Health Care System's mission is to provide accessible, courteous, comprehensive, and quality health care to veterans in an environment of excellence.

Overview

VA Eastern Kansas Health Care System, comprised of the Dwight D. Eisenhower Medical Center in Leavenworth and the Colmery-O'Neil Medical Center in Topeka, provides significant inpatient and outpatient services with a focus on primary care, psychiatric treatment, and extended care supported by nursing home care units and a domiciliary. The health care system has two medical centers and twelve Community Based Outpatient Clinics in Kansas and one Community Based Outpatient Clinic in Missouri. VA Eastern Kansas operates a total of 221 hospital beds. The goal to provide a continuum of care is seen with an additional 174 nursing home beds, and 178 domiciliary beds.

Specialized Care

VA Eastern Kansas offers a variety of specialized services, such as psychiatric programs, which are unequaled in the private sector. Unlike private sector hospitals, the atmosphere offers a strong identity and connection to past military service. Referrals

from medical centers within VHA throughout the nation are accepted by VA Eastern Kansas for our PTSD program, acute psychiatry services and for domiciliary care.

As the demographics for veteran population change, we now know that the largest group of veterans we serve fall into the era of the Viet Nam veterans. VA Eastern Kansas Health Care System proudly offers these veterans multiple specialty services like dermatology, agent orange screening and especially our Nationally known PTSD program. The Post Traumatic Stress Disorder program began in Topeka in 1982.

Access

Our commitment to rural health care for veterans began in 1985 when the Social Work Service at the Topeka VA Medical Center developed "Medical Outreach Teams". Initially, the teams had the goal to reach veterans in rural settings, not close to the Topeka VA Medical Center who may not have known about the services which they were eligible to receive. At that time, the teams provided care in community halls, and American Legion Posts, senior centers, and even a public library. Today, the 12 Community Based Outpatient Clinics in Kansas operated by the health care system serve veterans who come from any of the 105 counties in Kansas.

Building upon the successes of the health care system's facility-based programs, outreach efforts have been emphasized to expand the services provided to veterans in settings closer to their communities thereby eliminating the need for patients to travel to the medical centers for regular follow-up care. We are extremely proud of the 12 outreach clinics operated by VA Eastern Kansas in the following Kansas communities: Abilene, Chanute, Emporia, Fort Riley, Fort Scott, Garnett, Holton, Junction City, Kansas City, Lawrence, Russell, and Seneca.

Since October 2000, over 5,000 visits have occurred in these Community Based Outpatient Clinics. The Community Based Clinics are an extension of the traditional medical center based Primary Care offered to the veterans we serve. Veterans have an assigned Primary Care physician who they see yearly. The Community Based Clinics provide routine follow-up appointments in a professional medical setting. The clinics were established in those rural areas with the highest concentration of veterans or at sites where veterans from rural Kansas would not be able to access care.

The Community Based Clinics in addition to routine follow-up care will make referrals back to the medical centers for specialized care. Examples of other specialty areas would include women's health services, dermatology, urology, surgery, and podiatry. Also key to the success of the Eastern Kansas Health Care Community Based Clinics is that many mental health services can be provided in the community outpatient setting.

Conclusion

It's been a pleasure to share with you some of the some of the good work the staff from VA Eastern Kansas Health Care System has been pursuing to improve the quality of health care for the veterans in Kansas. With your continued support of Nation's veterans, we can do even more.