

**ACCESS TO U.S. DEPARTMENT OF VETERANS  
AFFAIRS HEALTHCARE: HOW EASY IS IT FOR  
VETERANS—ADDRESSING THE GAPS**

---

---

**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

APRIL 18, 2007

**Serial No. 110-13**

Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

35-632

WASHINGTON : 2008

---

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) 512-2104 Mail: Stop IDCC, Washington, DC 20402-0001

## COMMITTEE ON VETERANS' AFFAIRS

BOB FILNER, California, *Chairman*

CORRINE BROWN, Florida	STEVE BUYER, Indiana, <i>Ranking</i>
VIC SNYDER, Arkansas	CLIFF STEARNS, Florida
MICHAEL H. MICHAUD, Maine	JERRY MORAN, Kansas
STEPHANIE HERSETH SANDLIN, South Dakota	RICHARD H. BAKER, Louisiana
HARRY E. MITCHELL, Arizona	HENRY E. BROWN, JR., South Carolina
JOHN J. HALL, New York	JEFF MILLER, Florida
PHIL HARE, Illinois	JOHN BOOZMAN, Arkansas
MICHAEL F. DOYLE, Pennsylvania	GINNY BROWN-WAITE, Florida
SHELLEY BERKLEY, Nevada	MICHAEL R. TURNER, Ohio
JOHN T. SALAZAR, Colorado	BRIAN P. BILBRAY, California
CIRO D. RODRIGUEZ, Texas	DOUG LAMBORN, Colorado
JOE DONNELLY, Indiana	GUS M. BILIRAKIS, Florida
JERRY McNERNEY, California	VERN BUCHANAN, Florida
ZACHARY T. SPACE, Ohio	
TIMOTHY J. WALZ, Minnesota	

MALCOM A. SHORTER, *Staff Director*

---

## SUBCOMMITTEE ON HEALTH

MICHAEL H. MICHAUD, Maine, *Chairman*

CORRINE BROWN, Florida	JEFF MILLER, Florida, <i>Ranking</i>
VIC SNYDER, Arkansas	CLIFF STEARNS, Florida
PHIL HARE, Illinois	JERRY MORAN, Kansas
MICHAEL F. DOYLE, Pennsylvania	RICHARD H. BAKER, Louisiana
SHELLEY BERKLEY, Nevada	HENRY E. BROWN, JR., South Carolina
JOHN T. SALAZAR, Colorado	

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

# CONTENTS

April 18, 2007

	Page
Access to U.S. Department of Veterans Affairs Healthcare: How Easy is it for Veterans—Addressing the Gaps .....	1
OPENING STATEMENTS	
Chairman Michael H. Michaud .....	1
Prepared statement of Chairman Michaud .....	27
Hon. Shelley Berkley .....	8
Hon. Jerry Moran .....	3
Hon. John T. Salazar .....	4
WITNESSES	
U.S. Department of Health and Human Services, Marcia Brand, Ph.D., Associate Administrator, Rural Health Policy, Health Resources and Services Administration .....	5
Prepared statement of Dr. Brand .....	28
U.S. Department of Veterans Affairs, Gerald M. Cross, M.D., FAAFP, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration .....	24
Prepared statement of Dr. Cross .....	41
SUBMISSIONS FOR THE RECORD	
American Legion, Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission .....	16
Prepared statement of Ms. Middleton .....	34
Disabled American Veterans, Adrian M. Atizado, Assistant National Legislative Director .....	19
Prepared statement of Mr. Atizado .....	37
National Rural Health Association, Andy Behrman, Chair, Rural Health Policy Board, and President and Chief Executive Officer, Florida Association of Community Health Centers .....	14
Prepared statement of Mr. Behrman .....	30
SUBMISSIONS FOR THE RECORD	
Brown, Hon. Corrine, a Representative in Congress from the State of Florida, statement .....	46
Brown, Hon. Henry E., Jr., a Representative in Congress from the State of South Carolina, statement .....	46
Miller, Hon. Jeff, Ranking Republican Member, and a Representative in Congress from the State of Florida, statement .....	46
MATERIAL SUBMITTED FOR THE RECORD	
Post-Hearing Questions for the Record:	
Hon. Michael H. Michaud, Chairman, Subcommittee on Health, to Dr. Michael Kussman, Acting Under Secretary of Health, Veterans Health Administration, U.S. Department of Veterans Affairs, letter dated May 2, 2007 .....	48
Hon. Joe Donnelly to Dr. Michael Kussman, Acting Under Secretary of Health, Veterans Health Administration, U.S. Department of Veterans Affairs, letter dated May 2, 2007 .....	55
Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health, to Dr. Michael Kussman, Acting Under Secretary of Health, Veterans Health Administration, U.S. Department of Veterans Affairs, letter dated April 27, 2007 .....	57

	Page
Post-Hearing Questions for the Record—Continued	
Hon. Michael H. Michaud, Chairman, Subcommittee on Health, to Maurice Huguley, Legislative Analyst, Office of Deputy Assistant Secretary for Legislation for Human Services, U.S. Department of Health and Human Services, letter dated May 2, 2007 (forwarding question from Hon. Phil Hare) .....	68
Hon. Michael H. Michaud, Chairman, Subcommittee on Health, to Joe Violante, National Legislative Director, Disabled American Veterans, letter dated May 2, 2007 .....	73
Andy Behrman, Chair, NRHA Rural Health Policy Board, National Rural Health Association, to Hon. Michael H. Michaud, Chairman, and Hon. Phil Hare, Subcommittee on Health, Committee on Veterans' Affairs, letter dated June 5, 2007 .....	69
Steve Robertson, Director, National Legislative Commission, American Legion, to Hon. Michael H. Michaud, Chairman, Subcommittee on Health, Committee of Veterans' Affairs, letter dated November 28, 2007 .....	72

**ACCESS TO U.S. DEPARTMENT OF VETERANS  
AFFAIRS HEALTHCARE: HOW EASY IS IT  
FOR VETERANS—ADDRESSING THE GAPS**

---

**WEDNESDAY, APRIL 18, 2007**

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

The Subcommittee met, pursuant to notice, at 2:20 p.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Moran, Snyder, Hare, Berkley, Salazar.

**OPENING STATEMENT OF CHAIRMAN MICHAUD**

Mr. MICHAUD. Sorry for the delay. We got called for a vote so we will start. I would ask unanimous consent that all written statements be made part of the record. Without objection, so ordered.

I also ask unanimous consent that all Members be allowed 5 legislative days to revise and extend their remarks. Without objection, so ordered.

I apologize for a lot of the Members not being here. We have a lot of Committee meetings that are going on and we just broke up from a vote and Members will be drifting in and out throughout the hearing.

The Subcommittee on Health has a lot of issues that we have to deal with this upcoming session. The issue of providing rural healthcare affects each of our States in a very different way. In California, rural communities make up 92 percent of the land mass and 8 percent of the population. In my own State of Maine, over 40 percent of the population lives in rural areas. It is estimated that 60 million Americans, one in five, live in areas that have been classified as rural.

Rural populations tend to be older than urban populations and they tend to exhibit poor health behaviors. Economic factors also add to the challenges facing rural populations. Rural veterans make up 41 percent of the U.S. Department of Veterans Affairs' (VA's) patient workload. Access and resources present serious challenges to providing high quality care for these veterans. VA care can be second to none. Unfortunately the quality of care is not always the same throughout the VA system. For many veterans living in rural States like Maine, accessing that care is a significant challenge. For certain more complex procedures veterans in north-

ern Maine must endure 4 days of travel to and from the VA facility in Boston to receive care.

Addressing the distance to care and the travel burden in rural areas is extremely important. However, given the smaller population and frequency of certain complex procedures it does not make sense for VA to maintain a daily in-house capacity in every facility for something that is used on an infrequent basis.

This problem is not unique to VA. It is a problem facing many rural areas across the country while smaller patient population limit the resources available to rural hospitals, which in turn limits the services that hospitals can support and provide. Rural areas face difficulties in providing what has been termed "core healthcare services" by the Institute of Medicine. These services include primary care in the community, emergency medical service, hospital care, long-term care, mental health and substance abuse services, oral healthcare, and public health services.

For a variety of reasons, rural areas also face a greater problem recruiting and retaining healthcare professionals. These problems must be addressed because the demand of services from our veterans in rural areas is only going to increase. We have an aging population that will need long-term care. Over 40 percent of the new generation of veterans returning from Afghanistan and Iraq are from rural areas. They have their own unique needs including loss of limb, traumatic brain injury, and mental health concerns.

One important approach to providing access to care is the VA system and Community-Based Outpatient Clinics (CBOCs) which currently number more than 650. We have five CBOCs in Maine. The Capital Asset Realignment for Enhanced Services (CARES) Commission recommends a sixth CBOC in the Lewiston, Auburn area along with five part-time health access points. Only one of these facilities is close to opening while the CBOC is not expected to open until 2008 at the earliest.

During the CARES process, 250 CBOCs were identified by the VA as being needed, of which 156 were designated as priority. Since the CARES decision, VA has opened 12 of the 156, less than 8 percent. At this pace it will take VA over 30 years to open all the priority clinics. VA has also opened 18 clinics not on the CARES priority list, which calls into question the decision process and the ability of CARES to assist in decisions in the future.

The VA has also designated facilities as Veterans Rural Access Hospitals designed to provide inpatient service to veterans in rural areas in which these services can be supported. The VA has made great strides in exploring the use of telemedicine and other technological means of providing healthcare services. I would like to hear how these efforts are improving care and how we can help.

One of the problems we face in the area of recruitment and retention is the isolation that is often felt by healthcare professionals working in rural communities. I would like to explore how technology might be used to overcome these feelings of isolation and thus improve recruitment and retention.

Is the VA, and our rural communities, ready to meet the increasing and changing needs of our veterans and their families? What is the VA in rural America going to look like in the future? We must keep in mind that VA healthcare does not operate in a

vacuum but it is an integral part of our national healthcare system. I would also like to know when the priority CBOCs are going to be built or if the VA no longer intends to follow the CARES process.

Today the Subcommittee hearing will provide us with the opportunity to begin this exploration, to begin to examine issues concerning access and the provision of care and the proper expectation of veterans in rural areas regarding the care that they can expect from the VA system.

At this point in time I would like to recognize the Acting Ranking Member, Mr. Moran.

[The prepared statement of Chairman Michaud appears on p. 27.]

#### **OPENING STATEMENT OF HON. JERRY MORAN**

Mr. MORAN. Mr. Chairman, thank you very much. I appreciate you recognizing me. I am delighted to be here this afternoon, although I have several meetings that are intruding. I am happy to be here to support your efforts. And I would like for you, Mr. Michaud, to consider me an ally. We share many similarities in our districts despite one is in New England and one is in the middle of the country, Midwest. I represent a district of approximately 60,000 square miles. There is not a VA hospital in the district. And we very much are interested in trying to find ways to improve access for our veterans.

Your remarks about CBOC I think are right on point. I am very interested in knowing what the plans are by the Department of Veterans Affairs to increase the number of CBOC. We have significant needs in that regard and are particularly troubled to learn about the issue of not being on the priority list and still having CBOC when those that are on the priority list are still waiting.

I also would encourage you and the Subcommittee to take seriously a piece of legislation that I introduced earlier this year, the Rural Veterans Access to Care Act, giving veterans the opportunities of utilizing their local healthcare providers, both hospitals and physicians, clinics, in the circumstances when a VA hospital is miles, hundreds of miles away from where the veteran lives and where the CBOC is as well.

And I am hopeful that this Committee will take that form of legislation, that theory behind that legislation seriously and work with me to see that we address the needs of our veterans who are miles away. I spoke on the House floor recently about this topic, veterans who are told to drive 260 miles to get their prescriptions for their eye glasses when there's an optometrist on Main Street three blocks away.

We need assistance when it comes to filling prescriptions and issuing the script. The idea that our veterans must travel hundreds of miles, particularly our World War II veterans at ages 80 and 90, to simply have an examine so that their prescription can be refilled in many cases it is physically not possible.

I also am interested in hearing what Dr. Petzel has to say in his role as Director of VISN 23 in regard to the Project Hero. And that VISN includes six Kansas counties and I am interested in knowing the status and findings of that pilot program.

Last December, legislation was signed creating the VA Office of Rural Healthcare. And I have not heard from the VA as to the status of the implementation of that office. Whether it is being staffed and what role it is now playing or is foreseen to play. And finally I would raise a point that we have been pushing for a long time, the opportunity access also includes, particularly in rural America, the access to other providers than a physician and chiropractic care continues to be inadequate in many of our VISNs across the country. And, I hope to be here to ask some questions of our Department of Veterans Affairs witnesses.

Again, Mr. Michaud, you have been a champion in regard to rural healthcare. I would like to be your ally, and look forward to working with you to see that we accomplish the goal of meeting the needs of veterans who live across the country, regardless of whether they are in the same community as a VA hospital. Thank you.

Mr. MICHAUD. Thank you very much, Mr. Moran. I will work very closely with you on these issues, and I agree with your comments. We have scheduled a hearing, I don't know if the notice has been sent to your office yet, for one of your bills on April 26th at 10 o'clock. And we will be sending you a notice to testify.

Mr. Salazar?

#### **OPENING STATEMENT OF HON. JOHN T. SALAZAR**

Mr. SALAZAR. Thank you, Mr. Chairman. And I thank you, Mr. Moran, for your fine comments. I associate myself with both of your comments. I think all of us share some commonalities in that we all represent some very rural areas in our distant communities in Kansas and in Colorado for example.

But I want to thank you, Mr. Chairman, for you calling this important hearing. I think that a 2004 study by the Under Secretary of Veterans Health found that veterans living in rural areas in fact are in poor health, in poorer health than those living in urban areas. And because of the distances, as Mr. Moran referred to, and other difficulties associated with obtaining care, many rural veterans put off preventative healthcare.

I think last Congress the Office of Rural Health and the VA was created to better focus on our veterans in rural areas. I am looking forward to today's testimony. But in reality, over 25 percent of the veterans, I believe, live in rural areas. And I believe it is a fair expectation that the men and women who sacrifice for us are taken care of.

I am heartened today that we got notice from Secretary Nicholson that, it is not really CBOC, but it is called a Community-Based Outreach Center which is actually going to be installed in Craig, Colorado, one of the remotest areas in Colorado. Veterans have to travel 5 hours over the mountains to try to get to Grand Junction for healthcare.

I want to thank the Secretary for that. We do indeed share many, many issues when it comes to veterans' healthcare. I think, though, that if we find that the VA is incapable of providing that care to all of our veterans, that we can't afford it, then I think we must look for a new direction. And I agree with Mr. Moran on pos-

sibly looking at trying to address the issues of allowing our veterans to obtain healthcare from our local physicians.

But I want to thank you, Mr. Chairman, once again. And I look forward to today's testimony. Thank you.

Mr. MICHAUD. Thank you, Mr. Salazar. On our first panel is Dr. Marcia Brand who is Associate Administrator for Rural Health Policy, Health Resources and Services Administration, of the U.S. Department of Health and Human Services. Dr. Brand.

Dr. BRAND. Thank you.

Mr. MICHAUD. Thanks for coming this afternoon. I look forward to hearing your testimony.

**STATEMENT OF MARCIA BRAND, PH.D., ASSOCIATE ADMINISTRATOR, RURAL HEALTH POLICY, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Dr. BRAND. Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to meet with you today on behalf of Dr. Elizabeth Duke. She is the Administrator of the Health Resources and Services Administration. Thank you. We welcome this opportunity to discuss rural health access issues and what is being done to meet the healthcare needs of the Nations rural populations. We appreciate your interest in and support for rural healthcare and access to healthcare for rural veterans.

The Health Resources and Services Administration, which I will call HRSA, is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable. HRSA grantees provide healthcare to the uninsured, people living with HIV and AIDS, and pregnant women, mothers and children. They train health professionals and improve systems of care in rural communities.

For HRSA, the Health Center Program, the National Health Service Corps, and rural healthcare needs are priorities. For more than 40 years, the Health Center Program has been a major component of the healthcare safety net for the Nation's indigent populations. Health Centers lead the Presidential initiative to increase healthcare access in the Nation's most needed communities. Health Centers provide regular access to high quality, family oriented, comprehensive primary and preventative healthcare regardless of one's ability to pay.

President Bush's initiative to expand the Health Centers began in 2002. The initiative will significantly effect over 1,200 communities through the support of new or expanded access points. In 2001 HRSA funded 3,317 Health Center sites across the Nation. We expect the number of Health Centers sites to grow to 4,053 by the end of 2008.

Just over half of all the Health Center grantees serve rural populations. Besides the new access points, HRSA has distributed 385 grants to expand the medical capacity of our existing delivery sites and another 340 grants to existing grantees to add or expand oral health, mental health and substance abuse services. And these are special challenges for our rural communities.

Through these efforts, the number of patients treated annually with Health Centers has grown from 10.3 million in 2001 to an es-

estimated 16.3 million patients by the end of 2008. The National Health Service Corps improves the health of the Nation's underserved by uniting communities in need with caring health professionals. Currently more than half the National Health Service Corps doctors, dentists, nurses, and mental health and behavioral health providers serve in Health Centers around the Nation. And about 60 percent of them work in areas.

HRSA's Office of Rural Health Policy is charged with informing and advising the Department of Health and Human Services on matters effecting rural hospitals and healthcare. We coordinate rural healthcare activities and maintain a national rural health and human services information clearinghouse. HRSA, with the Office of Rural Health Policy, is the leading Federal proponent for better healthcare services for the 55 million people who live in rural America.

ORHP promotes State and local empowerment to meet the country's rural health needs in several ways. I would like to highlight a couple of our grant programs. We manage the Medicare Rural Hospital Flexibility Grant Program which provides funding to State governments to work with 1,300 small rural hospitals. We work with the State Office of Rural Health. There are 50 State offices of Rural Health.

Additionally, we support a number of community-based grant programs that increase access to primary care or improve rural healthcare services. As you can see, HRSA administers a range of programs that serve rural communities. HRSA also provides staff support to the Department's cross-cutting rural efforts. This includes the HHS Rural Taskforce which has representatives from each of HHS's agencies and staff offices.

Effective, coordinated healthcare improves the health and well-being of American's, regardless of where they live. However, effective coordination is especially critical in rural communities where services and providers are limited and resources are scarce. The challenges of providing healthcare for rural communities is compounded by higher rates of poverty, a lack of insurance. Rural people are a little bit older and they have higher rates of chronic disease. And there are significant transportation barriers.

We take great pride in the work that we do to provide better healthcare services for our rural populations. However, we are humbled by the significant challenges that remain for healthcare in rural areas and the underserved. We are pleased that the Department of Veterans Affairs is establishing an Office of Rural Health to assist the Under Secretary in issues affecting rural veterans.

We have contacted the individuals who are creating this Office and their charge sounds very familiar. With 20 years of experience, we have some expertise around rural and policymaking and research. And we look forward to collaborating with the new Office. And we offer our assistance.

And, I would be pleased to answer any questions at this time, sir.

[The prepared statement of Dr. Brand appears on p. 28.]

Mr. MICHAUD. Thank you very much, Doctor, for your testimony. You had mentioned that the Office of Rural Health, which is get-

ting under way within the VA System, and the fact that HHS has 20 years of experience in this area. What would you tell the VA would be the number one problem that your agency encountered in dealing with rural healthcare issues as far as access goes?

Dr. BRAND. I think that it would be difficult to say that there is a single issue that is most challenging around access. In rural communities we face a lot of the challenges that we face nationwide in access—it's just that much more difficult because it is rural. It is harder to recruit and retain providers because infrastructure is not there and the folks who use those services have higher healthcare needs and lower rates of insurance.

Mr. MICHAUD. Okay.

Dr. BRAND. It has over the past several years become clearly a significant problem to provide mental health services for rural communities and also to provide oral healthcare. It is very difficult to recruit and retain providers.

Mr. MICHAUD. Has it been a problem trying to find qualified staff to work in the rural healthcare arena?

Dr. BRAND. There are a number of different programs that seek to improve recruitment and retention of providers for rural communities. A number of them focus on the fact that folks who are from rural communities are more likely to go back there and practice. And so a number of State programs and several of the Federal programs try to recruit folks from rural communities, encourage them to go to health profession schools, and then return to practice in those areas.

Also the National Health Service Corps. Roughly 60 percent of the folks in the National Health Service Corps practice in rural communities. So that is another affect of Federal program.

Mr. MICHAUD. You are familiar with the CARES process that the VA went through a number of years ago?

Dr. BRAND. Sir, I read the materials in preparation for this hearing, but I wouldn't consider myself familiar with it.

Mr. MICHAUD. A lot of time and effort went into the CARES process, and I commend everyone who put all the effort in there. My concern is that that is pretty much it. We haven't seen, at least in VISN 1, any movement or much movement in that particular area.

My question is, when you look at rural healthcare, what you are doing at HHS and if you look at what the CARES process actually recommends, a lot of—there are a lot of areas that are very similar. Do you think that that is something that your agency could work very closely with the VA to actually speed up the process under the CARES process?

And a good case in point is, one of the clinics under the CARES process that was recommended in Maine, the VA actually was working with the local hospital, was working with the healthcare clinic in the region. And at the very last minute they decide to go it alone.

So now we have a situation where we have a hospital that is expanding in a rural area. You have a Federally qualified healthcare clinic that is building a new facility in a rural area. And then you have the VA building a new facility in the rural area in the same town, which I think is a waste of Federal dollars. And I think there should be some collaboration going on.

So I hope you would actually look at the CARES process as far as where they are recommending clinics or CBOCs and see how you might have facilities out there where we used additional Federal dollars in other areas to be able to help collaborate with the VA and to move forward in a collaborative way so we can take care of veterans in rural areas. At the same time it will help out rural healthcare providers as well.

Dr. BRAND. I think that we have a significant investment in expanding the Health Centers and certainly there are opportunities for collaboration with the Health Centers. There are also 3,500 Rural Health Clinics located in those areas. And somewhere around 1,300 small rural hospitals that we call Critical Access Hospitals. And given the fact that resources in rural communities are so scarce, it would be—I would be hopeful that we would be able to find ways to collaborate more effectively. And we are certainly willing to try to do that.

Mr. MICHAUD. Great. Well thank you very much, Dr. Brand. Mr. Salazar.

Mr. SALAZAR. Thank you, Mr. Chairman. Dr. Brand, my questions are similar to Mr. Michaud's questions. It just seems to me to make a lot of sense that if you have to transport veterans over a 250 mile range, that it would make more sense to be able to provide them the same opportunity as normal residents have in rural communities, for example.

What are the obstacles to VA refunding or making the payments for a patient who is a veteran who would go to a local hospital to get the same kind of treatment? Is there a rulemaking process that has to take place or is it just rules within VA or is it something that the Members of Congress could actually do to change the—

Dr. BRAND. I can speak to the Health Centers and certainly to small rural hospitals. Our Health Centers, frankly at this moment don't ask veterans' status. And so they do not know who is a veteran. And similarly I think for many small rural hospitals when someone presents either through the outpatient departments or coming through the emergency department it is not asked.

And, so I think that frankly opportunities to improve collaboration are missed because Health Centers and Critical Access Hospitals don't know who is a veteran and who might be eligible for benefits. I think also it is important to note that the Health Centers will see someone regardless of their ability to pay or their veteran status. So if they present at the Health Center, they would be seen.

Mr. SALAZAR. Well what about preventative healthcare? Like, for example, just to be able to go to the local primary care physician—do you have any mechanism for veterans in rural areas to be able to do that?

Dr. BRAND. They could certainly present at any of those facilities. Whether or not those would be reimbursed by the Veterans—through their veterans benefits, I think is just depending upon a pre-existing relationship. And I am sure my colleagues from Veterans Affairs could speak to that more effectively than I can in terms of what those relationships might be.

Mr. SALAZAR. Okay. Thank you.

Mr. MICHAUD. Thank you, Mr. Salazar. Ms. Berkley?

**OPENING STATEMENT OF HON. SHELLEY BERKLEY**

Ms. BERKLEY. Thank you very much, Mr. Chairman. I am very glad that we are here to discuss access to VA healthcare, which is obviously a very important issue to our veterans across the country.

As you are aware I represent a very urban district and I just want to emphasize that access to healthcare is not, for our veterans, is not only a rural issue. With 218,000 veterans in southern Nevada, we have no VA healthcare facilities. And of course because of the CARES study, finally the CARES Commission determined that with 218,000 veterans and no healthcare facilities, that perhaps Las Vegas ought to have its own healthcare facility.

So many of my veterans, aside from the fact that they have got 80-year old veterans standing in 110 degree temperature waiting for a shuttle to take them from one temporary location to another awaiting the building of our VA hospital, outpatient clinic, long-term care facility. So many of my veterans that have more specialized problems have to continue to go to Long Beach to get their healthcare needs taken care of. And it is just so difficult because oftentimes they are in a very low-income bracket. Their families cannot afford to accompany them. They go there by themselves. Many of them are Korean War veterans and World War II vets. And this is an issue that is bigger than our rural areas. It is pervasive across the United States.

I have got 1,600 Nevada veterans who have just returned from Iraq and Afghanistan. And we are estimating that there will be at least another 2,100 coming back in the next year or two. I can't be here for the third panel, but I think what I would ask you as Chairman if you could please ask the third panel how is the VA preparing to meet the needs of the growing number of returning servicemembers who will need increased healthcare and mental healthcare as well?

Right now in Las Vegas, we don't have facilities to handle what we have. In 2011, which is when they are anticipating that the facilities will be completed, is an awfully long time to have to wait if you are a World War II vet, if you are a disabled vet and have to keep going to Long Beach or if you are returning from Afghanistan or Iraq and it is 2007. And you are coming home to nothing.

So those are the questions that I would like addressed and I am just sorry I won't be here to hear the answers. But I thank you very much for letting me talk to you about my extraordinary frustration and, frankly, shame that we send young men and women to war and when they come back, we don't do what we have promised that we are going to do, and don't adequately fund this VA healthcare center. As I have said, the healthcare system—as I have said before, veterans healthcare and other benefits is the cost of war. And we ought to be taking this into account because the men and women that are coming back from Iraq and Afghanistan we are going to be taking care of their healthcare needs and mental healthcare needs for many decades to come. And we can't handle the load we have now.

So I would like to know how the VA intends to take care of these people. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much. You have been a true advocate for veterans. Your questions are the same that a lot of us have as well, and you can be assured that they will be asked. Thank you.

Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman. Thank you very much for having the hearing.

Dr. Brand, I just have a couple questions. One, you know, I represent an area, a congressional district, with a lot of rural areas. And you know you were talking about transportation. And you mentioned in your testimony that there are significant transportation barriers that affect the coordination of services. And I am wondering if you could elaborate on that and what HHS has done to address the issue of providing transportation to rural patients?

Dr. BRAND. Transportation is a significant challenge in rural communities. And HHS has a process to try to improve coordination and collaboration around transportation. And it would be my pleasure to submit that information to you after the hearing, sir.

[The information was provided by the U.S. Department of Health and Human Services to Mr. Hare in the post hearing questions for the record, which appears on p. 48.]

Mr. HARE. Thank you very much. And then you were talking about hospital care. You said that out of the 2,000 hospitals, I believe 1,500 have fewer than 50 beds.

Dr. BRAND. Yes, sir.

Mr. HARE. And just a couple of questions. Can you describe the type of care that is provided there and have you run into problems finding qualified people to staff and to work at the small hospitals?

Dr. BRAND. Of the 2,000 hospitals, about 1,500 have less than 50 beds. And those hospitals typically provide some access to primary care through outpatient services and then standard services such as laboratory, radiology. They have an emergency department, they meet Medicare conditions of participation, but most of the patients that are seen are those patients with less complex conditions. And historically, lots of those places are places where individuals come and are first assessed and then it is important to have a good relationship with the next level of hospital, the referral hospital for those conditions that are more complex.

And so there are—

Mr. HARE. Thank you.

Dr. BRAND [continuing]. Part of a system or a network of hospitals.

Mr. HARE. And then specifically, what do you think are the benefits and the disadvantages of running a hospital that has fewer beds?

Dr. BRAND. I beg your pardon, sir?

Mr. HARE. What are the benefits and disadvantages of running a hospital with fewer beds from your perspective?

Dr. BRAND. I think that the benefits are that you could have contact—you can have an access point closer to where people live. That they don't necessarily have to drive 50, 100 miles to get to a hospital. The challenges of a small rural hospital are that with a limited, a low volume, it is always hard to ensure that you have

that financially you are in the positive margin, because you don't have a lot of patients to provide care for.

Mr. HARE. Okay. And I am sorry, Doctor, I think you answered this and I was jotting a note. Have you found it difficult to staff hospitals? To find people to staff at the smaller hospitals?

Dr. BRAND. Yes, sir.

Mr. HARE. Okay.

Dr. BRAND. It is difficult to recruit and retain physicians and nurses. It is a challenge to effectively staff your business office and your housekeeping and your dietician department. It is the same challenge that all small rural hospitals face—

Mr. HARE. Sure.

Dr. BRAND [continuing]. In retaining workers.

Mr. HARE. Any ideas from your end on how we can do a better job of doing that or how we can—

Dr. BRAND. A number of the States have been very innovative in the programs that they have developed for recruiting and retaining providers using their academic Health Centers and their community colleges.

The National Health Service Corp is another fairly effective tool for getting folks out into those communities. I suspect that as long as there are remote areas, we are going to struggle to find ways to staff up those facilities.

Mr. HARE. Okay. Thank you, Doctor. I yield back.

Mr. MICHAUD. Thank you, Mr. Hare. Dr. Snyder?

Mr. SNYDER. Thank you, Mr. Chairman. Dr. Brand, I am curious what is your Ph.D. in?

Dr. BRAND. My Ph.D. is in higher education. My original discipline was dental hygiene, but I couldn't sit still.

Mr. SNYDER. Oh, yeah. Yeah. I see it. About half the time people with Ph.D. either don't know what the subject field is or simply don't understand the title of the theses. But I am always trying to educate myself.

I have two questions. When we had our discussion in the Armed Services Committee, one of the issues that we had difficulty with about 2, 3, or 4 years ago with the TRICARE system was an adequate number of obstetricians that had signed up to provide TRICARE services to military families.

And I think a lot of it was a reimbursement problem. And I think that has dramatically improved, at least our TRICARE contractors are saying it has dramatically improved. And I think it was something they learned from our Committee system.

So when they testified from our Committee hearings over the last couple of years, so when they testified in the last month and I asked them, where do they see their gap is now? They testified they think their biggest gap is in mental health services. To the point that they have just gone out and contracted with a provider for full time, that they would assign to different geographic areas because they just can't find services in such an area.

And that shouldn't be—I am sure that is not a surprise to you as somebody who works in rural health a lot. Because before we had the war in Iraq or Afghanistan we had, I think, big gaps in mental health services throughout the country, both urban and rural. Would you agree with that? Yeah.

And now this niche of people, we have military veterans and military families with these mental health things. I may have missed it in your written statement, but I didn't really see much of a discussion about mental health. And because it seems to me the challenge we are talking about making it easier for veterans but we are trying to do that in a system that has big gaps in care for non-veterans also.

When you talk about the mental health, where do you see that going?

Dr. BRAND. Yes, sir. One of the grants—

Mr. SNYDER. Would you pull that in a little closer? Maybe it is just my old ears or something.

Dr. BRAND. Is this better?

Mr. SNYDER. Yeah, it is.

Dr. BRAND. Sorry. One of the programs that we manage in our Office is an Outreach Services Grant Program and it provides resources for communities to define what their need is and then they write to that particular program need rather than being categorical like so many of the grants.

And if you look at the applications that the community submits the gap that they are trying to fill, is the mental health services gap. A significant number of them try to fill that gap. It is—I have heard it suggested that, you know, our jails become the waiting rooms for our mental health facilities in rural communities because there is just not enough care to provide folks who meet those challenges.

One of the things that HRSA is hopeful to do is improve the whole location of primary care and mental health services. And there has been a significant expansion of Health Centers and mental health services. And the idea is if you can have both of those services provided in the same facility it is much easier for the patients and for the clients. And frankly, in the rural communities where there is significant stigma, you can pull your car up in front of the clinic and no one knows if you are taking your child in for a well baby visit or if you are accessing the mental health services.

So you are right, sir, the recruitment of providers and the provision of mental health services is a significant challenge.

Mr. SNYDER. I don't think it has helped at all by this. What I think is just an invisible public health policy that a lot of private insurance companies take in terms of their reimbursement on mental health services. There is not much of an incentive for a small rural—well a typical rural practice of three to five physicians and maybe a nurse practitioner and maybe a deal. There is not much incentive to put in a full-time mental health worker with very poor reimbursement for the kinds of services that people could benefit from.

I notice we had this occur with regard to the Iraq War was, as Guard members and Reserve component members were being activated, and then their families were being put on to TRICARE as their healthcare system, they were then going to their local doctor and finding out that the doctor just didn't accept TRICARE. A lot of times I think it was because they just didn't know that there were people in their area that would benefit from that.

Is that an issue that you have dealt with at all or do you have any kind of—I think it has gotten better as word has gotten around to physicians. They really do need to sign up for this program in the spirit of patriotism.

Do you have an information network that you could disseminate information out there to providers about, here's the, you know, consider this, sign up for this?

Dr. BRAND. I believe that the Health Centers have a way of communicating. They have sort of a list serve system. And a number of the small rural hospitals do. In terms of whether or not they have been encouraged to participate in TRICARE and other programs, I don't know.

Mr. SNYDER. One of the problems that we had with that was hospitals signed up, but there were no physicians that had signed up.

Dr. BRAND. I see.

Mr. SNYDER. And so there was no one to take care of them while they were there. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Dr. Snyder. And just to follow up on your last question about TRICARE, I know there is an issue regarding reimbursement rates, particularly as they relate to Critical Access Hospitals getting lower reimbursements. This is a problem.

But I do want to thank you once again, Dr. Brand, for your testimony. There will probably be additional questions—

Dr. BRAND. Yes, sir.

Mr. MICHAUD [continuing]. For you to answer in writing and look forward to our continuing working relationship. And on a closing comment, as you heard from Mr. Moran and other Members here and from those Members who aren't here, access to healthcare in rural areas is a big concern. It is an extremely big concern about the CARES process moving so slowly to a point where I have heard other Members talking about authorizing another agency to do delivery on the CARES process versus the VA.

So I look forward to working with you and thanks again for your testimony.

Dr. BRAND. Thank you, sir.

Mr. MICHAUD. At this time I would like to welcome the second panel, Andy Behrman, who is Chairman of the Rural Health Policy Board for the National Rural Health Association; Shannon Middleton, who is Deputy Director for Health for the American Legion; and Adrian Atizado, who is the Assistant National Legislative Director for the Disabled American Veterans.

I want to thank our panelist for coming today and look forward to your remarks. And we will start off with Andy.

**STATEMENTS OF ANDY BEHRMAN, CHAIR, RURAL HEALTH POLICY BOARD, NATIONAL RURAL HEALTH ASSOCIATION, AND PRESIDENT AND CHIEF EXECUTIVE OFFICER, FLORIDA ASSOCIATION OF COMMUNITY HEALTH CENTERS; SHANNON MIDDLETON, DEPUTY DIRECTOR FOR HEALTH, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; AND ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS**

**STATEMENT OF ANDY BEHRMAN**

Mr. BEHRMAN. Mr. Chairman, distinguished Members of this Subcommittee, I am Andy Behrman, President of the Florida Association of Community Health Centers and the Chair of the National Rural Health Associations Rural Health Policy Board. I am also a veteran. And I have proudly served the United States Navy. I want to thank you for the opportunity to speak and testify on behalf of the National Rural Health Association and for my fellow veterans.

NRHA is a national, non-profit and non-partisan membership organization and our mission is to improve the health of rural Americans and to provide leadership on rural health issues. NRHA members have long maintained concern for the health and mental healthcare needs of rural veterans.

Since our Nation's founding, rural Americans have always answered the call when America has gone to war. And whether motivated by their values, patriotism, or economic concerns the picture has not changed much in 230 years. Simply put, rural Americans serve at rates higher than the proportion of the population. Though only 19 percent of the Nation lives in rural areas, 44 percent of our recruits are from rural America and nearly one-third of those who died in Iraq are from small towns and communities across the Nation.

There is a national misconception that all veterans have access to comprehensive care. This is simply not true. Access to the most basic primary care is often difficult, sometimes impossible, in rural America. Combat veterans returning to their rural homes in need of specialized care due to war injuries, both physical and mental, likely will find access to that care extremely limited.

What this means is that because there is a disproportionate number of rural Americans serving in the military, there is a disproportionate need for veterans care in rural areas. Additionally, we must all be mindful of long-term needs. And while NRHA is pleased that both the House and the Senate for fiscal 2008 budget calls for greater increases in VA medical care spending than in past years, long-term healthcare planning is critical. The wounded veteran who returns today won't need care for just the next few fiscal years, they will need care for the next half century.

To meet those long term needs, the NRHA respectfully makes the following recommendations to the Committee. One: Increase access by building on current successes. CBOCs opened the door for many veterans to obtain primary care services within their home community and outreach Health Centers help meet the needs of many rural veterans.

NRHA applauds these efforts and supports the expansion of these successful programs.

Two: Increase access by collaborating with non-VHA facilities. Many rural veterans cannot access VHA care simply because the facilities are too far away. Linking quality VA services with rural civilian services can vastly improve access to healthcare for rural veterans. As long as quality standards of care and evidence-based medicine guide treatment for rural veterans, the NRHA supports collaborative efforts with a number of organizations.

First, Federally Qualified Community Health Centers. Community Health Centers serve millions of rural Americans and provide high quality community-based primary care and preventative healthcare. And most importantly they are located where most rural veterans live.

A limited number of collaborations between the VHA and Community Health Centers already exist and have proven to be prudent cost effective solutions to serving veterans in rural areas. These successful models should be expanded to reach all of rural America.

Critical Access Hospitals. These facilities provide essential comprehensive services to rural communities. If these facilities were linked with VA services and model the quality, access to care would be greatly enhanced for thousands of rural veterans.

And Rural Health Clinics. These clinics serve populations in rural medically underserved areas. And in many rural and frontier communities these clinics are the only source of primary care available.

The third recommendation is to increase Traumatic Brain Injury care. Unfortunately it appears that traumatic brain injuries, TBI, will most likely become the signature wound of the Afghanistan and Iraqi wars. Such wounds require highly specialized care. The current VHA TBI Case Managers Network is vital, but has limited access for rural veterans. We need to expand this program.

Four: Target care and services to rural veterans. Rural veterans have an especially strong bond with their families. Returning veterans adjusting to disabilities and the stresses of combat need the security and support of their families in making their transition back into civilian life.

Vet Centers do a tremendous job in assisting veterans, but their resources are limited. The NRHA supports increases in funding for counseling services for veterans and their families. And more women today serve in active duty than any other time in our Nation's history. And unfortunately, more women are then wounded or are war casualties than ever before in our Nation's history.

We must target care for today's women veterans and culturally competent care to meet the unique needs of rural minority and female veterans.

And finally, Mr. Chairman, the NRHA calls on the Congress and the Veterans Administration to fully implement the functions of the newly created Office of Rural Veterans to develop and support ongoing mechanisms for study and articulate the needs of rural veterans and their families.

Mr. Chairman, thank you again for this opportunity. The National Rural Health Association looks forward to working with you

and this Committee to improve rural healthcare access for the millions of veterans who live in rural America. Thank you.

[The prepared statement of Mr. Behrman appears on p. 30.]

Mr. MICHAUD. Thank you very much, Mr. Behrman. Ms. Middleton?

#### STATEMENT OF SHANNON MIDDLETON

Ms. MIDDLETON. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present The American Legion's views on access to quality healthcare for veterans in rural communities.

Research conducted by the Department of Veterans Affairs indicated that veterans residing in rural areas are in poorer health than their urban counterparts. It was further reported that nationwide, one in five veterans who enrolled to receive VA healthcare lives in rural areas. Providing quality healthcare in a rural setting has been—has proven to be very challenging, given factors such as a limited availability of skilled care providers and inadequate access to care.

Even more challenging would be VA's ability—excuse me—to provide treatment and rehabilitation to rural veterans who suffer from the signature illness of the ongoing Global War on Terror—traumatic blast injuries and combat-related mental health conditions.

VA's efforts need to be especially focused on these issues. A vital element of VA's transformation in the 1990's was the creation of CBOCs, or Community-Based Outpatient Clinics, to move access closer to the veterans communities. A recent VA study noted that access to care might be a key factor in why rural veterans appear to be in poorer health.

CBOCs were designed to bring care closer to—I'm sorry. I already said that. Over the last several years VA has established hundreds of CBOCs throughout the system, and today there are over 700 that provide healthcare to the Nation's veterans.

CBOCs have been very successful, however, of concern to The American Legion is that many of the CBOCs are at or near capacity and many still do not provide adequate mental health services to veterans in need.

One of the recommendations of the Capital Assets Realignment for Enhanced Services or CARES was for more, not less, CBOCs across the Nation. The American Legion strongly supports this recommendation, especially those identified for rural areas. However, limited VA discretionary funding has limited the number of new CBOCs each fiscal year.

There is great difficulty serving veterans in rural areas. Veterans in States such as Nebraska, Iowa, North Dakota, South Dakota, Wyoming, and Montana face extremely long drives and a shortage of healthcare providers and also bad weather. The Veterans Integrated Service Networks or VISN, rely heavily upon CBOCs to close this gap.

The provision of mental health services in CBOCs is even more critical today with the ongoing war in Iraq and Afghanistan. It has been estimated that nearly 30 percent of the veterans who are returning from combat suffer from some type of mental stress. Fur-

ther, statistics show that mental health is one of the top three reasons our returning veterans seek VA healthcare.

The American Legion believes that VA needs to continue to emphasize to the facilities the importance of mental health services in CBOCs. And we urge the VA to ensure the adequate staffing of mental health providers in the CBOC setting.

CBOCs are not the only avenue with which VA can provide access to quality healthcare to rural veterans. Enhancing existing partnerships with communities and other Federal agencies such as the Indian Health Service will help to alleviate some of the barriers that exist, such as the high cost of contracting for care in the rural setting.

Coordinating services with Medicare or with other healthcare systems that are based in rural areas is another way to help provide quality care.

In the July 2006 report entitled, "Health Status of and Services for Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans After Traumatic Brain Injury Rehabilitation," the Department of Veterans Affairs Office of Inspector General examined the Veterans Health Administration's ability to meet the needs of OIF and OEF veterans who—sorry—who suffered from traumatic brain injury.

Fifty-two patients from around the country were interviewed at least 1 year after completing inpatient rehabilitation from a Lead Center. Some of them did reside in States with rural populations. Many of the obstacles for the TBI veterans and their families remain, they were very similar. Forty-eight percent of the patients indicated that there were resources in the community—there were few resources in the community for brain injury-related problems. Thirty-eight percent indicated that transportation was a major obstacle. And 17 percent indicated that they did not have money to pay for medical rehabilitation and injury related services.

Some of the challenges noted by family members who care for these veterans in rural settings include the necessity for complicated special arrangements and the absence of VA rehabilitative care in their communities. Case managers working at Lead Centers and several secondary centers noted a limited ability to follow patients after discharge to rural areas and lack of adequate transportation.

These limitations placed undue hardship on the veterans families as well. Those contributing to the report, as well as veterans who have contacted The American Legion, have shared many examples of the manner in which families have been devastated by caring for TBI injured veterans. They have sacrificed financially, they have lost jobs that provided the sole income for family and have endured extended separations from children.

Vet Centers are another important resource, especially for combat veterans experiencing readjustment issues who do not live in close proximity to a VA medical facility. Because Vet Centers are community-based and veterans are assessed the day they seek care, they receive timely care and are not subjected to wait lists. Some of the services provided include individual and group counseling, family and marital counseling, military sexual trauma counseling, and bereavement counseling.

Realizing the value of Vet Centers to those who may encounter obstacles when seeking mental healthcare in the VA Medical Centers, The American Legion decided to get a glimpse of services and needs of Vet Centers nationwide. The American Legion's 2007 System Worth Saving report will focus on Vet Centers as well as the polytrauma centers.

The American Legion's staff selected a sample of Vet Centers that were located near the demobilization sites throughout the country to ascertain the effects of the number of returning veterans on the services provided by the Center. The report will illustrate the types of veterans utilizing their respective Vet Centers as well as services requested by these veterans and outreach services offered.

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

And although access is a very important issue, The American Legion believes timeliness of access is just as critical. For example, VA establishes its own acceptable access standard for primary care at 30 days. But to most Americans with private healthcare plans, 30 days would not be acceptable. Unfortunately, the continued disparity between demands for services and available resources continues to cause delays in the delivery of healthcare.

The current Global War on Terror has placed many more demands on VA healthcare, the VA healthcare system to meet its obligations to the men and women of the armed forces, past, present, and future. As a grateful Nation welcomes with open arms the newest generation of wartime veterans, veterans of previous conflicts and the Cold War are being denied enrollment and, therefore, access to their healthcare delivery system of choice.

By 2003, former VA Secretary Anthony Principi decided the enrollment of any new priority veterans—sorry—decided to terminate the enrollment of any new priority veterans, therefore, prohibiting access to VA medical care to hundreds of thousands of Priority 8 veterans due primarily to limited resources.

The American Legion disagrees with the decision to deny access to any eligible veterans and many of these veterans are Medicare-eligible or have other third-party health insurance that can reimburse VA's reasonable charges for services rendered. Yet, little has been done to improve third-party reimbursements from private insurers and nothing has been done to allow VA to begin receiving third-party reimbursements from the Nation's largest healthcare insurer; the Centers for Medicare and Medicaid Services.

The restriction of enrollment for Priority 8 veterans creates another "access gap" for recently separated veterans who did not serve in the combat setting. Some recently separated veterans must wait until their VA disabilities claims are approved in order to enroll. For others, unless they are economically indigent, they are prohibited from enrolling. Those recently separated veterans that successfully transition may very well never be eligible for enrollment in the Nation's best healthcare system.

None of these situations are very welcoming messages to the men and women currently serving in the Nation's armed forces

Mr. MICHAUD. Could you quickly summarize? I notice your time is running out.

Ms. MIDDLETON. Yes, sir.

Mr. MICHAUD. Or ran out, I should say.

Ms. MIDDLETON. Okay. Thank you, Mr. Chairman, for giving The American Legion the opportunity to present views on such important issues.

This hearing was very timely and we look forward to working with the Subcommittee to bring an end to the disparities that exist in access to quality care in rural areas. Thank you.

[The prepared statement of Ms. Middleton appears on p. 34.]

Mr. MICHAUD. Thank you very much for that excellent testimony. Mr. Atizado?

#### **STATEMENT OF ADRIAN M. ATIZADO**

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to provide testimony on behalf of the Disabled American Veterans and the Independent Budget Veterans Service Organizations regarding the issue before us today, access to VA medical care particularly on access to care in rural areas.

We would like to thank Congress, the hard work of and commitment of this Subcommittee and the Full Committee in having provided VA additional funding in the previous two fiscal years. But we do remain concerned about access to VA speciality care as well as to care in rural areas.

We are especially concerned about how VA plans to address rural veterans needs in the coming years, given that about 44 percent of all veterans returning from Operations Enduring and Iraqi Freedom reside in rural communities. After having served their country, these veterans should not have to be neglected for their healthcare needs simply because they live in rural or remote areas.

Provisions in Public Law 109-461 represents the most significant advances to date to address the healthcare needs of rural veterans and the needs of returning OIF/OEF veterans. Notably, however, the final legislative language failed to include a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from outside the Department.

We hope that Congress will reconsider this mandate and we do urge the Secretary to use existing authority to establish such a Committee as well as to include representatives from our organizations as part of it's membership. And although we acknowledge benefits of the Public Law, it also raises concerns about unintended consequences it may have on the VA Healthcare System regarding the use of VA purchased medical care.

We believe this tool should be used judiciously so as not to endanger VA's full range of specialized services. Putting additional budget pressure on the specialized system of services without making specific appropriations available for new rural VA Healthcare Programs could only exacerbate problems.

This new legislation also holds the VA accountable for improving rural veterans access to care, by requiring the development and implementation of a plan using CBOCs and other access points. The

Capital Assets Realignment for Enhanced Services process, known as the CARES, includes a May 2004 decision by the Secretary which identifies 156 priority CBOCs to address outpatient care. Furthermore, as part of the CARES Initiative the VA employed Medicare's Critical Access Hospital model as the guide to establish a new VA policy to govern many of VA's rural and remote facilities now designated as Veterans Rural Access Hospitals in addressing rural acute inpatient care.

We note that VA receives no appropriations dedicated to support the establishment of rural CBOCs or Veterans Rural Access Hospitals. And thus VA must manage any additional expenses from within generally available medical services appropriations. We, therefore, urge Congress to include specific funding in fiscal year 2008 to address at least some of these needs in rural areas and to avoid the scavenging of resources.

In addition to the lack of resources to meet the healthcare needs of rural veterans, health worker shortages and recruitment and retention of healthcare personnel remains a key challenge to rural veterans access to care as well as quality of that care. The 2005 IOM report titled, "The Future of Rural Health," recommended that the Federal Government renew its efforts to enhance the supply of healthcare professionals working in rural areas.

To this end, we believe VA's academic affiliation as well as health professions education programs possess special attributes that could be brought to bear in improving the situation in VA facilities as well as in the private sector.

Another often overlooked component of improving veterans access to medical care is VA's beneficiary travel program. As you are aware, sir, the mileage reimbursement rate of 11 cents a mile has not been changed in almost 30 years, even though Congress has delegated authority to the Secretary to make rate changes when warranted. DAV and several other service organizations have a long-standing resolution to reinstate the effectiveness of the travel program. We support legislation that has been introduced in Congress and we urge approval and enactment of this legislation this year.

Given the cost of transportation in 2007, including record-setting gasoline prices and reimbursement rates unchanged since 1977, pales in comparison to the actual cost of travel.

Mr. Chairman, thank you for the opportunity to provide testimony on these very important issues which relate to access to VA healthcare services. In the Independent Budget for fiscal year 2008, our organizations have made a number of recommendations in this document to Congress as well as VA that are relevant to the issues discussed today.

We do invite you to review these recommendations. And as always, I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado appears on p. 37.]

Mr. MICHAUD. Thank you very much. And once again, I want to thank the entire panel for your testimony. It has been very helpful.

A quick question for the DAV. You heard from Mr. Behrman of the National Rural Health Association. In his testimony he talked about building upon the successes that VA has had with approaching rural healthcare by collaboration, whether it is with the Feder-

ally Qualified Healthcare Clinics, Critical Access Healthcare Clinics. And I heard your testimony saying you didn't really disagree with that, but you said it should be used judiciously.

How do you determine judiciously? Because one of my concerns is the fact that if you are a veteran in a rural area, and I can state this from DAV members in Maine, where some were pleased with what the VA did, some disapproved with what VA did as far as the clinic in Lincoln.

How do you determine judiciously, and how far should the VA deal with contracting for services, particularly in rural areas?

Mr. ATIZADO. Mr. Chairman, as part of my written testimony, we do outline current authority with regards to the use of contract care as well as fee-based care. Just on the outright I would like to clarify that we are not opposed to the judicial use of collaboration. We are opposed—we are advocating for judicial use of the purchased care.

As far as a current criteria that VA has to use or is required to use for contract care, as well as fee-based care, we think that those criteria set out specifically to protect VA's core services. The reason why purchased care can become dangerous is because it is considered an open access point. In other words, if VA will agree to pay for services at a local facility or a private facility, that is an access point that can be challenging with regards to quality of care, and also with making sure that the veterans come into the VA system for tertiary or specialty care.

It is very important that when these tools are used to make sure that not only the quality but the continuum of care that VA is known to provide remain intact.

Mr. MICHAUD. Okay. I would ask Ms. Middleton to answer that same question. And I would also ask Mr. Behrman afterward.

Ms. MIDDLETON. Sir, your question was how do you determine what is judicial?

Mr. MICHAUD. I can understand the VSOs concerns with contracting out services because one of the concerns is that they don't want the VA to become an insurance agency—

Ms. MIDDLETON. Yes.

Mr. MICHAUD [continuing]. Which I agree with. However, at the same time, my concern is veterans being able to access that care. Good quality care is important, but you need to have access to that quality care.

How does The American Legion feel about the remarks that you heard this afternoon from the National Rural Health Association as far as utilizing critical access, hospitals and rural healthcare clinics? What is The American Legion's reaction to that?

Ms. MIDDLETON. Well, as you said, we also feel that the VA should not be an insurance agency just, you know, handing out money. But we definitely believe that veterans who require care, especially if they are in rural areas, they should be provided that care. If it is not available through the VA then, what is near them is best.

We have been in contact with a few veterans who have actually had very traumatic injuries and there was no care near them and their families. As I said in my testimony, they have gone through

hardship just trying to get this care. But if it was local then it wouldn't be such a hardship on the family.

So only when necessary. And if it is not necessary, the VA can provide it, that is one thing. But if the veteran is going to experience a hardship especially if he is not able to physically take the travel, then it would be necessary and we believe that that is the best way.

Mr. MICHAUD. Okay. Mr. Behrman, how do you think the VA can move forward with the recommendations that you mentioned while at the same time address some of the concerns that we hear from some of the VSOs?

Mr. BEHRMAN. Thank you, Mr. Chairman. Well, first I think we have established that there is a hardship already. That is part of the reason that we are having these hearings. Excuse me.

But the reality is, first it has got to be about the patient, what the patient's needs are, where are they going to get their service. That would be the first thing. And I am sure the VA looks at that as the most important criteria first.

Secondly, there needs to be a little bit more understanding of what these organizations are about and what they do. When we mentioned quality of care, this is a critical component of Federally Qualified Health Centers and Critical Access Hospitals. Most of the Community Health Centers in this country are JCAHO accredited.

So quality of care is a important issue that has to be reviewed. Certainly the VA would be looking at an organizational structure that would have to have at least the quality of care that is being provided at a VA institution.

The second thing about this, in particular, when it relates to Rural Health Clinics and Community Health Centers, is that primary care is what they do. This is what they are about. A continuum of care needs to be considered where you can take certain pieces and this may be the judiciary part that we are talking about. Where it makes sense to provide primary care in a medical home in a community where the veteran lives, they will be comfortable. They know the individuals in a lot of these small towns who are providing the services, the healthcare services.

So there may not be the necessity to travel 150 or 200 miles to get primary basic care, comprehensive care. And preventative care as well. A lot of the mental health issues, alcoholism, substance abuse, all of these things come into play. Community Health Centers have to have these services available to them.

I agree that a judicious review of how services would be purchased is important. Nobody wants to double pay for things. Certainly we don't want to do that. But we also don't want to make—we also want to make sure that there is care available, quality care available and these access points that I would think could be worked through some process so that the VA—I mean these organizations could figure out who does what so we don't duplicate services.

Mr. MICHAUD. Thank you very much. Mr. Salazar?

Mr. SALAZAR. Well, thank you, Mr. Chairman. Just a brief question to Ms. Middleton. In your written testimony under inpatient bed requirements you state that the, "VA continues to ignore the Federal mandate for inpatient care, especially in the areas of long-

term. The American Legion believes that the VA is focused on shifting long-term care from VA to State Veterans Homes and private nursing home industry.”

Could you expand on that, please?

Ms. MIDDLETON. That is in reference to the number of beds that have been established as mandatory under law. And at this moment I don't have the number, but I know that each year the number has been below that has been—has been available has been below that number.

I mean it comes up in our testimony every year. But—

Mr. SALAZAR. Was this—

Ms. MIDDLETON [continuing]. This side—

Mr. SALAZAR. Was this an issue of basically funding? Maybe the VA can actually respond to that.

Ms. MIDDLETON. I am not sure if it is an issue of funding, but I do know that each year the number of beds that are mandated by law have not been available. And by doing this that is—by not having them available that is how the long-term care has been shifted to the State Veterans Home, because it is not they are not available—the number of beds are not available.

Mr. SALAZAR. Okay. Thank you. Mr. Atizado, is that the way you pronounce the name, Mr. Michaud?

[Laughter.]

I have messed it up so.

Mr. MICHAUD. You can pronounce it any way you want to. It is probably easier just to call him Adrian.

Mr. SALAZAR. Okay. Adrian, well the only question I have for you is that you mentioned the issue of providing healthcare for veterans and I guess there is a mechanism already in place for remote rural areas where a veteran can go to local hospitals or primary healthcare physicians, right?

Doesn't it make more sense to you to look at the economy or the numbers and try to figure out the economies scale to where maybe it will save the VA money by providing these services where there are already local hospitals or local doctors?

Mr. ATIZADO. Well let me first be clear. We are not opposing the use of VA to purchase care. What we are concerned about is the amount that may end up being used to care for rural veterans.

With regard to—let me give an example. With regard to contract care, generally it is a very good program on the outset for VA. But what we have seen is that the out years after the first 2, 3, 4 years of the contract it becomes a much higher dollar amount for that contract. So the out years become very, very much out of control for VA financially. For fee-based care, as mentioned earlier, it is much like TRICARE where these payments are really at a reduced rate. So it becomes disadvantageous for a physician, not only in an urban area, but more so in a rural area where the cost of care can be that much higher. Hence, the Critical Access Hospital model that Medicare uses, which is a cost-based reimbursement, that actually provides higher than normal Medicare reimbursement rates simply because to have that kind of a facility and that kind of medical care out in the rural community does cost more.

In other words, our concern is these tools may be used to the point where they lose control such that core services at the facility

may be in danger. And that is what we don't want to happen. We want to make sure that if they do use this that it is with a thought of making sure that other services that they provide are protected.

Thank you.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Mr. Chairman, in the interest of time, I know we have votes. If it would be okay with you, Mr. Behrman, I have three questions but if I could submit them to you and maybe have you get them back to me regarding rural healthcare and access to healthcare for Vets if that would be okay I would appreciate that.

Mr. BEHRMAN. Yes, sir.

Mr. HARE. Thank you very much. I yield back.

Mr. MICHAUD. Thank you, Mr. Hare. I would like to thank the panel once again. We will follow up with additional questions.

I would like to ask the last panel to come up. Dr. Gerald Cross who is Acting Principal Deputy Under Secretary for Health. He is being accompanied by Dr. Robert Petzel, Dr. Adam Darkins, and Patricia Vandenberg.

Yeah. And Dr. Cross if you could try to summarize your remarks, we will try to move this along quickly, hopefully before the votes.

**STATEMENT OF GERALD M. CROSS, M.D., FAAFP, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA VANDENBERG, MHA, BS, ASSISTANT DEPUTY UNDER SECRETARY FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ROBERT A. PETZEL, M.D., DIRECTOR, VA MIDWEST HEALTHCARE NETWORK, VETERANS INTEGRATED SERVICES NETWORK 23, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND ADAM DARKINS, M.D., MPH, FRCS, CHIEF CONSULTANT, OFFICE OF CARE COORDINATION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Dr. CROSS. Good afternoon, Mr. Chairman and Members of the Subcommittee. And thank you for the opportunity to discuss our ongoing efforts to provide safe, effective, efficient, and compassionate healthcare to veterans residing in rural areas.

And I am accompanied today by Patricia Vandenberg, VHA's Assistant Deputy Under Secretary for Policy and Planning; Dr. Adam Darkins, VHA's Chief Consultant for Care Coordination. And you can read into that telehealth—telemental health. And I am especially pleased to have Dr. Robert Petzel of VHA's Network Director for VISN 23.

And I should say that by profession as was brought up earlier, I am a Board Certified Family Physician. Grew up in a rural environment on a farm. Did home visits by training. And I am a veteran as well.

My remarks will briefly review the national challenge presented by rural healthcare and VHA's strategic direction in the initiatives that we have underway. Among the entire enrolled VA population almost 39 percent were classified as rural at the end of FY 2006.

And among the entire enrolled VA population a little bit less than 2 percent, about 1.6 percent were classified as highly rural.

Researchers have studied this population and a number of articles have looked at the VA care in the rural environment as well. First, studies have found that veterans living in rural areas tend to be slightly older, have lower income, and these same veterans will also be less likely to be employed. The studies agree that rural veterans had slightly more physical health problems, but fewer mental health problems as compared to suburban and urban veterans.

VHA's strategic direction is to enhance non-institutional care with less dependence on large institutions. Instead we are providing more care at home and in the community. VHA now has 717 Community-Based Outpatient Clinics or CBOCs. Of this total, 320 or 45 percent of these are located in rural or highly rural areas. But we have done much more than that. We created the Consolidated Mail Out Patient Pharmacies, CMOPPs so that medications are delivered to the patients home instead of having the patient travel to the hospital.

We provide home-based primary care where the folks go to the patients home directly. Devoting more than \$175 million in this program in FY 2008 and more than \$95 million for other home-based programs, we are using telemedicine and telemental health to reach into the veterans homes and into community clinics. This allows us to evaluate and follow patients without them having to travel to large medical centers.

We are far along with our Mental Health Enhancement Initiative that will add resources and greater mental health expertise in primary care clinics. We are also using special Internet sites to provide information to veterans in their home including the ability to refill prescriptions from home. Here is a key point as to how we are doing: At the end of FY 2006, 92.5 percent of the 5.4 million patients enrolled were within 60 minutes of VA Healthcare Facilities, and 98.5—98.5 percent were within 90 minutes.

And among those who live outside the 60-minute range, some veterans are in highly rural areas living in tribal areas and so forth. A study on veterans satisfaction, and this is another result, in 2006 compared rural versus urban veterans finding that rural patients in the VA system were actually more satisfied with their care than their urban counterparts.

And here is one more result: We looked at the quality of care comparing rural versus urban clinics. We looked at 40 standard measures of quality, they were virtually identical across the range. Rural versus urban.

To continue this strategic support for access in rural healthcare, we have approved 24 CBOCs in 2007. Forty-three percent of these CBOCs are in highly rural areas. And I am pleased to share with Congressman Salazar that the Secretary advised me today of the approval of the Colorado Outreach Clinic.

In addition to these clinics, the VA is implementing more care coordination home telehealth in rural areas. And since January of 2004, we have trained over 3,500 staff to provide this telehealth-care.

Our Vet Centers support our veterans including rural veterans. Vet Centers provide quality readjustment counseling and remove unnecessary barriers to the care for veterans and their family members. And they engage in remarkable community outreach to the veteran community and to other aspects of the community as well. And we are continuing to expand our Vet Centers.

By the way, the Vet Centers also maintain nontraditional hours to accommodate veterans traveling in from greater distances. And in accordance with Public Law 109-461, we continue to develop our Office of Rural Health within our Office of Policy and Planning.

VHA recognizes the importance and the challenge of service to our rural areas. And we believe our current and planned efforts are addressing these concerns.

Mr. Chairman, thank you.

[The prepared statement of Dr. Cross appears on p. 41.]

Mr. MICHAUD. Thank you very much. Mr. Salazar do you have any questions?

[No response.]

Okay. I have several questions, Dr. Cross, but unfortunately we have to vote and looking at all the votes we have we will be tied up over there for probably well over an hour or so. And I don't want to hold the panel here.

So we will submit our questions in writing and hopefully you will be able to respond in a timely manner so we can move forward. But I want to thank you for your time this afternoon along with the other panels for your efforts as we move forward on rural access to healthcare for our veterans. We have to do better and I know the VA is intending to do better. Hopefully with the new budget that was just passed we will be able to improve access for our veterans.

So, once again, I would like to thank this panel. Are there any other questions? Mr. Salazar.

Mr. SALAZAR. I just wanted to thank the Secretary for his continued diligence on trying to provide access to rural healthcare. So if you would convey that to him, I would appreciate that.

Dr. CROSS. I will certainly do that, sir. Thank you.

Mr. SALAZAR. Thank you. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. With no further questions, this hearing is adjourned.

[Whereupon, at 3:50 p.m., the Subcommittee was adjourned.]

## A P P E N D I X

### **Statement of Hon. Michael H. Michaud Chairman, Subcommittee on Health**

The Subcommittee on Health will come to order. I would like to thank everyone for coming today.

The issue of providing rural healthcare is one that affects each of our States and in very different ways. In California, rural communities make up 92 percent of the landmass, and 8 percent of the population. In my own State of Maine, over 40 percent of the population lives in rural areas.

It is estimated that 60 million Americans, one in five, live in areas that have been classified as rural. Rural communities tend to be older than urban populations, and they tend to exhibit poorer health behaviors. Economic factors also add to the challenges facing rural populations.

Rural veterans make up 41 percent of VA's patient workload. Access and resources present serious challenges to providing high quality healthcare for these veterans.

VA care can be second to none. Unfortunately the quality of care is not always the same throughout the VA system, and for many veterans living in rural States like Maine, accessing that care is a significant challenge.

For certain more complex procedures, veterans in northern Maine must endure 4 days of travel to and from VA facilities in Boston to receive care. Addressing the distance to care and the travel burden in rural areas is extremely important.

However, given the smaller population and infrequency of certain complex procedures, it does not make sense for VA to maintain a daily "in-house" capacity in every facility for something that is used on an infrequent basis.

This problem is not unique to VA. It is a problem facing many rural areas across the country where smaller patient populations limit the resources available to rural hospitals which in turn limits the services that hospitals can support and provide.

Rural areas face difficulties in providing what have been termed "core healthcare services" by the Institutes of Medicine. These services include primary care in the community, emergency medical services, hospital care, long-term care, mental health and substance abuse services, oral healthcare, and public health services.

For a variety of reasons, rural areas also face a greater problem recruiting and retaining healthcare professionals.

These problems must be addressed because the demand for services from our veterans population in rural areas is only going to increase.

We have an aging population that will need long term care.

Over 40 percent of the new generation of veterans returning from Afghanistan and Iraq are from rural areas. They have their own unique needs, including loss of limb, traumatic brain injury and mental health concerns.

One important approach to providing access to care is the VA's system of Community-Based Outpatient Clinics, which currently number more than 650.

We have five CBOCs in Maine. The CARES Commission recommended a sixth in the Lewiston-Auburn area along with five part-time health access points. Only one of these facilities is close to opening while the CBOC is not expected to open until 2008 at the earliest.

During the CARES process, 250 CBOCs were identified by the VA as being needed, of which 156 were designated as "priority." Since the CARES decision, VA has opened 12 of the 156, less than 8 percent. At that pace it will take VA over 30 years to open all the priority clinics.

VA has also opened 18 clinics not on the CARES priority list, which calls into question the decision process and the ability of the CARES to assist in decisions in the future.

The VA has also designated facilities as "Veterans Rural Access Hospitals," designed to provide inpatient services to veterans in rural areas where these services can be supported.

The VA has taken great strides in exploring the uses of telemedicine and other technological means of providing healthcare services. I would like to hear how these efforts are improving care and how we can help.

One of the problems in the area of recruitment and retention is the separation from other healthcare professionals often felt by those working in rural communities. I would like to explore how technology might be used to overcome this feeling of isolation and thus improve recruitment and retention.

The questions I would like to start to answer today are: Is the VA, and really are our rural communities, ready to meet the increased and changing needs of our veterans and their families? What is the VA in rural America going to look like in the future?

And we must keep in mind that VA healthcare does not operate in a vacuum, but is an integral part of our national health system.

I would also very much like to know when the priority CBOCs are going to be built or if VA no longer intends to follow CARES.

Today, the Subcommittee hearing will provide us with the opportunity to begin this exploration, to begin to examine issues concerning access, the provision of care, and the proper expectations of veterans in rural areas regarding the care they can expect from the VA.

---

**Statement of Marcia Brand, Ph.D., Associate Administrator  
Rural Health Policy, Health Resources and Services Administration  
U.S. Department of Health and Human Services**

Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to meet with you today on behalf of Dr. Elizabeth Duke, Administrator of the Health Resources and Services Administration (HRSA), to discuss rural access issues as they affect the Nation and what is being done to meet the healthcare needs of the rural populations in this country. We appreciate your interest and support of rural healthcare and access to care for rural veterans.

The Health Resources and Services Administration (HRSA) is the primary Federal agency for improving access to healthcare services for people who are uninsured, isolated or medically vulnerable. HRSA grantees provide healthcare to uninsured people, people living with HIV/AIDS, and pregnant women, mothers and children. They train health professionals and improve systems of care in rural communities. For HRSA, the Health Center Program, the National Health Service Corps and rural healthcare needs are priorities.

The Health Center Program, a major component of America's healthcare safety net for the Nation's indigent populations for more than 40 years, is leading the Presidential initiative to increase healthcare access in the Nation's most needy communities. Health Centers provide regular access to high quality, family oriented, comprehensive primary and preventative healthcare, regardless of ability to pay, and improve the health status of underserved populations living in inner cities and rural areas.

President Bush's initiative to expand the Health Centers, begun in FY 2002, will significantly affect over 1,200 communities through the support of new or expanded access points. In FY 2001, HRSA funded 3,317 Health Center sites across the Nation. After distributing 514 New Access Point grants over the past few years, that count had grown to 3,831 sites by the end of 2006. We expect the number of Health Center sites to grow to 4,053 by the end of FY 2008. Just over half of all Health Center grantees serve rural populations.

Besides the 514 new access points, HRSA has also distributed 385 grants to expand the medical capacity of existing service delivery sites; and another 340 grants to existing grantee organizations to add or expand oral health, mental health and substance abuse services. Through these efforts the number of patients treated annually at Health Centers has grown from 10.3 million in 2001 to 14.1 million in 2005, a 37 percent increase. Of those 14.1 million patients, 5.6 million were uninsured, 1.6 million more than were served in 2001 (a 40 percent increase). We anticipate that Health Centers will serve an estimated 16.3 million patients by the end of 2008.

The National Health Service Corps (NHSC) is committed to improving the health of the Nation's underserved by uniting communities in need with caring health professionals and supporting communities' efforts to build better systems of care. The NHSC provides comprehensive, team-based healthcare that bridges geographic, financial, cultural, and language barriers.

Health Centers need committed staff and the National Health Service Corps plays an important role in the Health Center expansion. Currently more than half of the NHSC's doctors, dentists, nurses and mental and behavioral and other healthcare professionals serve in Health Centers around the Nation. Some 60 percent of all NHSC clinicians—about 2,700 healthcare professionals—currently work in rural areas.

HRSA's Office of Rural Health Policy (ORHP) is charged with informing and advising the Department of Health and Human Services on matters affecting rural hospitals and healthcare, coordinating activities within the Department that relate to rural healthcare, and maintaining a national information clearinghouse. HRSA, through ORHP, is the leading Federal proponent for better healthcare services for the 55 million people that live in rural America.

ORHP specifically promotes State and local empowerment to meet rural health needs in several ways: by supporting State Offices of Rural Health, by encouraging the formation of State Rural Health Associations, and by working with a variety of State agencies to improve rural health. Through our Medicare Rural Flexibility (Flex) Grant Program, funding is provided to State governments to strengthen rural health. The Small Rural Hospital Improvement Program (SHIP) provides funding to small rural hospitals through the States to help them pay for costs related to the implementation of the Prospective Payment System, comply with provisions of HIPAA and reduce medical errors and support quality improvement. The State Office of Rural Health Grants are designed so the States can help their individual rural communities build healthcare delivery systems by collecting and disseminating information, providing technical assistance, helping to coordinate rural health interests Statewide and by supporting efforts to improve recruitment and retention of health professionals.

Additionally, the Rural Healthcare Services Outreach Grant Program increases access to primary healthcare services for rural Americans. The Rural Health Network Development Grant Program helps rural health providers develop community-based, integrated systems of care. Grants support rural providers for up to 3 years who work together in formal networks, alliances, coalitions, or partnerships to integrate administrative, clinical, financial, and technological functions across their organizations. The Network Development Planning Grant Program provides 1 year of funding to rural communities that seek to develop a formal integrated healthcare network and that do not have a significant history of collaboration. We also support grants to the eight States in the Mississippi Delta for network and rural health infrastructure development and a cooperative agreement supporting targeted activities focusing on frontier extended stay clinics. The Small Healthcare Provider Quality Improvement Grant Program (SHCPQI) is designed to assist rural providers with the implementation of quality improvement strategies, while improving patient care and chronic disease outcomes. The Rural Access to Emergency Devices (RAED) Grant Program provides funding to rural communities to purchase automated external defibrillators (AEDs) and provide training in their use and maintenance. As you can see, HRSA administers a range of programs that serve rural communities.

HRSA also provides support staff to the Department's cross-cutting rural efforts. The HHS Rural Task Force is made up of representatives from each of the HHS agencies and staff offices and meets quarterly to discuss HHS programs and policies that affect the provision of healthcare and human services for rural Americans. Another cross-cutting rural effort supported by HRSA is the National Advisory Committee on Rural Health and Human Services (NAC). The NAC is a 21-member citizens' panel of nationally recognized experts that provide recommendations on rural health and human services issues to the Secretary.

Effective, coordinated healthcare improves the health and well-being of Americans, regardless of where they live. However, effective coordination is especially critical in rural communities, where services and providers are limited and resources are scarce. The challenges of providing healthcare for rural communities are compounded by higher rates of poverty and lack of insurance. Rural people are a little older and they have higher rates of chronic disease. There are significant transportation barriers. To provide for their needs, there are about 2,000 hospitals, nearly 1,500 of these with less than 50 beds. There are 3,500 Rural Health Clinics. These facilities are located in rural areas and are authorized for special Medicare and Medicaid payments. And there are nearly 2,000 Federally Qualified Health Centers which includes approximately 1,000 health center grantees. Fifty-two percent of these some 1,000 centers are located in rural areas.

HRSA takes great pride in the work we do in providing better healthcare services for the rural population. However, we are humbled by the significant challenges that remain for healthcare in rural areas and to the underserved.

We are pleased that the Department of Veterans Affairs is establishing an Office of Rural Health to assist the Under Secretary for Health in addressing issues affecting veterans living in rural areas. We have contacted the individuals who are creating this Office and their charge sounds familiar. With 20 years experience, we have some expertise regarding research and policymaking in this area. We look forward to collaborating with the new Office and offer our assistance.

I would be happy to answer any questions at this time.

---

**Statement of Andy Behrman, Chair, Rural Health Policy Board  
National Rural Health Association, and President and  
Chief Executive Officer, Florida Association of Community Health Centers**

The NRHA is a national nonprofit, nonpartisan, membership organization with approximately 12,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

I am Andy Behrman, President and Chief Executive Officer of the Florida Association of Community Health Centers, and the chair of the NRHA Rural Health Policy Board. I am also a veteran of the United States Navy. On behalf of the Association, I appreciate the opportunity to testify before this Committee.

The members of the National Rural Health Association have maintained a special concern for the health and mental healthcare needs of rural veterans for many years. The NRHA was one of the first non-veteran service organizations to develop a policy statement on rural veterans and this policy work is evidence of our members' concern for rural veterans.

My testimony discusses current VA successes in providing quality care for rural veterans, and suggestions for further improvements in quality of care. NRHA respectfully requests that the Committee give consideration to the following steps that would improve quality and access to care for rural veterans:

1. Increase the numbers of Veteran Centers, Outreach Health Centers, and Community-Based Outreach Centers (CBOCs) in rural areas.
2. Increase healthcare access points for rural veterans by building upon current successes of both VA service approaches and existing rural health approaches. Fully implement the contracting of services from the VA to Federally Qualified Health Centers (FQHCs) in rural areas. Develop approaches to link VA services and quality to existing rural health providers willing to provide care to rural veterans that follow standards of care and evidence-based medicine, including Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and mental health providers.
3. Increase the number of Veterans Hospital Administration Traumatic Brain Injury Case Managers in predominately rural States.
4. Use the high quality VA system to provide targeted and culturally competent care to rural, minority, and female veterans and train future rural health providers in these rural VA facilities.
5. Fully implement the functions of the newly created Office of Rural Veterans and establish a national advisory committee on rural veterans.

The following is additional background information and discussion of our recommendations.

**Overview**

Since the founding of our country, rural Americans have always responded when our Nation has gone to war. Whether motivated by their values, patriotism, and/or economic concerns, the picture has not changed much in 230 years. Rural individuals—along with American Indians, urban African Americans and Hispanics—serve at rates higher than their proportion of the population. Though only 19% of the Nation lives in rural America, 44% of U.S. Military recruits come from rural areas and nearly one-third of those who died in Iraq are from small towns and communities across the Nation.<sup>1</sup>

Where in rural America are veterans from? According to the most recent census, rural and non-metropolitan counties reported the highest concentration of veterans

---

<sup>1</sup>“Iraq War Takes Uneven Toll at Home,” April 3, 2004: NPR All Things Considered.

in the civilian populations aged 18 and over.<sup>2,3</sup> The proportion of veterans living in rural areas in 18 States is higher than the national average of 12.7 percent. These high-concentration States span the country, and include such geographically varied States as Montana (16.2%), Nevada (16.1%), Wyoming (16%), Maine (15.9%), West Virginia (14.4%), Arkansas (14.2%), South Carolina (14.2%), and Colorado (14.1%).<sup>4</sup>

The disproportionate number of rural Americans serving in the military has created a disproportionate need for veteran's care in rural areas and yet rural areas are less likely to have VA services available to them.<sup>5</sup> More than 22,000 soldiers have been wounded in Iraq. For those wounded veterans returning to their rural homes across the country, access to the specialized services they will need may be limited. Often access to the most basic of primary care is more difficult in rural America. Combat soldiers who need specialized care to assist with their readjustment to civilian life or adaptation to living with war injuries (both physical and mental) will likely find access to that care extremely limited.<sup>6</sup>

It is also important to note that both differences and disparities exist in the health status of rural and urban veterans. The Veterans Administration's Health Services and Outreach Network has reported that rural veterans "have worse physical and mental health" than their urban counterparts and concluded that "policy-makers should anticipate greater healthcare demand from rural populations. . . ."<sup>7</sup>

There is a national misconception that all veterans have access to comprehensive care because they are served by the Veterans Administration.<sup>8</sup> While this may be true for many veterans, it is not true for many small town veterans, rural veterans or those veterans who choose to be isolated due to the complicated symptoms of Post-Traumatic Stress Disorder.<sup>9</sup> The Veterans Hospital Administration (VHA) provided care to 4.5 million of the 7.2 million enrolled veterans in fiscal year 2003. While the quality of VHA care is equivalent to, or better than, care in other systems,<sup>10</sup> it often is not accessible to many rural and frontier veterans.

While the NRHA is pleased that both the House and Senate FY 2008 budgets call for greater increases in VA medical care spending than in past years, we all must be mindful that appropriations for the last decade have not kept up with the cost of maintaining current services.<sup>11</sup> Policymakers must not only make up for past funding deficits, they must appropriately plan for long-term funding—because the wounded soldiers who return today won't need care for just the next few fiscal years, they will need care for the next half century.<sup>12</sup>

## NRHA RECOMMENDATIONS

### 1. Increase Healthcare Access Points for Rural Veterans to Build on Current Successes

NRHA recognizes and appreciates the successes of veteran centers and healthcare outreach centers in meeting the needs of rural veterans. We should seize the opportunity to build upon this success and further improve quality of and access to care.

Community-Based Outreach Centers (CBOCs) open the door for many veterans to obtain primary care services within their home community. While outcomes research on CBOCs is mixed, some findings suggest that CBOCs have been successful in improving geographic access, an important objective of expanding community-

<sup>2</sup>"Veterans: 2000 Census Brief," p. 7.

<sup>3</sup><http://factfinder.census.gov/servlet/SAFFP>.

<sup>4</sup>"Veterans: 2000 Census Brief," p. 5.

<sup>5</sup>Veterans Health Administration, April 2000, "A Report By The Planning Systems Support Group, A Field Unit of the Veterans Health Administration Office of Policy and Planning—Geographic Access to Veterans Health Administration (VHA) Services in Fiscal Year 2000: A National and Network Perspective.

<sup>6</sup>Alvarez, L. and Lehen, A., "3,000th Fatality in Iraq, Countless Tears at Home." (New York Times, January 2, 2007) Miller, Laura J., June 2001, "Improving Access to Care in the VA Health System: A Progress Report," Forum, A publication of the Veterans Administration Office of Research & Development.

<sup>7</sup>Demakis, J.G., Jan. 2000, "Rural Health-Improving Access to Improve Outcomes," Management Brief Health Services Research & Development Service, No. 13: 1-3.

<sup>8</sup>Weeks, WB., et al. March 2004. Differences in Health Status in Rural and Urban Veterans. Presented to the 22nd National Meeting of HSR&D. Washington, D.C.

<sup>9</sup>Sorenson, G., "Hinterlands are home, not a hideaway, for Vietnam veterans," Vet Center Voice, Vol. VI, No. 9, October 1985, p. 1.

<sup>10</sup>The Independent Budget for 2005: Medical Care. Veterans Service Organizations. <http://www.pva.org/independentbudget/index.htm>.

<sup>11</sup>The Independent Budget for 2005: Medical Care. p. 44.

<sup>12</sup>The Independent Budget for 2005: Medical Care. p. 45.

based care to veterans.”<sup>13</sup> The VHA has improved procedures for planning and activating CBOCs and established consistent criteria and standard expectations for the over 450 CBOCs created since 1995.<sup>14</sup> CBOCs have also been successful in some States, such as West Virginia; however, Directive 2001–06 made this solution less available to more rural and remote veterans and other rural providers by raising the ceiling on the number of priority users in a given area. Outreach Health Centers provide an appropriate model to deal with the loss of CBOC eligibility to smaller and more remote rural areas, and their expansion should be considered. Furthermore, outreach efforts with rural veterans that focus on benefit education and psycho-social education of veterans and their family members can increase the effectiveness of services currently available through the VA system.

## **2. Increase Healthcare Access Points for Rural Veterans to Expand Access**

Time and distance prevent many rural veterans from getting their healthcare benefits through a VHA facility. There are approaches readily available in the VA system and in the rural health landscape that could improve this situation. These approaches include Vet Centers, Outreach Health Centers, and CBOCs, as mentioned above, as well as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs), and mental health providers. Policy regarding services to rural veterans needs to provide access through a variety of existing rural health facilities and access points because not all rural communities have access to all types of facilities. Quality through consistent applications of standards of care and evidence-based medicine, however, must guide all approaches to care for rural veterans.

Federally Qualified Community Health Centers (CHCs) serve millions of rural Americans, but most veterans cannot use their VA health benefits to receive care at these CHCs. These centers provide community oriented, primary and preventive healthcare and are located where rural veterans live. Congress has passed legislation encouraging collaborations (P.L. 106–74 and P.L. 106–117 §102(e), The Veterans Millennium Healthcare and Benefits Act). Despite the legislative intent, however, a national policy advocating VHA–CHC collaboration has not emerged in an effective way.

A limited number of collaborations between the VHA and CHCs already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas. Successful contracts exist in Wisconsin, Missouri, and Utah. In other States, contracts were successful but were discontinued for reasons not related to operational success. This model of collaboration between VHA and CHCs might do well in other rural States and with other rural providers and systems of care and should be implemented further.

Critical Access Hospitals provide comprehensive and essential services to rural communities and are specific to rural States. This model provides a great opportunity for policymakers to expand services to rural veterans in communities where CAHs are located. For instance, Montana has 45 Critical Access Hospitals and the highest percentage of veterans in the Nation. Working through these existing access points of care in many frontier communities in rural Montana by providing linkages with VA services and models of quality could greatly enhance care for rural veterans.

Designation as a Rural Health Clinic (RHC) provides enhanced reimbursement for Medicare and Medicaid services for private physicians who provide enhanced services to rural communities. RHCs are often physician-owned or sometimes owned by small, rural hospitals, including Critical Access Hospitals. In many rural and frontier communities, RHCs represent the only source of primary care available.

The literature provides much evidence that linking the quality of VA services with civilian services provides opportunities to improve the quality of healthcare services for all citizens. Linkages can improve the use of evidence-based medicine in chronic disease management, in screening and diagnosis, and in treatment of many health conditions. Linkages also provide greater opportunities for the dissemination of VA supported research. These are additional benefits of any collaboration between VHA and the existing rural health safety net infrastructure.

<sup>13</sup> Maciejewski, M., et al. CBOC Performance Evaluation Report 2, VA HSR&D, March 2000. [http://www.hsr.d.research.va.gov/publications/internal/cbocrpt2/cboc\\_performance\\_report2.htm](http://www.hsr.d.research.va.gov/publications/internal/cbocrpt2/cboc_performance_report2.htm).

<sup>14</sup> VHA Handbook 1006.1, April 11, 2003. Department of Veterans Affairs, Veterans Health Administration. Washington, D.C.

### 3. Increase Traumatic Brain Injury Care

Throughout our history all citizens in our Nation have benefited from medical research focused on the signature wounds of war. Currently, it appears that Traumatic Brain Injury (TBI) will most likely become the signature wound of the Afghanistan and Iraqi wars. While the VA is gearing up for returning veterans with this condition, the importance of the TBI Case Manager Network and other services in the provision of quality care for these rural veterans cannot be understated.

The Defense and Veterans Brain Injury Network of nine VA and one civilian center provides the needed and highly specialized services that these disabled veterans require. However, only three of these network centers are located in two of the 18 States with high rates of rural veterans, Virginia and Florida. Eleven western States with many rural and frontier veterans, and the other southern States with high numbers of rural veterans have very limited access to these centers once discharged from inpatient care. Therefore, the VHA TBI Case Managers Network is vital to these veterans and their families. A review of the number and location of TBI case managers finds them very limited in coverage in States with high numbers of rural veterans—expansion is needed.

### 4. Target Care to Rural Veterans

**A. Needs of the Rural Family.** Rural individuals value their families and have strong bonds and ties to their homeplace and home communities. Our returning veterans adjusting to disabilities and the stresses of combat need the security and support of their families in making their transitions back into civilian life and to manage lifestyle changes due to disabling conditions. The Vet Centers do a tremendous job in assisting veterans with this readjustment, but the demand for services is too great for current funding levels. The NRHA supports increases in funding for counseling services for veterans' families and significant others.

**B. Needs of Rural Women Veterans.** Additionally, the NRHA supports better assessment of the needs of women and minority women veterans. Currently women make up approximately 15 percent of the active military force. Thirty-seven percent of these women are African American. These women serve in all branches of the military, and are eligible for assignment in most military occupational specialties except for direct combat roles. The highest number of women in history to serve in a war zone is currently serving in Iraq and Afghanistan. Our Nation is also seeing the highest numbers in history of female wounded and war casualties.<sup>15</sup>

According to the Center for Women Veterans, by the year 2010, the women veteran population is projected to be over 10 percent of the total veteran population. The breakdown on these women by rural and urban residence is not readily available, however, it is reasonable to assume that a higher number of both genders from rural areas go into military service. The VA is beginning to address changes needed to serve an increased female veteran population, but more can be done. Targeted and culturally competent care for today's women veterans is needed. Additionally, the VA offers a golden opportunity to train rural providers through rural rotations in all VA facilities and programs, thereby exposing our future rural providers to the unique needs of rural, minority, and female veterans.

### 5. Improve Office of Rural Veterans

The NRHA calls on Congress and the Veterans Administration to fully implement the functions of the newly created Office of Rural Veterans to develop and support an ongoing mechanism to study and articulate the needs of rural veterans and their families. Additionally, the NRHA supports collaboration of this office with the Federal Office of Rural Health Policy within HRSA to better meet the access needs of rural veterans. Finally, the NRHA urges this office to establish a National Advisory Committee on Rural Veterans to provide information to policymakers on the needs of this population as it ages.

### Conclusion

While NRHA recognizes the purpose of this hearing is not to discuss specific legislation, we do recognize that H.R. 5524, the Rural Veterans Healthcare Act of 2006, introduced in the last Congress, includes many of the items long recommended by NRHA. H.R. 5524 calls for expansion and improved quality of services provided by Vet Centers, Outreach Health Centers, and CBOCs in rural areas; a heightened

<sup>15</sup>[news.yahoo.com/s/afp/20070306/lf\\_afpwomensurapmilitary\\_070306170626-33k-March](http://news.yahoo.com/s/afp/20070306/lf_afpwomensurapmilitary_070306170626-33k-March) 15, 2007.

focus on the needs of rural minority veterans; a focus on rural medical education for VA residents, and new research and outreach efforts. We hope similar legislation will again be introduced in the 110th Congress and eventually be enacted into law.

Mr. Chairman, thank you for the opportunity to testify.

---

**Statement of Shannon Middleton, Deputy Director for Health  
Veterans Affairs and Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on access to quality healthcare for veterans in general and veterans in rural communities in particular. Research conducted by the Department of Veterans Affairs (VA) indicated that veterans residing in rural areas are in poorer health than their urban counterparts. It was further reported that nationwide, one in five veterans who enrolled to receive VA healthcare lives in rural areas. Providing quality healthcare in a rural setting has proven to be very challenging, given factors such as limited availability of skilled care providers and inadequate access to care. Even more challenging will be VA's ability to provide treatment and rehabilitation to rural veterans who suffer from the signature ailments of the ongoing Global War on Terror—traumatic blast injuries and combat-related mental health conditions. VA's efforts need to be especially focused on these issues.

*Community-Based Outpatient Clinics (CBOC)*

A vital element of VA's transformation in the 1990's was the creation of CBOCs to move access closer to the veterans' community. A recent VA study noted that access to care might be a key factor in why rural veterans appear to be in poorer health. CBOCs were designed to bring healthcare closer to where veterans reside. Over the last several years, VA has opened up hundreds of CBOCs throughout the system and today there are over 700 that provide healthcare to the Nation's veterans. By and large, CBOCs have been pretty successful; however, of concern to The American Legion is that many of the CBOCs are at or near capacity and many still do not provide adequate mental health services to veterans in need.

One of the recommendations of the Capital Assets Realignment for Enhanced Services (CARES) was for more, not less, CBOCs across the Nation. The American Legion strongly supports this recommendation, especially those identified for rural areas; however, limited VA discretionary funding has limited the number of new CBOCs each fiscal year.

There is great difficulty serving veterans in rural areas. Veterans in States such as Nebraska, Iowa, North Dakota, South Dakota, Wyoming, and Montana face extremely long drives, a shortage of healthcare providers and bad weather. The Veterans Integrated Services Networks (VISNs) rely heavily upon CBOCs to close the gap.

The provision of mental health services in CBOCs is even more critical today with the ongoing wars in Iraq and Afghanistan. It has been estimated that nearly 30 percent of the veterans who are returning from combat suffer from some type of mental stress. Further, statistics show that mental health is one of the top three reasons a returning veteran seeks VA healthcare. The American Legion believes that VA needs to continue to emphasize to the facilities the importance of mental health services in CBOCs and we urge VA to ensure the adequate staffing of mental health providers in the CBOC setting.

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

The Presidential Task Force to Improve Healthcare Delivery for Our Nation's Veterans made several recommendations for DoD and VA, one of which: *VA and DoD should declare that joint ventures are integral to the standard operations of both Departments.* (Recommendation 4.8) Since this Task Force's final report in May 2003, none have materialized—yet there are military bases in many rural communities.

*Traumatic Brain Injury Patients*

In a July 2006 report entitled *Health Status of and Services for Operation Enduring Freedom and Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*, the Department of Veterans Affairs Office of Inspector General examined the Veterans Health Administration's ability to meet the needs of OIF/OEF

veterans who suffered from traumatic brain injury (TBI). Fifty-two patients from around the country—including Montana, Colorado, North Dakota, and Washington State—were interviewed at least 1 year after completing inpatient rehabilitation from a Lead Center (Minneapolis, MN; Palo Alto, CA; Richmond, VA; and Tampa, FL) including those who lived in States with rural veteran populations.

Many of the obstacles for the TBI veterans and their family members were similar. Forty-eight percent of the patients indicated that there were few resources in the community for brain injury-related problems. Thirty-eight percent indicated that transportation was a major obstacle. Seventeen percent indicated that they did not have money to pay for medical, rehabilitation, and injury-related services.

Some of the challenges noted by family members who care for these veterans in rural settings include: the necessity for complicated special arrangements and the absence of VA rehabilitative care in their communities.

Case managers working at Lead Centers and several secondary centers noted limited ability to follow patients after discharge to rural areas and lack of adequate transportation.

These limitations place undue hardship on the veterans' families as well. Those contributing to the report, as well as veterans who have contacted The American Legion, have shared many examples of the manner in which families have been devastated by caring for TBI injured veterans. They have sacrificed financially, have lost jobs that provided the sole income for the family, and have endured extended separations from children. It is The American Legion's belief that VA needs to continue to improve access to quality primary and specialty healthcare services for veterans residing in rural and highly rural areas.

#### *Vet Centers*

Vet Centers are another important resource, especially for combat veterans experiencing readjustment issues who do not live in close proximity to a VA medical facility. Because Vet Centers are community-based and veterans are assessed the day they seek services, they receive timely care and are not subjected to wait lists. Some of the services provided include: individual and group counseling; family and marital counseling; military sexual trauma counseling; and, bereavement.

Realizing the value of Vet Centers to those who may encounter obstacles when seeking mental healthcare in the VA medical facilities, The American Legion decided to get a glimpse of services and needs of Vet Centers nationwide. The American Legion's 2007 System Worth Saving report, a compilation of information gathered from site visits conducted by field service representatives and the System Worth Saving Task Force members, will focus on Vet Centers, as well as poly-trauma centers. The American Legion staff selected a sample of Vet Centers that were located near demobilization sites throughout the country to ascertain the effects of the number of returning veterans on the services provided by the centers. The report will illustrate the types of veterans utilizing the respective Vet Centers, as well as services requested by these veterans and outreach services offered.

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

Although "access" is an important measure, The American Legion believes "timeliness of access" is just as critical. For an example, VA established its own acceptable access standard for primary care at 30 days, but to most Americans with private healthcare plans—30 days would be unacceptable. Unfortunately, the continued disparity between demand for services and available resources continues to cause delays in the delivery of healthcare. The current Global War on Terror has placed even more demands on the VA healthcare system to meet its obligation to the men and women of the armed forces—past, present, and future. As a grateful Nation welcomes with opened arms the newest generation of wartime veterans, veterans of previous conflicts and the Cold War are being denied enrollment and, therefore, access to their healthcare delivery system of choice.

Since the decision within VA to begin transformation from an inpatient-based healthcare delivery system to an integrated healthcare delivery system in the early 1990s and Congress' enactment of eligibility reform in 1996, access to VA healthcare has increased dramatically. In 1990, the patient population of the VA medical system was somewhere in the neighborhood of 2 million. Today, VA's patient population is closer to 6 million with a total enrollment of approximately 8 million veterans.

In fact, by 2003, former VA Secretary Anthony Principi decided to terminate the enrollment of any new Priority Group 8 veterans; therefore, prohibiting access to VA

medical care to hundreds of thousands of Priority Group 8 veterans due primarily to limited resources. The American Legion disagrees with the decision to deny access to any eligible veterans. Many of these veterans are Medicare-eligible or have other third-party health insurance that could reimburse VA reasonable charges for services rendered. Yet little has been done to improve third-party reimbursements from private insurers and nothing has been done to allow VA to begin receiving third-party reimbursements from the Nation's largest healthcare insurer, the Centers for Medicare and Medicaid Services (CMS).

Both the Department of Defense (DoD) medical system and Indian Health Services (IHS) are authorized to bill, collect, and receive third-party reimbursements from the Centers for Medicare and Medicaid Services, yet VA continues to face the restriction from billing CMS. Repeatedly, VA's average cost-per-patient remains well below Medicare's average cost-per-patient (and the billions of dollars VA saves Medicare is not even calculated into Medicare's final funding levels).

The restriction of enrollment for Priority 8 veterans creates another "access gap" for recently separated veterans who did not serve in a combat setting. Some recently separated veterans must wait until their VA disability claims are approved in order to enroll. For others, unless they are economically indigent, they are prohibited from enrolling. Those recently separated veterans that successfully transition may very well never be eligible to enroll in the Nation's best healthcare delivery system. None of these situations are very welcoming messages to the men and women currently serving in the Nation's armed forces.

Over the years, VA has transformed itself into the Nation's best healthcare delivery system and probably the most cost-efficient as well. There are many reasons why the VA healthcare system has become the best healthcare option for eligible veterans:

- Quality of care,
- Patient safety,
- Electronic medical records,
- Cost-efficient formulary,
- Accessibility,
- World-class specialized services,
- State-of-the-arts medical and prosthetics research, and
- Minimal fraud, waste, and abuse.

For these and many other intangible reasons, VA is a "healthcare magnet" attracting veterans, many of which have never used the VA healthcare delivery system before. As the veteran population continues to age and the healthcare industry evolves, more and more veterans on fixed incomes turn to VA as their best healthcare option—even those with other healthcare options such as Medicare, TRICARE, or private health insurance coverage. Many of these veterans are combat veterans of World War II, Korea, and Vietnam. Although their transition from active-duty to civilian life may have been "seamless" for many years, they now believe their individual healthcare needs would be better met by VA.

#### *Returning Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans*

The American Legion fully supports the decision to provide recently separated veterans from OEF/OIF to access to the VA healthcare delivery system for 2 years after separation. However, now that they have been presented with conditions having delayed onset, like Post-Traumatic Stress Disorder (PTSD) and symptoms of Traumatic Brain Injury (TBI), The American Legion supports extending those 2 years to 5 years. The American Legion also believes that VA must ensure that it makes every effort to outreach to eligible Reservists components, who sometimes endure multiple deployments, to keep them aware of their eligibility for access to the VA healthcare system and provide them with timely access to care.

Although they were promised priority due to their combat service, OEF/OIF veterans are encountering obstacles when trying to access the system. We are beginning to hear stories. One veteran was told to call back the following week for an appointment, only to be told when he called back, that he had to wait 30 days later for an appointment. Another OIF veteran reported having his appointment cancelled and rescheduled 30 days later. Many conditions experienced by these veterans may not qualify as emergencies, but are urgent enough to require immediate care.

#### *Inpatient Bed Requirements*

VA continues to ignore the Federal mandate for inpatient care, especially in the area of long-term care. The American Legion believes VA is focused on shifting long-term care from VA to the State Veterans' Homes and private nursing home indus-

try. Access to long-term care is often translated into being placed on a waiting list that may very well exceed the life expectancy of the veteran placed on the list. The Veterans' Millennium Healthcare Act clearly set the bar, but VA seems to have ignored this Federally mandated statute.

During the CARES process, long-term care and mental health were not included in the initial decisionmaking process. In other words, two critical elements were included *after* rather than during the final recommendations for the future infrastructure of VA. The American Legion was extremely critical of that decision, especially when the closing recommendations revealed medical facilities with primarily long-term care and mental health missions. In addition, the facilities were primarily in rural communities.

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

---

**Statement of Adrian M. Atizado**  
**Assistant National Legislative Director, Disabled American Veterans**

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear today at the request of the Subcommittee to offer testimony on behalf of the Disabled American Veterans (DAV) related to access to medical care services in the Department of Veterans Affairs (VA) healthcare system, particularly on access to care in rural areas. I offer this statement on behalf of *The Independent Budget* (IB) for fiscal year 2008, a product of the joint efforts of DAV, Veterans of Foreign Wars of the United States, Paralyzed Veterans of America and AMVETS.

Congress provided VA additional funding in fiscal years 2006 and 2007, for which we are very grateful, but we continue to hear from veterans that their access to VA specialty care is often delayed for months. Likewise, access to VA care in rural areas of the country has been—and continues to be—a challenge for many veterans. We are especially concerned about how VA plans to address rural veterans' needs in the coming years, given reports that 44 percent of all veterans returning from Operations Enduring and Iraqi Freedom (OEF/OIF) reside in rural communities. After serving their country, veterans' healthcare needs should not be neglected by VA simply because they live in rural or remote areas at a distance from major VA healthcare facilities.

Without question, sections 212 and 213 of Public Law 109-461, signed into law by the President on December 22, 2006, represent the most significant advances to date to address healthcare needs of veterans living in rural areas. Under this legislation, the VA is mandated to establish an Office of Rural Health within the Veterans Health Administration (VHA). This office must carry out a series of steps intended by Congress to improve VA healthcare for veterans living in rural and remote areas. This legislation is also aimed importantly at better addressing the needs of returning veterans who have served in OEF/OIF. Among its features the law requires VA to conduct an extensive outreach program for veterans who reside in these communities. In that connection VA is required to collaborate with employers, State agencies, Community Health Centers, Rural Health Clinics, Critical Access Hospitals (as designated by Medicare), and the National Guard, to ensure that returning veterans and Guard members, once completing their deployments, can have ready access to adequate VA healthcare. The legislation also requires an extensive assessment of the existing VA fee-basis system of private healthcare, and eventual development of a VA plan to improve access and quality of care for enrolled veterans who live in rural areas.

Rural veterans, veterans service organizations and other experts need a seat at the table to help VA consider important program and policy decisions such as those being discussed here that would positively affect veterans who live in rural areas. The final legislative language of Public Law 109-461 failed to include a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans, and other rural experts, to recommend policies to meet the challenges of veterans' rural healthcare. We hope that Congress will reconsider this mandate, but the VA Secretary retains the authority to establish such an Advisory Committee without specific statutory authorization. The *IBVSOs* urge the Secretary to take this action, and to include representatives of our organizations in the membership of that Committee.

Although the authors of the *Independent Budget* acknowledge this legislative measure will be beneficial to veterans living in rural and remote areas, the legislation also raises potential concerns about the unintended consequences it may have on the mainstream VA healthcare system. In general, current law places limits on VA's ability to contract for private healthcare services to instances which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when existence of a medical emergency prevents a veteran from receiving care from a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services of certain scarce medical specialists. Beyond these limits, there is no general authority in law to support broad-based contracting for the care of populations of veterans, whether rural or urban. The authors of the *IB* believe VA contract care for eligible veterans should be used judiciously and only in circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a critical mass of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems such as blindness, amputations, brain and spinal cord injury, or chronic mental health problems. Putting additional budget pressure on this specialized system of services, without making specific appropriations available for new rural VA healthcare programs, could only exacerbate the problems currently encountered.

The VA has had continuing difficulty securing sufficient funding through the Congressional discretionary budget and appropriations process to ensure basic and adequate access for the care of sick and disabled veterans. Congress repeatedly has been forced to provide additional funds to maintain VA healthcare services. Also, VA receives no Congressional appropriation dedicated to support the establishment of rural Community-Based Outpatient Clinics or to aid facilities VA designated as "Veterans Rural Access Hospitals" (VRAH), and thus VA must manage any additional expenses from within generally available Medical Services appropriations. VA has established and is operating 717 Community-Based Outpatient Clinics (CBOCs) as sources of primary care. VA considers 320 of these clinics to be in rural or "highly rural" areas. Given current financial circumstances within VA healthcare, we are skeptical that VA can continue to cost-effectively establish additional facilities in areas with even sparser veteran populations.

### **Rural Hospitals**

Under the federal Medicare program, a "Critical Access Hospital" (CAH) is a private hospital that is certified to receive cost-based reimbursements from Medicare. The higher reimbursements that CAHs receive under this program compared to urban facilities are intended to improve their financial security and thereby reduce rural hospital closures. In other words, the Centers for Medicare and Medicaid Services (CMS) policy is to financially aid struggling rural hospitals in hopes that the additional support can help them survive. Also the CAH facilities are certified under Medicare "conditions of participation" that are more flexible than those used for other acute care hospitals. As of March 2006 (the latest data available), there were 1,279 certified CAH facilities in rural and remote areas.

As a part of the VA's Capital Assets for Enhanced Services (CARES) initiative, the VA employed Medicare's CAH model as a guide to establish a new VA policy to govern operations of, and planning for, many of VA's rural and remote facilities, now designated VRAH. In 2004, however, the CARES Advisory Commission questioned whether VA's policy was adequate and recommended VA ". . . establish a clear definition and clear policy on the CAH [now VRAH] designation prior to making decisions on the use of this designation."

Following this guidance from the CARES Commission, on October 29, 2004, VA issued a directive that is still in force setting a significant number of parameters for VRAH designations, but that directive seems pointed in the opposite direction from that of Medicare for the CAH facilities in the rural private sector. Illustrative of our concern is the basic definition of VRAH, as follows:

"A VRAH is a VHA facility providing acute inpatient care in a rural or small urban market in which access to healthcare is limited. The market area cannot support more than forty beds. The facility is limited to not more than twenty-five acute medical and/or surgical beds. Such facilities must be part of a network of healthcare that provides an established referral system for tertiary or other specialized care not available at the rural facility. The facility should be part of a system of primary healthcare (such as a network of Community-Based Outpatient Clinics (CBOCs)). The underlying principle is that the facility must be a critical component of providing

access to timely, appropriate, and cost-effective healthcare for the veteran population served. The activation and operation of a VRAH will be similar to that of any other VHA hospital. The designation of a facility as a VRAH will not remove or diminish that facility's responsibility in meeting appropriate VHA requirements, directives, guidance, etc." (VHA Directive 2004-061, October 29, 2004)

We believe VA must carefully monitor the scope and quality of services performed at its smaller, rural facilities, specifically for those procedures that are complex in nature. Further, as medical care advances in the use of high technology and thereby elevates the standard of care, small VA inpatient facilities may find it increasingly difficult to effectively maintain, and actually use these new tools, to provide healthcare at its most sophisticated levels. However, we believe VA must maintain a safe and high quality healthcare service within each of its facilities, and to the greatest degree possible offer a comprehensive health benefit to veterans at each of its facilities, whether rural, suburban or urban.

The *IBVSOs* remain concerned about whether VA's VRAH policy fully considers the implications of large-scale referrals from rural VA Medical Centers in continuing to provide high quality healthcare in those locations, particularly when veterans are referred to other far off medical centers within a Veterans Integrated Service Network (VISN), or to private facilities. VA must also consider patient satisfaction, continuity of care, family separation and travel burdens in the criteria they use for determining which rural facilities should retain acute care services. If acute care beds are to be retained in one facility because of distances that veterans must travel to access inpatient care or receive specialized services, we believe this logic should be standardized and used systemwide to the greatest extent possible.

#### **Community-Based Outpatient Clinics**

The new legislation discussed above holds VA accountable for improving access for rural veterans through CBOCs and other access points by requiring VA to develop and implement a plan for improving veterans' access to care in rural areas. The May 2004 Secretary's CARES decision identified 156 priority CBOCs and new sites of care nationwide. The VA Secretary is also required to develop a plan for meeting the long-term and mental healthcare needs of rural veterans. We urge Congress to include specific funding in fiscal year 2008 to address at least some of these needs in rural areas without eroding VA's Medical Services appropriation.

#### **Workforce**

Health worker shortages and recruitment and retention of healthcare personnel are a key challenge to rural veterans' access to VA care and to the quality of that care. *The Future of Rural Health* report (National Academy of Science, Institute of Medicine, Committee on the Future of Rural Health Care, 2005) recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of healthcare professionals working in rural areas. To this end, VA's deeper involvement in health professions education of future rural clinical providers seems essential in improving these situations in VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities each year. In addition, more than 32,000 associated health science students from 1,000 schools—including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants and nurse practitioners, receive training in VA facilities. These relationships of VA facilities to health professions schools should be put to work in aiding rural VA facilities with their personnel needs.

#### **Beneficiary Travel Program**

Another component of making sure that veterans get access to the care they need relates to the VA beneficiary travel program. This program is intended by Congress to assist veterans in need of VA healthcare to gain access to that care. As you are aware, the mileage reimbursement rate is currently fixed at 11 cents per mile, but actual reimbursement is limited by law with a \$3.00 per trip deductible capped at \$18.00 per month. The mileage reimbursement rate has not been changed in almost 30 years, even though the VA Secretary is delegated authority by Congress to make rate changes when warranted. The law also requires the Secretary to make periodic assessments of the need to authorize changes to that rate. Unfortunately, no Secretary has acted to make those changes, despite the obvious need to update the rate of reimbursement to reflect rises in travel and transportation costs.

In 1987, the DAV, in coordination with VA's Voluntary Service program, began buying and donating vans to VA for the purpose of transporting veterans for out-

patient care. Since that time, the DAV National Transportation Network has become a very significant and successful partnership between VA and DAV. We have donated almost 1,800 vans to VA facilities at a cost exceeding \$20 million. These vans and their DAV volunteer drivers and medical center volunteer transportation coordinators have transported nearly 520,000 veterans over 388 million miles. We plan to continue and enhance this program, not only because the VA beneficiary travel rate is so low, but also we have found our transportation network serves as a truly vital link between rural veterans and crucial VA healthcare. Its absence would equate to the actual denial of care for eligible veterans because many of them have no means to substitute.

DAV, along with several others, has a longstanding resolution (DAV Resolution 212) supporting repeal of the beneficiary travel pay deductible for service-connected veterans and to increase travel reimbursement rates for all veterans who are eligible for reimbursement. Additionally, we support legislation that has been introduced in Congress to repeal the mandatory deductible and increase the rate veterans are reimbursed for their authorized travel to and from VA services. We believe H.R. 963 (introduced by Mr. Stupak); H.R. 1472 (introduced by Mr. Barrow, with Mr. Baca, Mr. Burton of Indiana, Mr. Boswell, Ms. Bordallo, Mr. Boucher, Mr. Abercrombie, Mr. Boren and Mr. Courtney); and S. 994 (introduced by Senator Tester and Senator Salazar), all termed the "Veterans Travel Fairness Act," offer a fair and equitable resolution to this dilemma about which we have been concerned for many years. We urge this Committee and your Senate counterpart to approve and enact legislation this year to reform the VA beneficiary travel program. Given the cost of transportation in 2007, including record-setting gasoline prices, a reimbursement rate unchanged since 1977 pales in comparison to the actual cost of travel.

#### **Mental Healthcare**

As indicated above, given that 44 percent of newly returning veterans from OEF/OIF live in rural areas the *IBVSOs* believe that they too should have access to specialized services offered at VA's Readjustment Counseling Service's *Vet Centers*.

*Vet Centers* are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives counseling for military-related trauma. Building on the strength of the *Vet Centers* program, VA should be required to establish a pilot program for mobile *Vet Centers* that could better outreach to veterans in rural and remote areas.

#### **Homelessness**

Helping homeless veterans in rural and remote locations recover, rehabilitate, and reintegrate into society is complex and challenging. VA has no specific programs to help community providers who focus on rural homeless veterans. The rural homeless also deserve attention from VA to aid in their recoveries. Likewise, Native American, Native Hawaiian, and Native Alaskan veterans have unique healthcare needs that VA needs to address with additional outreach and other activities.

Mr. Chairman, thank you for the opportunity to provide testimony on these very important issues related to access to VA healthcare services. In *The Independent Budget* for fiscal year 2008, our organizations made a number of recommendations to Congress and VA that are relevant to the issues discussed today in this testimony. We invite you to review these recommendations, reprinted below.

#### **Recommendations**

VA must fully support the right of rural veterans to healthcare and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reductions in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

VA must ensure that the distance veterans travel as well as other hardships they face be considered in VA's policies in determining the appropriate location and setting for providing VA healthcare services.

The VA Secretary should use existing authority to establish a Rural Veterans Advisory Committee, to include membership by the veterans service organizations.

VA rural outreach should include a special focus on Native American, Native Hawaiian, and Alaska Native veterans' unmet healthcare needs.

Through its affiliations with health professions schools, VA should develop a policy to help supply health professions clinical personnel to rural VA facilities and to rural areas in general.

Mobile *Vet Centers* should be established, at least on a pilot basis, to provide outreach and counseling for veterans in rural and remote areas.

VA must focus some of its homeless veteran program resources, including contracts with, and grants to, community-based organizations, to address the needs of homeless veterans in rural and remote areas.

---

**Statement of Gerald M. Cross, M.D., FAAFP  
Acting Principal Deputy Under Secretary for Health  
Veterans Health Administration, U.S. Department of Veterans Affairs**

Good Afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to discuss ongoing efforts in the Veterans Health Administration (VHA) to provide safe, effective, efficient and compassionate healthcare to veterans residing in rural areas.

In fiscal year 2006, the Department of Veterans Affairs (VA) served about 5.4 million patients. Approximately 39 percent of these veterans resided in rural areas and another 2 percent resided in highly rural areas.<sup>1</sup> VA is fulfilling its mission by providing the highest quality of care to all veterans and understands that although veterans in rural areas face many of the same health concerns as veterans in urban areas, rural area veterans often face additional and unique challenges such as limited finances and fewer specialists. The primary challenge in serving veterans who reside in rural areas is to effectively address access to quality care in areas where veteran populations are usually widely distributed over a large geographical area.

The VA has undergone a profound transformation in the delivery of healthcare over the last decade. VA has moved from a hospital driven healthcare system to an integrated delivery system that emphasizes a full continuum of care. New technology and treatment modalities have changed how and where care is provided with a significant shift from inpatient to outpatient and in-home services. Throughout that transformation, VA has considered our veterans who live in rural areas and how best the VA can enhance their access to the quality health services that we strive to provide to all veterans.

VA's comprehensive approach for providing care to veterans residing in rural areas has proven successful. We are setting the industry standards for using advanced technology with our telehealth healthcare delivery programs. With this advanced technology, we are providing services directly to veterans in their homes and expanding specialized care in our Community-Based Outpatient Clinics (CBOCs) through telemedicine capabilities. We have been successful in creating greater access to quality services through expansion of CBOCs. Over 92 percent of enrollees reside within 1 hour of a VA facility, and 98.5 percent are within 90 minutes.

Our veterans tell us that they are satisfied with the services and high quality care we are providing to them. This is substantiated by their high satisfaction reporting, with veterans in rural areas reporting comparable satisfaction to their urban counterparts.

I share the Committee's concern for these veterans and would like to take a few minutes to discuss our strategic direction and current programs that will reveal how VA is moving toward a comprehensive plan with initiatives to address rural veterans' issues.

***RURAL HEALTH INITIATIVES***

The strategic direction for providing services to veterans residing in rural areas is to provide non-institutionalized care; to bring care into veterans' homes. Examples of this are telehealth, mail pharmacies, and home-based primary care. If it is not possible to provide services in the home, veterans will come to one of the many access points that VA has established. VA has systematically undertaken a number of efforts aimed at addressing delivery of healthcare services to veterans who reside in rural areas. Central to these efforts are several major initiatives now being implemented throughout the VA system: establishing an Office of Rural Health to focus attention on issues of veterans who reside in rural areas; our telehealth and telemedicine programs, which are using new technology to bring healthcare providers to their patients, rather than patients to their healthcare providers; establishment of CBOCs to increase access to care; and utilization of fee-based service with private healthcare providers. I will now discuss these efforts and others in

<sup>1</sup>Definitions: Urban—areas defined by U.S. Census as urbanized areas; Rural—all other areas excluded in U.S. Census defined urbanized areas; Highly Rural—any rural area within a county with less than 7.0 civilians per square mile.

greater detail while providing information on key health concerns facing many of our veterans.

#### *VHA's OFFICE OF RURAL HEALTH*

VHA is focusing attention on the special needs of veterans who reside in rural areas. In accordance with section 212 of the Public Law 109-461, VHA is establishing an Office of Rural Health. The mission of the office is to promulgate policies, best practices and innovations to improve services to veterans who reside in rural areas of the United States.

#### *TELEHEALTH—IMPACTS ON RURAL CARE*

VA is an acknowledged national leader in the development of telehealth. VA's telehealth programs have reached a size and complexity that are unparalleled elsewhere. VA continues to implement telehealth through further expansion of its care coordination/telehealth programs. This approach embeds telehealth within an appropriate, effective and cost-effective clinical environment. Consequently, access to care is expanding and enabling convenience in how veteran patients receive services to become a predominant consideration, one that fits with the overarching mission for these programs of providing the right care at the right time in the right setting.

For veteran patients with chronic disease, when it is appropriate and their choice, the preferred setting for care is the home. Care coordination/home telehealth programs (CCHT) are well established in all 21 Veterans Integrated Service Networks (VISNs) and currently care for 24,921 patients. This patient census (point prevalence figure) already represents a 25 percent increase over fiscal year 2006 numbers and places VA on target to meet a projected growth in the program of 50 percent by the end of fiscal year 2007. CCHT supports patients with chronic conditions such as diabetes, chronic heart failure, chronic obstructive pulmonary disease, post-traumatic stress disorder, and depression to remain living independently in their own homes. The program design is such that care can be delivered remotely from VA Medical Centers and 25 percent of CCHT patients are in rural areas and another 1 percent are in highly rural areas.

The next phase of expansion in CCHT programs and ongoing extension into rural areas involves VA's implementation of a home telemental health initiative that will support veterans with PTSD and those who need treatment for substance abuse to be managed at home. These new CCHT home telemental health services are intended to support the care of an additional 2,000 veterans by the end of fiscal year 2008. VA anticipates that such services will initially develop and thereafter further expand in the same geographic locations as existing CCHT programs. VA is currently working on telecommunications strategies to facilitate the provision of CCHT services in rural areas, thus improving access to care for veteran patients and reducing their need to travel for services. Since January 2004, VHA has trained over 3,500 staff nationally to provide care via CCHT. This training is done via distance learning techniques to enhance service development and ensure their sustainability in rural and remote areas.

In fiscal year 2006, over 19,000 unique veteran patients received care in CBOCs and outlying VA Medical Centers via telemental health. Already, in the first quarter of fiscal year 2007, over 8,000 patients have received care via telemental health. Current projections are that VA will provide care in this manner to over 30,000 veterans during fiscal year 2007.

The VA's Rocky Mountain Telehealth Training Center is focusing on making distance learning available to the providers in rural areas who are providing services via telehealth. Additionally, the VA readjustment counseling program (Vet Centers) is currently working on a strategy to expand services in rural areas by further expansion of its telehealth capacity.

VHA has now implemented its national teleretinal imaging program to screen veteran patients with diabetes for diabetic eye disease. This program was instituted at a total of 159 image acquisition sites over the past 18 months. This implementation represents a 60 percent increase over that which was originally planned. Currently 50 percent of these image acquisition sites are in rural areas. Overall the program has provided services to 18,000 patients with a projected census of 110,000 by the end of fiscal year 2007 and 200,000 by the end of fiscal year 2008. VA's teleretinal imaging training center in Boston has trained the necessary image acquisition and reading staff and helps ensure that remote sites can be established and remain viable.

#### *IMPROVING ACCESS THROUGH CBOCs*

CBOCs have been the anchor for VHA's efforts to expand access to veterans in rural areas. VHA's CBOCs are complemented by contracts in the community for

physician specialty services or referrals to local VA Medical Centers, depending on the location of the CBOC and the availability of specialists in the area.

VA has continued to improve access to care for veterans in rural areas through a variety of mechanisms. VA outpatient clinics offer rural veterans a full array of primary care services in communities where they live and work. VA has opened 717 new CBOCs since 1995.<sup>2</sup> Of this total, 320 or 45 percent of these are located in rural or highly rural areas. Additionally, there are a number of rural outreach clinics that are operated by a parent CBOC to meet the needs of rural veterans. Furthermore, there are several additional outpatient clinics that, although located in more populated areas, are positioned to provide care for veterans in the surrounding rural communities. The fee-basis program, authorized under 38 U.S.C. 1703, also provides a local VAMC director with an option in meeting the needs of veterans.

VA's current policy for the planning and activation of CBOCs ensures that new CBOCs meet VA's goal to improve access by current users by placing CBOCs in those areas where users travel significant distances and/or experience excessive travel time to access care.

VA reviews and selects CBOCs through a national approval process based upon the proposals from VA Medical Centers and the Veterans Integrated Service Networks (VISNs). This process allows decisions regarding needs and priorities to be made in the context of local market circumstances and veterans' preferences.

CBOC proposals are reviewed against national planning criteria including the needs of veterans living in rural areas. The planning criteria include items such as access standards that address veterans living in rural and highly rural areas, as well as additional considerations that include the impact of new CBOCs on waiting times, cost effectiveness, unique demographic or geographic considerations, current workload, quality of care, and enrollment decisions. As noted earlier, CBOC criteria do address unique demographic and geographic concerns such as geographic barriers, low population density, medically underserved or health manpower shortage areas which will enhance care for rural veterans. Criteria points are added for these unique considerations.

VA reviews and revises its policy on the planning and activation of CBOCs annually and new planned CBOCs are centrally integrated into the annual development of resource and budget needs. VA is currently reviewing the CBOC criteria to emphasize those areas of the country that have less than 70 percent of enrollees within drive time standards to access care. (VA Drive Time standards recommend that 70 percent of market enrollees be within 30 minutes of primary care for veterans residing in urban and rural areas, and 60 minutes for those living in highly rural areas). VA will then use this information to develop infrastructure planning and budget needs.

#### *MENTAL HEALTH SERVICES/SPECIAL NEEDS*

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

VA is making changes to address these needs. In fiscal year 2005, VHA began an investment to improve access to mental health services throughout the entire VA healthcare system, in both rural and urban settings. Resources are funding services that are utilized by veterans living in rural areas, including expansion of telemental health programs to provide expert mental healthcare in rural areas, and providing an innovative rural Mental Health Intensive Case Management program (MHICM-RANGE) where the population needing care was not large enough to require a full team.

Some examples of VA's mental health program initiatives that will benefit rural veterans include:

- Integrating specialty mental healthcare into primary care and other medical settings;
- Continuing to expand access to specialty mental health services at all CBOCs, either by direct staffing, local contracts, or telehealth;
- Developing and piloting a model for rural areas for implementation of the concepts of the Mental Health Intensive Case Management (MHICM) programs; and
- Providing timely access for homeless veterans to mental health/substance abuse assessments.

<sup>2</sup>Nomenclature clarification: In 1995, the term used for access points was community-based or ambulatory clinic. In 2000, Community-Based Outpatient Clinic or CBOC became the commonly used term.

Performance Measure data indicates that as a result of our intensive efforts to expand services for rural veterans, veterans have access to service much nearer to home. In 1996, VA users of mental health services lived an average of 24 miles from the nearest VA clinic; as of 2006, they now live only 13.8 miles away (just half as far).

These and other Performance Measures in Mental Health help to identify success related to the mental health initiatives and to identify areas for continued improvement. In relation to the needs of veterans in rural areas, we are especially committed to expanding telemental health resources, to provide the most effective opportunity for enabling even the smallest and most rural of the CBOCs to improve the quantity of their basic mental healthcare and also to improve access to more specialized mental health services when clinically appropriate.

#### *HOMELESS PROVIDERS GRANT AND PER DIEM (GPD) PROGRAM*

VA Homeless Providers Grant and Per Diem (GPD) Program provides grants through a competitive process to community agencies providing services to homeless veterans. The purpose of the program is to promote the development and provision of supportive housing and/or services to help homeless veterans achieve residential stability, increase their skill levels and income, and independence. Efforts are made during funding cycles to award these grants recognizing geographic dispersion. Since GPD's inception, the program has funded more than 75 projects that are in rural locations. It is expected that these grants will support or create over 1,200 transitional housing beds for homeless veterans. Most of the grants were awarded to provide operational funding; however, grants were also awarded to assist in the renovation, acquisition, or construction of buildings to create facilities for the veterans who are homeless.

#### *READJUSTMENT COUNSELING SERVICE/VET CENTERS*

The Vet Center program service mission is designed to provide quality readjustment counseling and to remove all unnecessary barriers to care for veterans and family members. The Vet Centers are community-based facilities located at convenient locations within the community to promote ease of access for veterans and family members. All Vet Centers engage in extensive community outreach activities to directly contact and inform area veterans and to maintain active community partnerships with local leaders and service providers to facilitate referrals for veterans in need.

Some Vet Centers are, by plan, established and maintained in rural areas, e.g., Grants Pass, OR; Caribou, ME; Missoula, MT; and Cheyenne, WY, to ensure that rural veterans and families have access to readjustment counseling services. Additionally, we have established Vet Center outstations in rural areas such as Cedar Rapids, IA; the Michigan's Upper Peninsula; and Keams Canyon, AZ on the Hopi Reservation. Outstations are administratively connected to a full sized Vet Center, utilize permanently leased space and are usually staffed by one or two counselors who provide full time services to area veterans on a regular weekly basis. The Vet Centers also maintain some nontraditional hours keeping the Vet Center open after normal business hours or on weekends to accommodate veterans traveling in from greater distances.

Another important aspect of the Vet Center program for maintaining care for veterans in rural areas is to actively establish and maintain partnerships with other community providers such as State employment services, community substance abuse programs and healthcare providers such as Indian Health Service (IHS). The Vet Center program also maintains a contract program with over 300 private sector providers under contract with VA to deliver readjustment counseling to veterans living at a distance from existing Vet Centers. Some Vet Centers in rural areas have telehealth linkages to their support VAMC which provides veterans in more remote areas access to VA mental health and primary care. The Vet Centers in Santa Fe, NM; Logan, WV; and Chinle, AZ on the Navajo reservation are examples of such sites with active telehealth programs.

Since the onset of hostilities in Afghanistan and Iraq, the Vet Centers have taken a lead role in providing outreach services to returning war veterans. Since 2003 through the first quarter of fiscal year 2007, the Vet Centers have provided services to 165,153 Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans. Following initial contact with Vet Center outreach workers at demobilization sites, many of these veterans disperse home to rural areas of the country. Without the initial Vet Center outreach contact, subsequent access to VA services would be far more of a challenge for many rural veterans.

To further enhance services to the growing numbers of the new generation of returning warriors, VA announced, in February 2007, its plan to expand the Vet Cen-

ter program. Site selections for new Centers were established based on evidence-based analysis of veteran demographic distributions. In addition, site selection for some of the new Vet Centers was based on special consideration for relatively underserved veterans residing in rural areas at a distance from other VA facilities. There have been 23 new Vet Centers identified to be opened, 8 of them, or approximately 23 percent, are in rural areas. Examples of Vet Centers planned to serve rural veteran populations in rural locations include: Grand Junction, CO; Manhattan, KS; Escanaba, MI; and Watertown, NY.

#### *LTC/NURSING HOMES/DAY HEALTHCARE FACILITIES*

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

VA believes that LTC services should be provided in the least restrictive setting where services are appropriate to a veteran's health status, functional status, and personal circumstances, and, whenever possible, in HCBC non-institutional settings. We make every effort to identify options that maximize the veteran's ability to stay within the community for as long as possible. When nursing home care is needed, especially for a veteran residing in a rural area, VA identifies options for the patient from the broad spectrum of LTC venues available in the veteran's community, including the local State Veterans Home or contracted nursing home care. Contracts with rural community nursing homes are maintained so that beds are available when needed by veterans residing in rural areas.

Newer options of VA geriatric healthcare that provide more opportunities for the veteran to stay close to home and family include: (1) Integration of Care Coordination and Home Telehealth into Home-Based Primary Care to expand coverage into rural areas; (2) Collaboration with Administration on Aging and Indian Health Service for Home-Based Primary Care outreach and care giver support; (3) Promotion of Hospice-Veteran Partnerships to improve veteran access to community hospice care in rural areas; and (4) development of Medical Foster Home program, where veterans can receive an array of services including Home-Based Primary Care and community hospice care in a supportive home environment in their own community.

#### *COLLABORATIONS*

In addition to our internal efforts outlined earlier, VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of healthcare for rural veterans. We also have partnerships with HHS, including the Indian Health Service and Office of Rural Health providing healthcare in rural communities. We are also working to establish relationships with other entities, such as with the National Rural Health Association.

#### *CONCLUSION*

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

Mr. Chairman, this concludes my statement. At this time I would be pleased to answer any questions that you may have.



**SUBMISSIONS FOR THE RECORD**

**Statement of Hon. Corrine Brown, a Representative in Congress from the State of Florida**

Thank you, Mr. Chairman, for calling this hearing today.

In my home State of Florida, we have a large amount of rural land and one of the largest populations of veterans in the country. Our veteran population is the oldest in the country.

The wars we are currently fighting are using the National Guard and Reserves at a higher level than any other war. Many of the veterans coming back from OEF/OIF are not living in a traditionally military area. There are not a lot of retirees who served at the local base living nearby, creating a ready-made support group. These reserves go home. There are no support services nearby.

What plans does the VA have to address these veterans 3, 4, 5 or more years down the road?

We will hear from an expert from HHS which has been involved in rural healthcare for decades. What can the VA learn from this Department? Will you try to find out?

I am pleased the VA is building a CBOC in my district in Gainesville. This will bring necessary mental health and other services to those veterans living in that area. However, we need more for them.

I look forward to hearing the testimony from all the witnesses today.

**Statement of Hon. Henry E. Brown, Jr., a Representative in Congress from the State of South Carolina**

Chairman Michaud and Ranking Member Miller, thank you for calling this important hearing to address a continuing concern of this Committee: the challenges that many of our veterans face in accessing healthcare through the VA system. While my district is home to the Johnson VAMC in Charleston, a veteran from Myrtle Beach needing treatment or a test has to invest the larger part of an entire day for this visit. While treatment at our VA medical facilities is some of the best in the world, there is something about what I just said that doesn't make sense at all.

Last Congress, when I served as Chairman of this Subcommittee, I was honored to travel up to Maine for a field hearing in Mr. Michaud's district to examine some of these very same challenges. During that hearing we discussed some of the serious challenges that rural veterans face—not because of lack of dollars—but simply because they live in rural areas.

One of the messages that I came away from that hearing with is the need for Congress to continue to prod the VA forward in thinking outside the box to deliver care in innovative ways. We know the successful turnaround our VA hospitals have seen in the past decades. That turnaround required a commitment not just from Congress or the VA's political leadership, but a commitment from within the heart of the VA's bureaucracy.

Technology certainly is a tool that can have an impact—especially in the case of the veteran in Myrtle Beach who now has to spend their entire day traveling to and from Charleston for a test. For veterans in Maine and other extremely rural areas, we need to look at collaborating further with local healthcare providers to provide care through the VA system. Collaboration has worked at the VAMC level across the country—we should not be afraid of it across other areas of the VA system.

Thank you again, Mr. Chairman, and I look forward to working with my colleagues and the VA to address the access needs of our veterans.

**Statement of Hon. Jeff Miller  
Ranking Republican Member, Subcommittee on Health, and a  
Representative in Congress from the State of Florida**

Rural America has a strong tradition of military service. According to the 2000 U.S. Census, rural and non-metropolitan counties have the highest concentration of veterans. Both my State of Florida and the Chairman Michaud's State of Maine are included in the top 18 States with a greater than average proportion of rural veterans.

Not surprisingly, in the Global War on Terror, we continue to see a high rate of combat veterans from rural settings. About 41 percent of returning veterans from Operation Enduring Freedom and Operation Iraqi Freedom live in small communities.

A study conducted by VA researchers, published in the Winter 2006 Journal of Rural Health, “corroborate a concern that living at a distance from regionalized healthcare implicitly restricts access to and utilization of health services. Veterans may have an additional healthcare option not available to the general public, but those veterans who live in non-metropolitan areas, far from regionalized high technology or specialized care, continue to experience substantial unmet needs, greater than those of veterans in metropolitan settings.”

Central to VA’s efforts to address access to healthcare in less populated settings has been the establishment of Community-Based Outpatient Clinics (CBOCs). Today, VA operates about 700 CBOCs. The May 2004 Capital Asset Realignment for Enhanced Services (CARES) decision document provided a framework for prioritizing 156 new CBOCs to improve veteran’s access to care. More than half of these new CBOCs were given priority because they were located in rural areas. Yet, of these recommended new sites of care, VA has opened only 12 and expects to activate only an additional 12 in 2007.

CBOCs are important to improving geographic access to care. However, these primary care sites alone, cannot effectively overcome all the barriers that exist for rural veterans to obtain high quality care within their home community. Addressing the identified gaps in mental health services and specialty and acute hospital care, requires developing new approaches for delivering care. This includes the use of emerging technologies, partnering with existing non-VA rural healthcare providers and enhancing the training and recruitment of health professionals in rural communities.

I thank Chairman Michaud for holding this hearing to examine how we can best ensure all veterans have access to services when and where they are needed. With our current combat operations and an aging veteran population from previous wars, we can anticipate a substantial and rapid increase in demand for VA healthcare in rural areas. VA must step up to meet both the immediate physical and mental healthcare needs of all veterans and their families and bear in mind the special and unique rural healthcare delivery challenges in planning future services.

## POST-HEARING QUESTIONS FOR THE RECORD

Committee on Veterans' Affairs  
 Subcommittee on Health  
 Washington, DC  
 May 2, 2007

Michael J. Kussman, MD, MS, MACP  
 Acting Under Secretary for Health  
 U.S. Department of Veterans Affairs  
 810 Vermont Avenue, NW  
 Washington, DC 20420

Dear Dr. Kussman:

In reference to our Subcommittee on Health hearing "Access to VA Healthcare: How Easy is it for Veterans—Addressing the Gaps" held on April 18, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Sincerely,

MICHAEL H. MICHAUD  
 Chairman

**Questions from Hon. Michael H. Michaud, Chairman, Subcommittee on Health, to Dr. Michael Kussman, Acting Under Secretary of Health, Veterans Health Administration, U.S. Department of Veterans Affairs**

**"Access to VA Healthcare: How Easy is it for Veterans—Addressing the Gaps"**

**Question 1: *Providing Healthcare in a Rural Setting.*** Forty-one percent of the 5.4 million veterans that VA treated in fiscal year 2006 were from rural or highly rural areas. That is a pretty significant portion of the population that VA provides services to. Additionally, over 40 percent of the returning OEF/OIF veterans are from rural areas:

**Question 1(a):** What do you believe is a reasonable expectation of care for these 2.2 million veterans?

**Response:** The Department of Veterans Affairs (VA) believes reasonable expectations for healthcare for veterans who reside in rural areas fall into two broad categories; access and delivery of appropriate services.

To ensure reasonable access, Veterans Health Administration (VHA) uses established guidelines of drive time to access care. For rural veterans: 70 percent of patients should be within 30 minutes to primary care, and 65 percent of patients should be with 90 minutes to acute care and 240 minutes to tertiary care. For highly rural areas, 70 percent of patients should be within 60 minutes to primary care, and 65 percent of patients should be within 120 minutes to acute care and tertiary care is based on the standard for that area.

Regarding healthcare delivery, VHA is committed to providing a full range of services as outlined in the medical benefits package. This includes a standard health benefits plan available to all enrolled veterans. The plan emphasizes preventive and primary care, and offers a full range of outpatient and inpatient services within VA healthcare system. (<http://www.va.gov/healtheligibility/coveredservices/StandardBenefits.asp>)

VHA will continue to provide care consistent with our access guidelines and review these guidelines as needs change.

**Question 1(b):** What level of care do you believe should be easily accessible to these veterans, including specific services?

**Response:** VA believes primary care services, general medical and preventative services including mental health, should be easily accessible. VA supports providing high quality care balancing access requirements within our appropriated budget.

**Question 1(c):** If you had to draw a line—where would you draw it—and say, VA can't provide that care?

**Response:** VA will honor its obligation to provide a full range of services to enrolled veterans within our appropriated budget. VHA will first provide services to enrollees through its network of healthcare facilities ranging from primary care services to tertiary care services.

If VA is unable to provide care, care may be purchased by VA in the community, as determined appropriate by the VA Medical Center based on the particular clinical circumstance.

**Question 2: Telehealth.** Your testimony elaborates on the VA's care coordination/home telehealth programs.

**Question 2(a):** What are some of the challenges that VA is facing in procuring equipment that is standard throughout the system for these programs?

**Response:** The challenges that VA faces procuring technology that is standard for home telehealth fit into two broad categories: (1) equipment interoperability and (2) scalability of technology. The home telehealth industry is relatively small and emerging. When it is appropriate to do so, VA is working with the vendor community to ensure systems are interoperable and to extend the functionalities available to support the care of veteran patients in their own homes.

VA has a very large installed base of home telehealth technologies with which to support the timely care of veteran patients in their own homes. The home telehealth network VA has created is unprecedented in size and complexity. As this network continues to grow, VA is working with the vendor community to ensure systems are robust, sustainable, and compatible.

**Question 2(b):** Please elaborate on the telecommunications strategies VA is currently working on to facilitate the provision of CCHT services in rural areas to improve access and reduce travel times for veterans?

**Response:** In the first phase of its national care coordination home telehealth (CCHT) expansion—2004–2008—VA has relied upon telephone connectivity to veteran's homes. This strategy was pursued because: (1) telephone lines were relatively ubiquitous, (2) it was the dominant telecommunication infrastructure chosen by the vendor community, (3) ease of installation for patients and staff and (4) staff and patients had the technical skills necessary to "troubleshoot" any problems. VA is now considering how other telecommunications modalities could help support the care of veteran patients when telephone lines are not available or adequate. Ease of use by patients and staff continues to remain of paramount concern as VA continues to explore such future options.

**Question 2(c):** What is the actual number of veterans taking advantage of the CCHT services? What percentage does that represent in the overall veteran population that VA treats?

**Response:** On May 5, 2007, CCHT programs in VA were supporting 25,556 patients nationally. This number represents 0.1 percent of the total population VHA treats. However, this CCHT figure represents 50 percent of the population of patients with chronic disease for which the program was implemented to provide care. Given the necessary evolution of the technology and attendant clinical and business support processes, a possible 1.1 million (20 percent) of veterans could benefit from such assistive devices in the home.

**Question 3: CBOCs.** In the last CBOC report received by this Subcommittee, dated March 30, 2007, VA reported a growth of 8 percent over the last 3 years in the activation of the 156 priority CBOCs that were listed in the CARES Decision of May 2004. At that rate it will take 30 years to open these 156. Realizing that VISNs can propose the activation of CBOCs not in the CARES document:

**Question 3(a):** Do you think that a pace of 8 percent over 3 years is going to be effective?

**Response:** The Capital Asset Realignment for Enhanced Services (CARES) decision document indicated a plan to have all 156 open by 2012 (pending availability of resources and validation with the most current data available). In fiscal year (FY) 2007, after data validation, only CARES priority Community-Based Outpatient Clinics (CBOCs), or newly identified CBOCs that met the CARES priority criteria were placed on the list to open.

The newly identified CBOCs had to meet one of the following CARES priority criteria. The CBOC must be:

- Located in a market with less than 70 percent of enrollees within access guidelines, and having more than 7,000 clinic stops planned for the CBOC.
- Located in a market with less than 70 percent of enrollees within access guidelines, and located in a rural or highly rural county.
- Part of a Department of Defense (000) collaboration.
- Needed for a CARES realignment decision.
- Needed to relieve space constraints at the parent facility and located within 20 minutes of the parent facility.

As of May 25, 2007, VA has opened or approved to open 88 CBOCs. The following list shows where they are and when they are scheduled to open in FY 2007 or 2008.

VISN	Clinic	State	Approved	Status
2	Warsaw	NY	Jun-04	Open
4	Bangor	PA	Jun-04	Open
4	Dover	DE	Mar-06	Opening in FY2007
4	Fayette	PA	Jun-04	Open
4	Gloucester	NJ	Jun-04	Open
4	Monongalia County	WV	May-07	Opening in FY2007
4	Venango	PA	Jun-04	Open
4	Warren	PA	Jun-04	Open
5	Andrews AFB	MD	May-07	Opening in FY2008
5	Ft. Detrick	MD	May-07	Opening in FY2008
6	Charlottesville	VA	May-07	Opening in FY2008
6	Franklin	NC	Mar-06	Opening in FY2008
6	Hamlet	NC	Mar-06	Opening in FY2008
6	Hickory	NC	Mar-06	Opening in FY2008
6	Lynchburg	VA	Mar-06	Opening in FY2008
6	Norfolk	VA	Mar-06	Opening in FY2007
7	Aiken	SC	May-07	Opening in FY2008
7	Athens	GA	Mar-06	Open
7	Bessemer	AL	Mar-06	Opening in FY2007
7	Childersburg	AL	May-07	Opening in FY2007
7	Goose Creek	SC	Sep-04	Open
7	Spartanburg	SC	May-07	Opening in FY2008
7	Stockbridge	GA	May-07	Opening in FY2007
8	Camden County	GA	May-07	Opening in FY2008
8	Jackson County	FL	May-07	Opening in FY2008
8	Putnam County	FL	May-07	Opening in FY2008
8	Sumter—The Villages	FL	Sep-04	Open
9	Berea	KY	May-07	Opening in FY2007
9	Covington	TN	Sep-04	Open
9	Dupont	KY	Jun-04	Open

<b>VISN</b>	<b>Clinic</b>	<b>State</b>	<b>Approved</b>	<b>Status</b>
9	Grayson County	KY	May-07	Opening in FY2008
9	Hamblen	TN	Mar-06	Opening in FY2007
9	Hawkins County	TN	May-07	Opening in FY2008
9	Hazard	KY	Mar-06	Opening in FY2008
9	Madison County	TN	May-07	Opening in FY2008
9	Memphis—South Clinic	TN	Jun-04	Open
9	Standiford	KY	Jun-04	Open
9	Vine Hill	TN	Jun-04	Open
9	Morehead	KY	Sep-04	Open
10	Cambridge	OH	Mar-06	Open
10	Florence/Boone City	KY	Mar-06	Open
10	Hamilton	OH	May-07	Opening in FY2007
10	Marion	OH	Jun-04	Open
10	New Philadelphia	OH	Jun-04	Open
10	Newark	OH	Mar-06	Open
10	Parma	OH	May-07	Opening in FY2008
10	Ravenna	OH	Jun-04	Open
11	Alpena County	MI	May-07	Opening in FY2008
11	Clare County	MI	May-07	Opening in FY2008
11	Elkhart County	IN	May-07	Opening in FY2007
15	Daviess County	KY	May-07	Opening in FY2007
15	Graves County	KY	Sep-04	Opening in FY2009
15	Hopkins County	KY	Sep-04	Open
15	Hutchinson	KS	May-07	Opening in FY2008
15	Jefferson City	MO	May-07	Opening in FY2008
15	Knox County	IN	May-07	Opening in FY2008
16	Branson	MO	May-07	Opening in FY2008
16	Conroe	TX	Mar-06	Open
16	Eglin	FL	Feb-06	Opening in FY2008
16	Hammond	LA	Feb-06	Open
16	La Place/St Johns	LA	Feb-06	Open
16	Pine Bluff	AR	May-07	Opening in FY2008
16	Slidell	LA	Feb-06	Open
17	San Antonio—VA/DoD Joint	TX	Sep-04	Open
18	Miami/Globe	AZ	Mar-06	Opening in FY2008
18	NW Tucson	AZ	Mar-06	Opening in FY2007
18	SE Tucson	AZ	Mar-06	Opening in FY2008
19	Cut Bank	MT	May-07	Opening in FY2008

VISN	Clinic	State	Approved	Status
19	Lewistown	MT	May-07	Opening in FY2008
19	Western Salt Lake City Valley	UT	May-07	Opening in FY2008
20	Canyon City	ID	Mar-06	Opening in FY2007
20	North Idaho	ID	May-07	Opening in FY2008
20	Northwest WA	WA	May-07	Opening in FY2007
20	Central Washington	WA	Feb-07	Opening in FY2007
21	American Samoa		Mar-06	Opening in FY2007
21	Fallon	NV	Mar-06	Opening in FY2007
22	Orange	CA	Mar-06	Opening in FY2007
23	Bellevue	NE	May-07	Opening in FY2007
23	Bemidji—Fosston	MN	Mar-06	Opening in FY2007
23	Carroll	IA	May-07	Opening in FY2007
23	Cedar Rapids	IA	May-07	Opening in FY2007
23	Holdredge	NE	Mar-06	Opening in FY2007
23	Marshalltown	IA	May-07	Opening in FY2007
23	Shenandoah	IA	May-07	Opening in FY2007
23	Spirit Lake	IA	Mar-06	Opening in FY2007
23	Wagner	SD	May-07	Opening in FY2007
23	Watertown	SD	May-07	Opening in FY2007
23	Western WI (Rice Lake)	WI	Mar-06	Opening in FY2007

**Question 3(b):** What do you think the pace should be?

**Response:** We believe the current pace is reasonable. It is important that VHA grow at a manageable rate as the organization continues to make significant improvements to access.

**Question 3(c):** Do you believe the cumbersome planning and activation process currently in place at VA is a stopgap for those medical centers who serve the rural community?

**Response:** The difficulty in opening a CBOC in rural markets is related to the unique challenges in providing care in remote areas. Staff are at times difficult to hire, and partners or other contracting entities are scarce. VA is constantly exploring and establishing alternatives to CBOCs to provide care in these rural communities such as outreach clinics and telemedicine capabilities.

**Question 3(d):** How would you streamline the process so rural veterans are not waiting 25 years for a CBOC to be activated in their area?

**Response:** As evidence of the fact that improving access in rural areas is a high priority for VHA, of the 156 CBOCs on the priority list, 103 are in rural areas. In some rural areas, as noted above, outreach clinics may be more appropriate than a CBOC due to the unique challenges in these remote areas.

**Question 3(e):** What good did the prioritization of the CBOCs do if VA is not following their own plan? What is the role of the priority list if the VA opens clinics not on the priority list?

**Response:** In FY 2007, only CARES priority CBOCs, or newly identified CBOCs that met the CARES priority criteria were placed on the list to be considered. As veteran populations and demographics are constantly changing, some of the CARES priority CBOCs will no longer meet the criteria, while alternative locations meet the criteria and the needs of the patient population served. VA will continually need to

update the plans for establishing additional CBOCs in order to reflect the changes in veteran population, as well as advances in healthcare delivery practices.

**Question 4: *Access to Transportation.*** The issue of access to transportation is vital to providing healthcare to veterans in rural communities.

**Question 4(a):** With the veteran population aging and increasingly rural, how can VA better connect veterans with their ongoing healthcare needs?

**Response:** Technological advancements are, and will continue to be, the primary way that VA can better connect with veterans, in their own homes, to deliver healthcare services. VHA's Office of Care Coordination oversees VA's CCHT program. This program uses a variety of home-telehealth technologies to monitor the care of patients with chronic conditions directly from their homes. The CCHT program encourages patient self-management and a national network of care coordinators in every Veterans Integrated Service Network (VISN) facilitates access to appropriate care across the continuum.

VA has a variety of arrangements across the system for transportation assistance. VA operates more than 1,300 vans donated primarily by service organizations, which assist in bringing veterans into VHA facilities. Once donated, VA maintains these vans, assists with recruiting volunteer drivers, and has developed a training and medical clearance program for all volunteers. Today, VA has almost 10,000 volunteers that have donated more than 1.8 million hours to serve as volunteer drivers.

Further assistance in transportation is provided by the local healthcare system and varies depending on the ability to secure donated vans and volunteer drivers and the need of the veteran patient. Some systems use an 'out-placed van' method where they have pre-determined pick-up stops and/or will pick up a veteran at their home to bring them into a VA facility for appointments or services. Others operate a shuttle service between their facilities, with some including stops at pre-determined pick-up locations.

**Question 4(b):** Has the agency looked to review partnerships with community-based public transportation systems operating in these areas?

**Response:** At the national level, a partnership with community-based public transportation systems has not been addressed. However, at the local level, VA healthcare systems work with localities to assist with transportation. Examples of this are providing bus and/or train passes for veterans needing transportation.

**Question 5: *Interventions to Improve Healthcare in Rural America.*** In a study done in 2005, the Institute of Medicine found that a wide range of interventions are available to improve health and healthcare in rural America, such as education, community and environmental planning. Making explicit the full range of options available to rural communities to improve personal and population health should lead to more optimal allocation of scarce financial.

**Question 5(a):** Has the VA implemented any interventions to improve personal or population health among the rural veteran population?

**Response:** To address both personal and population health, VHA's Office of Public Health and Environmental Hazards has several strategic healthcare groups that have implemented programs and policies to improve the health of rural veterans.

In particular, the Public Health Strategic Healthcare Group, (PHSHCG) has addressed the needs of enrolled veterans living with human immunodeficiency virus (HIV) residing in rural areas. For example, employing a postage paid mail-back card allowing patients to self report results of purified protein derivative (PPD) testing (for exposure to mycobacterium tuberculosis), eliminates the need for rural patients to make a return visit to the medical center. Care delivery models which allow patients in rural areas to locally access routine services such as blood specimen drawing through modification of CBOC contracts and/or linkage with community-based programs located in rural areas have been implemented.

Additionally, the Women Veterans Strategic Healthcare Group, which is committed to providing the highest quality care to women veterans, has continued to advocate for access for women's gender related care, such as mammograms and obstetrical care must be provided within 1 hour drive/50 miles, using non-VA providers when necessary (Handbook 1330.01, Proposed revisions 2007).

Through their work in national programs to improve the health of all veterans, these strategic healthcare groups have implemented programs and policies to improve the health of rural veterans.

The Department of Health and Human Services (HHS) and VA signed a memorandum of understanding (MOU) in February 2003 to encourage cooperation and re-

source sharing between the Indian Health Service (IHS) and the VHA to deliver quality healthcare services and enhance the health status of American Indian and Alaska Native (AI/AN) veterans.

*Outreach:* Most networks are engaged in a variety of outreach activities, including meetings and conferences with IHS program and tribal representatives, VA membership in the Native American Healthcare Network, VA participation in traditional Native American ceremonies, transportation support to AI/AN, etc.

*Clinical Programs:* An example of clinical collaborations involves a diabetes prevention program that has been developed jointly by VHA and IHS staff in San Diego, Albuquerque, and Greater LA. The goal is to reach Native Americans in their communities.

*Education:* VHA provides training programs to IHS staff and the tribal community. In 2006, VHA delivered 145 training programs, of which 90 were made available using satellite technology and 55 using web-based technology. These educational programs will be continued in 2007, and VHA will also provide selected IHS staff an opportunity to attend regional workshops.

*Behavioral Health:* The Behavioral Health Workgroup developed a framework for AI/AN communities to assist returning Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) AI/AN servicemembers and veterans reintegrate with their families and communities and readjust to civilian life. The objective is to promote a community health model that gives tools to Tribal communities and families to help returning veterans address emerging adjustment reactions, traumatic stress, and post traumatic stress disorder (PTSD), emphasizing recovery as the goal. The Joint Committee has developed a slide presentation to be used by outreach teams when addressing various Tribal veterans. There have been briefings using the slide presentation in Montana, with approximately 30 veterans now receiving services from VA.

*Expanded Healthcare Services:* At the local level, 10 VHA networks are engaged in targeted initiatives aimed at providing a full continuum of healthcare services, such as; health fairs, VA/IHS advisories, use of health buddy, and education and/or shared services in substance abuse, domestic violence programs, cardiac rehabilitation, dietetics, behavioral medicine, etc.

*Care Coordination:* The VHA–IHS Shared Healthcare Workgroup has drafted an Interdepartmental Coordinated Care Policy, the goal of which is to optimize the quality, appropriateness and efficacy of the healthcare services provided to eligible AI/AN veterans receiving care from both VHA and IHS or Tribes; and to improve the patient's satisfaction with the coordination of care between the two Departments.

*Telemedicine:* Telemedicine has proven to be extremely effective in the treatment of PTSD in Alaskan Native villages. VA and IHS are working to spread the use of telemedicine services by AI/AN veterans, which will allow VA to bring physical and mental healthcare to the tribes, especially those in remote areas of the country.

*Traditional Healing:* Some VHA facilities and vet centers have incorporated traditional healing ceremonies along with modern methods of treatment and counseling. As a national initiative, VA has sent over 500 letters to tribal leaders to ask them to provide information on appropriate providers of traditional practices so that they may be called upon for religious/spiritual care of AI/AN veterans.

**Question 5(b):** Has VA collaborated with HRSA on any of these interventions?

**Response:** The Institute of Medicine (IOM) 2005 report *Quality Through Collaboration: The Future of Rural Healthcare* did not specifically recommend how rural veterans would benefit from a health resources and services administration (HRSA), collaboration, however, VHA has collaborated with Health and Human Services to address rural veterans in several ways; we currently have a small number of contracts with federally qualified health centers (FQHCs) and we have a MOU with IHS.

In addition, rural veterans with HIV who live at a great distance from the closest VA Medical Center were informed that they were eligible to receive HIV/AIDS care through community-based HRSA clinics who were recipients of Ryan White funding, if this care would be more convenient for them.

**Question 6: Hospital-at-Home.** Since 1994, Johns Hopkins Hospital has been developing a hospital-at-home model. In 2005, new research released suggested that many of the patients could be treated just as safely and effectively at home than in a hospital.

**Question 6(a):** Do you believe a program like this would work in rural areas?

**Response:** The work of Johns Hopkins Hospital in this area is commendable and adds to the weight of evidence supporting the direct provision of care in the home to acutely ill older patients, when it is safe and appropriate to do so. Caring for acutely ill patients via a hospital-at-home program is an outreach program that is geographically restricted to a defined radius (e.g. 25 miles) or set travel time (e.g. 20 minutes) from a suitably equipped acute hospital. As such, hospital-at-home models as currently conceived are not a readily deployable model for care in rural areas where distance, low population density and staff recruitment issues make them difficult to implement. VA is seeking to use telehealth to monitor such rural health patients and enable them to self-manage their condition. This approach relies upon early detection of patient deterioration and preemptive referral of patients across the continuum of care. VHA's care coordination model is conducive to this approach.

Although this may not be a model for all geographic areas, staffs in the Office of Geriatrics and Extended Care who are charged with both community-based care and with acute care for the elderly are interested in promoting expansion of this model, as appropriate, within VA. Plans are underway to initiate a hospital-at-home program at the New Orleans VA by July 1 to partially address the shortage of VA hospital beds due to Hurricane Katrina. Discussions have begun to explore a similar undertaking in Honolulu, with possibly broader application throughout the Hawaiian Island chain. Rural expansion from an urban center on Oahu, and one based out of CBOCs as has been already discussed as a second phase for New Orleans, will be logical next steps for assessing the feasibility of migration of the model into more rural settings.

**Question 7:** Partnerships. To what extent is VA working with existing state and federal healthcare providers, for example State veterans homes or CMS designated Critical Access Hospitals, in rural areas to coordinate and capitalize on limited resources available in rural communities to maximize range of services? If this is not occurring, is VA willing to explore coordinated efforts with these types of government supported healthcare providers?

**Response:** VHA has united with existing State and Federal healthcare providers to coordinate and capitalize on resources available in rural communities and to maximize the range of services. Currently, VHA has a relationship with 122 State-owned veteran's homes, 54 domiciliaries, 4 hospitals, and 2 adult daycare facilities. VA provides a per diem payment to the facilities for veterans care. Approximately 75 of VA's State home collaborations are in rural areas.

VHA also collaborates with FQHCs, including Community Health Centers, at the local level based on the local needs. VA will continue to collaborate and develop partnerships with various government and nongovernmental organizations to meet the individual needs of veterans.

VHA will continue to partner with other agencies, including collaboration by education and training on issues specific to providing care to veterans. Through VHA's Office of Rural Health, we will further explore ways to expand healthcare in rural areas.

---

**Questions from Hon. Joe Donnelly to Dr. Michael J. Kussman  
Acting Under Secretary for Health, U.S. Department of Veterans Affairs**

**Question 8: Elkhart County CBOC.** Convenient access to local healthcare for veterans is an important concern of both my constituents and of this Committee. While the CARES Commission of 2004 set out future priorities for facility management, CARES recommendations are not always followed and are sometimes altered. Through conversations my office and I have had with VA VISN 11 officials in Indiana, it is our shared expectation to soon open a CBOC in Elkhart County, Indiana. While an Elkhart County CBOC opening does not appear on the CARES priority recommendations, according to these officials, the proposal to open a CBOC in Elkhart County has successfully passed several preliminary stages within the Department and is pending final approval by the Secretary. VA officials in Indiana are optimistic that the opening of a new CBOC could begin in early FY 2008. Further, if a new CBOC is opened in Elkhart County, some constituents of mine are concerned that the VA will require some veterans who live within the county to receive care at a CBOC located in another county.

**Question 8(a):** Is the VA considering opening a new CBOC in Elkhart County, Indiana? If so, at what stage in the process is this decision; and if approved, when

can the people of Elkhart County expect the opening of the bidding process for management of the CBOC?

**Response:** The Elkhart County CBOC has been approved. Local VA officials are working on the activation of the clinic. We will keep all stakeholders informed as this proceeds.

**Question 8(b):** If a CBOC is opened in Elkhart County, will all Elkhart County veterans have the opportunity to choose to receive care at this new facility?

**Response:** The service area for the proposed Elkhart County CBOC includes 100 percent of Elkhart County. All veterans within the county may request care at the CBOC and will be accommodated based on eligibility, clinic capacity, and the care requirements of the Veteran.

**Question 9: *Peru, Indiana CBOC.*** The Secretary's CARES Decision included Peru, Indiana on the list of CBOC priority implementation. Officials at VA VISN 11 hope that a new CBOC could be opened in the Peru area during FY 2009. Is the VA considering opening a new CBOC in Peru, Indiana? If so, at what stage in the approval process is this decision; and if approved, when can the people of north central Indiana expect this CBOC to open?

**Response:** A business plan has not been prepared by the VISN for a CBOC in Peru, Indiana. The earliest that a CBOC for Peru could be requested would be in FY 2009 and a business plan would be prepared at that time.

**Question 10: *Fort Wayne Campus.*** The CARES Commission 2004 report proposed closing the acute care and lieu services provided at the Fort Wayne campus of the VA Northern Indiana Healthcare System, citing the availability of tertiary care at VA facilities at Ann Arbor and Indianapolis and initial low projections of anticipated demand for inpatient care. However, since the report was published, projections were updated and actually showed higher usage rates for the future. It is my understanding that, as a result, the VA is reexamining the 2004 report's proposal regarding Fort Wayne. Many veterans in my district, as well as many thousands more from across northern Indiana have come to count on high-quality care and valuable patient-provider relationships formed at the Fort Wayne inpatient facilities for meeting their health needs. Further, directing veterans in northern Indiana to seek care in Ann Arbor or Indianapolis would be a significant new hurdle in receiving VA medical services. In light of the new projections for the future use of the Fort Wayne inpatient services, and the thousands of new Hoosier veterans who will need care connected to their service in Operation Iraqi Freedom or Operation Enduring Freedom, it seems to me that limiting the services provide by Fort Wayne now would be counter-intuitive.

**Question 10(a):** What factors are being considered in the reevaluation of the 2004 recommendation on Fort Wayne?

**Response:** Factors that are being considered in the analysis of options for Fort Wayne include:

- **Access:** Considers barriers whether imposed by geography, disability, finances, or simply a lack of available services which can compromise the quality, satisfaction, and coordination of care, resulting in poor outcomes.
- **Flexibility:** Measures each options ability to manage change in demand.
- **Cost Effectiveness:** Evaluates the total life cycle costs for a project and then compares it against other viable project alternatives.
- **Impact on Other VA Goals/Missions:** Measures the impact on other VA goals/Missions.
- **Risk of Implementation:** Assesses risk on two dimensions, the probability that the risk will occur and the impact of the risk. Twenty-five individual risk factors are identified.

**Question 10(b):** When does the Department anticipate making a permanent decision regarding the services provided by the Fort Wayne VA hospital?

**Response:** The contractor will be submitting their final report in August, 2007. The Secretary will make a decision after this time.



Committee on Veterans' Affairs  
 Subcommittee on Health  
 Washington, DC  
 April 27, 2007

Michael J. Kussman, MD, MS, MACP  
 Acting Under Secretary for Health  
 U.S. Department of Veterans Affairs  
 Washington, DC 20420

Dear Dr. Kussman:

On Wednesday, April 18, 2007, Dr. Gerald Cross testified before the Subcommittee on Health. As a followup to the hearing, I am requesting the following questions be answered in written form for the record:

1. Please describe the process that VA undergoes to develop a new Community-Based Outpatient Clinic (CBOC) and obtain all necessary approvals. How long does each phase of that process take?
2. Have any new CBOCs been proposed *since* the May '04 CARES report? Please identify where they are, and when they are scheduled to be activated.
3. Have decisions been made not to proceed with any of the 156 CBOCs proposed in the May '04 CARES report? If so, please explain further.
4. Does VA currently impose enrollment limits or caps on CBOCs? If so, how does that work?
5. How would you characterize the limitations on marketing new CBOC enrollments? How is that implemented logistically?
6. What happens if OEF/OIF veterans want to enroll in a CBOC that has been prevented from enrolling additional new veterans?
7. Some CBOCs offer mental health services through VA staff and others through contractor personnel. What are the criteria that determine who provides mental health services in a given location?
8. What is the average length of time it takes for a contract provider to be credentialed by VA? Are there any significant issues that cause delays in provider credentialing throughout VA?
9. Mr. Behrman testified that there were a limited number of successful collaborations between VA and Community Health Centers. However, the contracts were discontinued. Why were these contracts discontinued? Should this type of partnership be expanded to other rural States?
10. Has VA established policies whereby VA will contract with Critical Access Hospitals and other primary care providers in rural areas to provide primary and preventive healthcare to rural veterans who lack reasonable access to VA facilities?
11. Does VA have performance measures in place to evaluate how effective the Vet Center program is in providing quality readjustment counseling and removing unnecessary barriers to care for veterans and family members?
12. VA's testimony stated: "VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of healthcare for rural veterans. We also have partnerships with HHS, including the Indian Health Services and Office of Rural Health providing care in rural communities." Where are the current collaborative efforts?
13. What percent of rural healthcare is provided through contract care?
14. What are the challenges of providing care to the aging veteran population in rural areas? How is VA addressing these challenges?
15. How does VA differentiate between a rural veteran traveling over an hour to a healthcare facility, and a veteran in an urban area traveling over an hour to a healthcare clinic in rush hour?
16. Public Law 109-461 directs the Secretary to expand mental health services in outpatient clinics. What is VA doing to expand this capability? How many CBOCs had mental health capabilities in April 2005 and how many have mental health capabilities today?
17. What are the challenges in providing mental health services in rural communities?
18. VA Central Office reviews waiting times. How do the waiting times for specialty care in rural areas compare with those in urban centers?
19. Musculoskeletal ailments (principally joint and back disorders) are among the top health problems of veterans returning from Iraq and Afghanistan according to a November 2006 VA study. Currently, chiropractic care is only available at about 20% of all VA facilities and most veterans do not have access

to care, despite back issues being the ailment that affects the most veterans. Has the VA developed plans on how to further implement chiropractic care into the VA healthcare system?

20. What is the status—and, if available, the initial findings—of the VA's Project HERO demonstration project?
21. The VA's March 30th report to Congress detailing CBOCs approved for activation only lists 6 CBOCs approved for an FY08 opening. Will more be approved? Was the proposed VISN-approved CBOC for Hutchinson, KS turned down or is it still under consideration by the VA?

Additionally, Dr. Petzel and Dr. Darkins accompanied Dr. Cross. I would request that they respond to the following for the record:

1. Dr. Petzel: One may consider VISN 23 as one of the most rural VISNs in the VA system. How has VISN 23 improved access for veterans? Have you been working with other VISN Directors to share some of the best practices from VISN 23 in providing access to veterans?
2. Dr. Darkins: How can telemedicine help provide access to veterans? What are the limitations of telemedicine? Are there any circumstances in which you would not recommend the use of telemedicine?

Respectfully,

Jeff Miller  
Ranking Republican Member

---

**Questions from Hon. Jeff Miller, Ranking Republican Member  
Subcommittee on Health, to Dr. Michael Kussman, Acting  
Under Secretary of Health, Veterans Health Administration  
U.S. Department of Veterans Affairs**

**Question 1(a):** Please describe the process that VA undergoes to develop a new Community-Based Outpatient Clinic (CBOC) and obtain all necessary approvals.

**Response:** *Planning process.* CBOC planning is a partnership between the Veterans Integrated Service Networks (VISN) and Headquarters' strategic planning process. This allows decisions regarding CBOC need and priorities to be made in the context of available resources, as well as local market circumstances and veteran preferences. During the Capital Asset Realignment for Enhanced Service (CARES) planning process, the VISNs identified 242 CBOCs to potentially address access and space issues. Of these 242 CBOCs, 156 were prioritized and published in the Secretary's CARES Decision Document in April 2004 since they met the requirements of:

- Located in a market with less than 70 percent of enrollees within the access guidelines (distance a veteran is required to travel to receive care) and having more than 7 DoD Clinic Stops planned for the CBOC.
- Located in a market with less than 70 percent of enrollees within access guidelines, and located in a rural or highly rural county.
- Part of a VA/Department of Defense (DoD) collaboration.
- Needed as a result of a CARES realignment decision.
- Needed to relieve space constraints at the parent facility and located within 20 minutes of the parent facility.

Plans for activating CBOCs are included in the VISNs' strategic plans, and are updated with the most current data after the strategic plan submission at the request of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) for the purposes of forecasting activation of CBOCs for budget cycles. CBOCs are primarily funded through existing VISN resources. As a result, planning for CBOCs is also dependant on fiscal year (FY) budget forecasts and allocations. VISN chief fiscal officers must certify that the facility can maintain services given current budget scenarios at the time the CBOC business plan is being reviewed against national planning criteria.

*Review process.* The review process for new CBOCs is documented in the Veteran Health Administration (VHA) Handbook 1006.1 *Planning and Activation of CBOCs* and consists of the following:

- VISNs submit CBOC business plans for review against national planning criteria. VISNs submit plans for CBOCs that were (1) identified in CARES, (2) identified in the network strategic plan and/or updates provided to DUSHOM

on plans for CBOC activation. VISNs certify that the CBOC can be implemented within existing funds once approved.

- National review panels (NRP) convene to review proposals against national planning criteria as below:
  - Located in a market not meeting VA access guidelines
  - Space deficits at the parent facility
  - Number of users and enrollees
  - Market penetration
  - Unique considerations—such as: targeted minority veteran populations, geographic barriers, highly rural and/or low population density, medically underserved, DoD sharing opportunity, parking and transit issues at parent facility
  - Cost effectiveness of proposed site
  - Impact on specialty care waiting times
  - The NRP submits results of review with recommendations to DUSHOM.

*Approval:* Business plans for new CBOCs that are recommended for approval by the national review panel require Under Secretary for Health (USH) and Secretary approvals and Congressional notification. The process is as follows:

- DUSHOM obtains approvals from USH and Secretary
- Office of Management and Budget (OMB) review
- Congressional notification

**Question 1(b):** How long does each phase of that process take?

**Response:** Timeframes involved in the review process are estimated below:

- Develop CBOC business plans: 2–3 months
- NPR review: 3 months
- USH and Secretary approval: 2–3 months

**Question 2:** Have any new CBOCs been proposed since the May '04 CARES report? Please identify where they are, and when they are scheduled to be activated.

**Response:** Since the May 2004 CARES report, VA has opened or approved to open 88 CBOCs. The following list shows where they are and when they are scheduled to open in FY 2007 or 2008.

VISN	Clinic	State	Approved	Status
2	Warsaw	NY	Jun-04	Open
4	Bangor	PA	Jun-04	Open
4	Dover	DE	Mar-06	Opening in FY2007
4	Fayette	PA	Jun-04	Open
4	Gloucester	NJ	Jun-04	Open
4	Monongalia County	WV	May-07	Opening in FY2007
4	Venango	PA	Jun-04	Open
4	Warren	PA	Jun-04	Open
5	Andrews AFB	MD	May-07	Opening in FY2008
5	Ft. Detrick	MD	May-07	Opening in FY2008
6	Charlottesville	VA	May-07	Opening in FY2008
6	Franklin	NC	Mar-06	Opening in FY2008
6	Hamlet	NC	Mar-06	Opening in FY2008
6	Hickory	NC	Mar-06	Opening in FY2008
6	Lynchburg	VA	Mar-06	Opening in FY2008
6	Norfolk	VA	Mar-06	Opening in FY2007
7	Aiken	SC	May-07	Opening in FY2008

<b>VISN</b>	<b>Clinic</b>	<b>State</b>	<b>Approved</b>	<b>Status</b>
7	Athens	GA	Mar-06	Open
7	Bessemer	AL	Mar-06	Opening in FY2007
7	Childersburg	AL	May-07	Opening in FY2007
7	Goose Creek	SC	Sep-04	Open
7	Spartanburg	SC	May-07	Opening in FY2008
7	Stockbridge	GA	May-07	Opening in FY2007
8	Camden County	GA	May-07	Opening in FY2008
8	Jackson County	FL	May-07	Opening in FY2008
8	Putnam County	FL	May-07	Opening in FY2008
8	Sumter—The Villages	FL	Sep-04	Open
9	Berea	KY	May-07	Opening in FY2007
9	Covington	TN	Sep-04	Open
9	Dupont	KY	Jun-04	Open
9	Grayson County	KY	May-07	Opening in FY2008
9	Hamblen	TN	Mar-06	Opening in FY2007
9	Hawkins County	TN	May-07	Opening in FY2008
9	Hazard	KY	Mar-06	Opening in FY2008
9	Madison County	TN	May-07	Opening in FY2008
9	Memphis—South Clinic	TN	Jun-04	Open
9	Standiford	KY	Jun-04	Open
9	Vine Hill	TN	Jun-04	Open
9	Morehead	KY	Sep-04	Open
10	Cambridge	OH	Mar-06	Open
10	Florence/Boone City	KY	Mar-06	Open
10	Hamilton	OH	May-07	Opening in FY2007
10	Marion	OH	Jun-04	Open
10	New Philadelphia	OH	Jun-04	Open
10	Newark	OH	Mar-06	Open
10	Parma	OH	May-07	Opening in FY2008
10	Ravenna	OH	Jun-04	Open
11	Alpena County	MI	May-07	Opening in FY2008
11	Clare County	MI	May-07	Opening in FY2008
11	Elkhart County	IN	May-07	Opening in FY2007
15	Daviess County	KY	May-07	Opening in FY2007
15	Graves County	KY	Sep-04	Opening in FY2009
15	Hopkins County	KY	Sep-04	Open
15	Hutchinson	KS	May-07	Opening in FY2008
15	Jefferson City	MO	May-07	Opening in FY2008

VISN	Clinic	State	Approved	Status
15	Knox County	IN	May-07	Opening in FY2008
16	Branson	MO	May-07	Opening in FY2008
16	Conroe	TX	Mar-06	Open
16	Eglin	FL	Feb-06	Opening in FY2008
16	Hammond	LA	Feb-06	Open
16	La Place/St Johns	LA	Feb-06	Open
16	Pine Bluff	AR	May-07	Opening in FY2008
16	Slidell	LA	Feb-06	Open
17	San Antonio—VA/DoD Joint	TX	Sep-04	Open
18	Miami/Globe	AZ	Mar-06	Opening in FY2008
18	NW Tucson	AZ	Mar-06	Opening in FY2007
18	SE Tucson	AZ	Mar-06	Opening in FY2008
19	Cut Bank	MT	May-07	Opening in FY2008
19	Lewistown	MT	May-07	Opening in FY2008
19	Western Salt Lake City Valley	UT	May-07	Opening in FY2008
20	Canyon City	ID	Mar-06	Opening in FY2007
20	North Idaho	ID	May-07	Opening in FY2008
20	Northwest WA	WA	May-07	Opening in FY2007
20	Central Washington	WA	Feb-07	Opening in FY2007
21	American Samoa		Mar-06	Opening in FY2007
21	Fallon	NV	Mar-06	Opening in FY2007
22	Orange	CA	Mar-06	Opening in FY2007
23	Bellevue	NE	May-07	Opening in FY2007
23	Bemidji—Fosston	MN	Mar-06	Opening in FY2007
23	Carroll	IA	May-07	Opening in FY2007
23	Cedar Rapids	IA	May-07	Opening in FY2007
23	Holdrege	NE	Mar-06	Opening in FY2007
23	Marshalltown	IA	May-07	Opening in FY2007
23	Shenandoah	IA	May-07	Opening in FY2007
23	Spirit Lake	IA	Mar-06	Opening in FY2007
23	Wagner	SD	May-07	Opening in FY2007
23	Watertown	SD	May-07	Opening in FY2007
23	Western WI (Rice Lake)	WI	Mar-06	Opening in FY2007

**Question 3:** Have decisions been made *not* to proceed with any of the 156 CBOCs proposed in May '04 CARES report? If so, please explain further.

**Response:** The only CARES CBOCs for which a decision has been made not to proceed were in VISN 9. VISN 9, along with their stakeholders, embarked on a reassessment of all proposed CBOCs analyzing current demographics and comparing to national criteria. Based on this review, some did not meet national criteria, and others had overlapping coverage. The sites in VISN 9 deleted from the CARES priority list are:

Holston Medical Clinic, TN  
 Pennington Gap Clinic, VA  
 Thompson Clinic, VA  
 Haysi Clinic, VA  
 Davenport Clinic, VA  
 Davis Clinic, VA  
 West Lee County, VA  
 Pontotoc County, MS  
 Tunica, MS  
 Grenada, MS  
 Wynne–Cross County, AR  
 Glasgow, KY  
 Giles County/Pulaski, TN  
 London, KY

**Question 4:** Does VA currently impose enrollment limits or caps on CBOCs? If so, how does that work?

**Response:** While there is no national guidelines on when a CBOC would be declared “at capacity,” a VHA facility might infrequently determine that they are at capacity based on the number of patients per physician and other local factors. In these rare instances new patients would be cared for at the nearest VA Medical Center. This would apply to new patients only and not existing patients, and would generally be a short term in nature lasting only until additional resources in the form of providers and/or space can be identified.

**Question 5:** How would you characterize the limitations on marketing new CBOC enrollments? How is that implemented logistically?

**Response:** A public announcement in the local press is made that a CBOC has been approved. While the site is being finalized the medical center prepares letters that are sent to existing veterans who reside in the new service area. These veterans can elect to change their primary care provider to the new CBOC site or remain at the parent site.

Marketing new enrollment is not done, beyond the notification of an opened CBOC through press releases and ground breaking. New veterans who decide to use the VA for care complete an enrollment process. As part of that process they have the choice of selecting the new CBOC as their primary care site.

**Question 6:** What happens if OEF/OIF veterans want to enroll in a CBOC that has been prevented from enrolling additional new veterans?

**Response:** Cases in which Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans are not able to be seen at the clinic of their choice are very rare, but in these rare cases the veteran may need to be seen at the nearest VA Medical Center (VAMC). A small number of CBOCs across the country are at capacity and are referring patients to the nearest medical center for treatment. For example, if the OEF/OIF veteran has emergent care needs, the parent VAMC and CBOC will make every effort to accommodate.

**Question 7:** Some CBOCs offer mental health services through VA staff and others through contractor personnel. What are the criteria that determine who provides mental health services in a given location?

**Response:** All CBOCs must provide mental health services either by providing services onsite, purchasing services through a contract or providing telepsychiatry/telemedicine. The method for providing the care is determined locally based on the availability of services in the community, the availability of healthcare staff in the community and cost effectiveness.

**Question 8(a):** What is the average length of time it takes for a contract provider to be credentialed by VA?

**Response:** There is no distinction made in the credentialing of contract providers from other providers delivering care to veterans. There are approximately 15 DoD licensed independent providers appointed to the medical staff of VA facilities under contract or fee basis care authorities out of almost 61 DoD licensed independent providers.

Contract providers can be credentialed for a full appointment, expedited appointment, or a temporary appointment for urgent patient care needs. Additionally, if a

disaster is declared, contract providers can be appointed under the disaster credentialing and privileging procedures defined in facility policies.

For initial appointment to the medical staff, the average length of time for the credentialing process to be completed is 6 to 8 weeks. This time is reduced by half for those providers who were previously credentialed by any VA facility through VetPro. VetPro is VHA's electronic credentialing file that maintains the verifications of education, training, licensure, certifications as well as reference and personal history information. Providers who have been previously credentialed through VetPro only need to be brought up to date from their last VA appointment.

Temporary appointments to the medical staff for urgent patient care needs can be done in a matter of a day or two since there only needs to be verification of one full, current, active, unrestricted license, confirmation of comparable clinical privileges, and one reference obtained. Facilities have 45 workdays to complete the credentialing of these providers which is frequently expedited. Of the almost 61 DoD licensed independent providers, 59 have current temporary appointments for urgent patient care needs with 47 of them being contractors, fee basis or telemedicine providers.

**Question 8(a):** Are there any significant issues that cause delays in provider credentialing throughout VA?

**Response:** The largest delay in provider credentialing is the provider themselves submitting the complete application so that verification can be initiated. The "clock" does not start until the application is submitted by the provider so the 6 to 8 week period to credential a provider does not even begin until an application is complete.

Temporary appointments for urgent patient care needs can be done without an application, but the provider needs to submit a complete application upon arrival at the medical center. VA's experience is no different than other organizations in that delays are encountered when references do not respond in a timely manner or verification must be obtained from overseas. VA policy does allow for documentation of a good faith effort in these instances. Policy states that if primary source documents are not received, after a minimum of two requests, full written documentation of the efforts to obtain verification will be placed in the credentialing folder in lieu of the document sought. It is suggested that no more than 30 days elapse between each request before the attempt is deemed unsuccessful. The practitioner should be notified and assist in obtaining the necessary documentation through a secondary source.

**Question 9:** Mr. Behrman testified that there were a limited number of successful collaborations between VA and Community Health Centers. However, the contracts were discontinued. Why were these contracts discontinued? Should this type of partnership be expanded to other rural States?

**Response:** We have worked with the National Rural Health Association (NRHA), whom Mr. Behrman represents, in efforts to gain more detailed information on the locations of the discontinued Community Health Centers (CHC) contracts they sited. However, the NRHA was unable to provide the needed information thus VHA can not address the specific contracts in question.

VHA currently has a small number of contracts with the CHCs, and other Federally Qualified Health Centers (FQHCs). We are, and continue, to collaborate and develop partnerships with various government and nongovernmental organizations as we explore ways to expand healthcare in rural areas as part of our strategic initiatives in VA's Office of Rural Health. It is not our position that collaboration solely with FOHCs should be adopted at a national level, for they vary in scope, types of expertise and services. Rather, collaboration is best done at the local levels based on the needs, services and expertise available.

**Question 10:** Has VA established policies whereby VA will contract with Critical Access Hospitals and other primary care providers in rural areas to provide primary and preventive healthcare to rural veterans who lack reasonable access to VA facilities?

**Response:** VHA is currently establishing an Office of Rural Healthcare within the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. This new office will develop strategies for improving access to rural veterans that will be implemented throughout the system.

**Question 11:** Does VA have performance measures in place to evaluate how effective the Vet Center program is in providing quality readjustment counseling and removing unnecessary barriers to care for veterans and family members?

**Response:** Vet Center program services are monitored through several evidence-based measures to ensure ease of access for veterans and family members and the provision of quality readjustment counseling. Vet Center clinical measures include the global assessment of functioning (GAF) scale, quality of life measures, client waiting times, veteran satisfaction and employee satisfaction. Vet Centers do not have waiting lists and veterans who call or walk in may be seen the same day by a counselor for an assessment and to schedule a followup appointment. Vet Centers also maintain nontraditional hours in the evening or on the weekends when necessary to accommodate the working schedules of veterans and family members. Vet Centers are the gold standard for client satisfaction in VA. Over 99 percent of all veterans surveyed consistently report being highly satisfied with services received and that they would refer another veteran to the Vet Center. Based on the results of the One VA Employee Satisfaction Survey, Vet Center employees consistently exceed other VHA employees in outcomes. Results showed Vet Center employees have a significantly higher level of job satisfaction.

**Question 12:** VA's testimony stated: "VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of healthcare for rural veterans. We also have partnerships with HHS, including the Indian Health Service and Office of Rural Health providing healthcare in rural communities." Where are the current collaborative efforts?

**Response:** The Department of Health and Human Services (HHS) and VA signed a memorandum of understanding (MOU) in February 2003 to encourage cooperation and resource sharing between the Indian Health Service (IHS) and VHA to deliver quality healthcare services and enhance the health status of American Indian and Alaska Native (AI/AN) veterans.

*Outreach.* Most networks are engaged in a variety of outreach activities, including meetings and conferences with IHS program and tribal representatives, VA membership in the Native American Healthcare Network, VA participation in traditional Native American ceremonies, transportation support to AI/AN, etc.

*Clinical Programs.* An example of clinical collaborations involves a diabetes prevention program that has been developed jointly by VHA and IHS staff in San Diego, Albuquerque, and Greater Los Angeles. The goal is to reach Native Americans in their communities.

*Education.* VHA Employee Education System (EES) provides training programs to IHS staff and the tribal community. In 2006, VHA delivered 145 training programs, of which 90 were made available using satellite technology and 55 using web-based technology. These educational programs will be continued in 2007, and VHA will also provide selected IHS staff an opportunity to attend regional EES workshops.

*Behavioral Health.* The Behavioral Health Workgroup developed a framework for AI/AN communities to assist returning OEF/OIF AI/AN servicemembers and veterans reintegrate with their families and communities and readjust to civilian life. The objective is to promote a community health model that gives tools to Tribal communities and families to help returning veterans address emerging adjustment reactions, traumatic stress, and post-traumatic stress disorder (PTSD), emphasizing recovery as the goal. The Joint Committee has developed a slide presentation to be used by outreach teams when addressing various Tribal veterans. There have been briefings using the slide presentation in Montana, with approximately 30 veterans now receiving services from VA.

*Expanded Healthcare Services.* At the local level, 10 VHA networks are engaged in targeted initiatives aimed at providing a full continuum of healthcare services, such as; health fairs, VA/IHS advisories, use of health buddy, and education and/or shared services in substance abuse, domestic violence programs, cardiac rehabilitation, dietetics, behavioral medicine, etc.

*Care Coordination.* The VHA-IHS Shared Healthcare Workgroup has drafted an Interdepartmental Coordinated Care Policy, the goal of which is to optimize the quality, appropriateness and efficacy of the healthcare services provided to eligible AI/AN veterans receiving care from both VHA and IHS or Tribes; and to improve the patient's satisfaction with the coordination of care between the two Departments.

*Telemedicine.* Telemedicine has proven to be extremely effective in the treatment of PTSD in Alaskan Native villages. VA and IHS are working to spread the use of

telemedicine services by AI/AN veterans, which will allow VA to bring physical and mental healthcare to the tribes, especially those in remote areas of the country.

*Traditional Healing.* Some VHA facilities and Vet Centers have incorporated traditional healing ceremonies along with modern methods of treatment and counseling. As a national initiative, VA has sent over 500 letters to Tribal leaders to ask them to provide information on appropriate providers of traditional practices so that they may be called upon for religious/spiritual care of AI/AN veterans.

VHA's Office of Rural Health (ORH) has also established a working relationship with and sought consultation from HHS's Office of Rural Health. As the office matures, VHA's plan is to work closely with HHS to maximize the opportunities in a range of areas including education, training, research, and access.

**Question 13:** What percent of rural healthcare is provided through contract care?

**Response:** The National Fee Support Office, which oversees the processes of determining eligibility and payment of non-VA provided healthcare, does not differentiate between urban/rural care at this time. The Office of Rural Health will be performing an analysis of fee basis services and will be able to provide further data at the completion of the study.

**Question 14:** What are the challenges of providing care to the aging veteran population in rural areas? How is VA addressing these challenges?

**Response:** Frail, rural older veterans may be at particular risk of illness, disability, institutional placement and death if they receive a portion of their care from a more centralized urban VAMC. These rural elderly veterans, in addition to their usual burden of disability risks, have less access to VAMC-based care options. Moreover, non-VA health and social services—besides being fragmented from the client's perspective—are less available or nonexistent in rural areas (Dwyer, Lee and Coward 1990). Additional challenges include: long travel distances and lack of transportation services, frail, elderly primary caregivers with few resources, a lower level of service awareness among the elderly, and fewer financial resources.

VA is addressing these challenges with its shift from a hospital-driven healthcare system to an integrated delivery system that emphasizes a full continuum of care. The strategic direction for providing services to veterans residing in rural areas is to provide non-institutional care; to bring care into veterans' homes and home-like settings. Options include:

- Integration of care coordination and home telehealth into home-based primary care to expand coverage into rural areas;
- Pilot program on improvement of caregiver assistance services;
- Collaboration with Administration on Aging and IHS for home-based primary care outreach and caregiver support;
- Referral to and purchase of community nursing home, home care, hospice and adult day healthcare services;
- Promotion of hospice-veteran partnerships to improve veteran access to community hospice care in rural areas;
- Development of medical foster home program, where veterans can receive an array of services including home-based primary care and community hospice care in a supportive home environment in their own community;
- Establishing satellite home-based primary care programs at remote sites such as VA CBOCs; and
- Development of a model of rural longitudinal care management.

**Question 15:** How does VA differentiate between a rural veteran traveling over an hour to a healthcare facility and a veteran in an urban area traveling over an hour to a healthcare clinic in rush hour?

**Response:** VHA Planning Systems and Support Group (PSSG) differentiate travel time between rural and urban by using geographic information software (GIS). These travel times are determined based on road type and are adjusted using survey data from the annual urban mobility report and civilian population densities. Seasonal and daily adjustments (e.g. rush hour or weather), cannot be taken into account on a national scale, thus are not reflected in the drive time analysis. Therefore, VA cannot calculate the effect that rush hour, or other daily fluctuations, may have on either urban or rural veterans commute time. However, the involvement of VISNs in the planning process provides a mechanism for this type of information to be considered.

**Question 16:** Public Law 109-461 directs the Secretary to expand mental health services in outpatient clinics. What is VA doing to expand this capability? How many CBOCs had mental health capabilities in April 2005 and how many have mental health capabilities today?

**Response:** Mental health services are currently available at all VHA outpatient clinics either from primary care staff, who are trained to manage many common mental health problems, or from mental health specialists, who manage the more difficult cases. To expand the capability for specialty mental health, VHA has distributed \$42.7 million to 301 CBOCs since FY 2005 for mental health professionals to those clinics where there was a need. Eight million dollars in telemedicine equipment has been sent to base facilities and their corresponding CBOCs as infrastructure to provide telemental healthcare where direct access to mental health specialists is unavailable. In addition, VHA has allocated \$37.8 million in FY 2007 to 92 VA facilities to provide mental health specialists who will be integrated into existing primary care clinics.

In April 2005 (end of the second quarter), 315 of 408 CBOCs (77 percent) serving more than 1,500 unique veterans provided substantive mental health specialty services (i.e. 10% or more of the visits were in mental health clinics). In April 2007, 429 out of 449 CBOCs (96 percent) had reached that standard.

**Question 17:** What are the challenges in providing mental health services in rural communities?

**Response:** While CBOCs have been the anchor for VHA's efforts to expand access to veterans in rural areas we have encountered some challenges, such as:

- Availability of qualified mental health professionals in small rural communities is often limited.
- Very small rural CBOCs may require mental health specialists too infrequently to justify even part-time on-site mental health staff.
- VA salaries at times are not competitive in specific locations, both rural and urban.
- Transportation to and from CBOCs is problematic for many veterans living in sparse population areas. However, telemental health at remote clinics, where feasible, has proven to be convenient and is generally well accepted by veterans.
- VHA's CBOCs are complemented by contracts in the community for all physician specialty services, depending on the location of the CBOC and the availability of specialists in the area. Some contract CBOCs prefer using their own mental health staff rather than accepting VA providers, a situation which may present communication barriers with veterans or with VA staffed settings.
- VHA has used fee-basis care with private healthcare providers in smaller or more remote communities for many years. Quality control of fee basis care is difficult to achieve in part because these providers do not have access to VA's electronic medical record system.

**Question 18:** VA Central Office reviews waiting times. How do the waiting times of specialty care in rural areas compare with those in urban areas?

**Response:** Appointments are made within 30 days for rural areas 96 percent of the time. For highly rural areas 92 percent of appointments are made within 30 days. Urban CBOCs appointments are made within 30 days 94 percent of the time. These data are for specialty care using the 47 specialty clinics out of the 50 from FY 2007 thru February 2007.

**Question 19:** Musculoskeletal ailments (principally joint and back disorders) are among the top health problems of veterans returning from Iraq and Afghanistan according to a November 2006 VA study. Currently, chiropractic care is only available at about 20 percent of all VA facilities and most veterans do not have access to care, despite back issues being the ailment that affects the most veterans. Has VA developed plans on how to further implement chiropractic care into the VA healthcare system?

**Response:** Yes. In accordance with Public Law 107-135, VA is providing chiropractic care in each of the 21 VISNs and presently has 30 chiropractors across the country. Additionally, VHA established the Chiropractic Field Advisory Committee (FAC) to provide advice on clinical and administrative issues relating to chiropractic care for veterans and to serve as a communication channel between field-based practitioners and VHA Central Office. The FAC assists with identifying and providing data for evaluating the demographics of chiropractic care. Chiropractic care is in-

cluded in the medical benefits package, the standard health benefits plan generally available to all enrolled veterans. When the residence of the veteran is geographically distant from a VHA site providing on-station chiropractic care, the outpatient fee-basis care program is used to provide these services through community chiropractors.

**Question 20:** What is the status—and, if available, the initial findings—of the VA's Project HERO demonstration project?

**Response:** VA Project HERO (Healthcare Effectiveness through Resource Optimization) is a demonstration project that is being piloted in selected VISNs to maximize the care VA provides directly and better manage fee care. The ultimate goal of Project HERO is to ensure that all care delivered by VA—whether through VA providers or through community partners—is of the same quality and consistency for veterans.

VA issued a request for proposals (RFP) for a Project HERO specialty care provider network on January 12, 2007 and vendor proposals were received May 2, 2007 and are in the evaluation process. Contract award is anticipated in July 2007. This RFP applies only to fee care, which is care that is already being purchased and provided outside of the VA health system.

The Project HERO Program Office and VA acquisitions team met with vendors during due diligence sessions in March 2007. Due diligence sessions offered potential vendors the opportunity to learn more about VA's requirements and to ask specific questions related to their proposed solution. Many industry leaders participated in the sessions with representatives from the participating VISNs, the Project HERO Program Office and other representatives from VA and VHA.

In anticipation of the demonstration, the Project HERO Program Office is also conducting financial modeling activities to identify areas of potential cost savings under Project HERO. Using historical fee usage and cost data as well as projection rates from the VA Enrollee Healthcare Projection model, the Project HERO Program Office has been able to identify breakeven points for certain inpatient clinical areas and geographic locations (VAMCs). The outpatient model is currently being completed. Preliminary results from our inpatient financial modeling efforts indicate that there are potential areas for cost savings under Project HERO.

In addition to financial modeling efforts, the Project HERO Program Management Office is also working with representatives from each of the participating VISNs to identify opportunities to standardize and improve fee business process and contract administration procedures. VA anticipates Project HERO will contribute to current efforts to standardize and optimize fee business processes.

A Project HERO Governing Board, which includes senior leadership from VHA and participating VISNs, will oversee the demonstration to ensure that veterans continue to receive high quality care, and will review and approve any change in the terms, conditions and quantities of Project HERO contracts. The Project HERO Governing Board will regularly track and monitor Project HERO cost, quality, safety, vendor performance and other data relevant to the demonstration to ensure that Project HERO is meeting the goals and objectives outlined in Public Law 109-305. The Project HERO Program Office will prepare quarterly and annual reports monitoring key elements of the demonstration including: costs, the quality of care provided, veteran satisfaction, impact on academic affiliates, clinical information sharing, and financial analysis.

**Question 21:** The VA's March 30th report to Congress detailing CBOCs approved for activation only lists 6 CBOCs approved for an FY08 opening. Will more be approved? Was the proposed VISN-approved CBOC for Hutchinson, KS turned down or is it still under consideration by the VA?

**Response:** The VA's directive on establishment of new CBOCs is currently being revised. The Hutchinson, Kansas CBOC has been approved and VA anticipates its opening in FY 2008.

**Question 22:** One may consider VISN 23 as one of the most rural VISNs in the VA system. How has VISN 23 improved access for veterans? Have you been working with other VISN Directors to share some of the best practices from VISN 23 in providing access to veterans?

**Response:** VISN 23's primary method to improve rural access has been to establish a network of CBOCs. Since the inception of the VISN structure in 1995, VISN 23 has opened 36 CBOCs and/or outreach clinics. VISN 23 provides mental health

services in all of these locations by a combination of telepsychiatry and on-site services. VISN 23 had 21 additional CBOCs approved under CARES. Three of these have opened and three more will open this fiscal year. Several of these clinics are on remote American Indian Reservations in western South Dakota.

The other major modality for us to reach rural veterans is telehome healthcare. This program provides for monitoring and treatment of patients in their homes by using remote monitoring equipment, the Internet and multiple voice or television communication.

We also use case management and transportation networks operated by the service organizations and counties to facilitate rural veteran access.

The success of the CBOCs in providing better rural access has been widely shared across all of the networks. Telehome health or care coordination, as the program is known within VHA, has a very active program office that has been very effective in developing and promoting this modality.

**Question 23:** How can telemedicine help provide access to veterans? What are the limitations of telemedicine? Are there circumstances in which you would not recommend the use of telemedicine?

**Response:** Telemedicine enables changes to take place in the location of care such that healthcare access is increased by removing the travel component of a clinical encounter for either the patient, or for the healthcare practitioner who is providing consultation/care. Therefore, when it is an appropriate tool to use, telemedicine can make healthcare needs better match the available resources and in doing so take services out into remote locations.

Generally accepted limitations to telemedicine relate to the level of encounter that can take place between patient and healthcare practitioner with respect to clinical examination and restrictions that lack of telecommunications bandwidth imposes in providing care in certain areas.

Telemedicine applications that are recommended for national deployment in VHA are ones in which the necessary clinical, technology and business processes have been resolved to ensure they are appropriate, safe and effective to meet the underlying patient care need for which they have been created. The corollary of this is that ones that are not deemed appropriate, safe and effective to meet a defined patient need would not be recommended.

---

Committee on Veterans' Affairs  
Subcommittee on Health  
Washington, DC  
May 2, 2007

Maurice Huguley  
Legislative Analyst  
Office of the Deputy Assistant Secretary for Legislation for Human Services  
U.S. Department of Health and Human Services  
Washington, DC 20201

Dear Mr. Huguley:

In reference to our Subcommittee on Health hearing "Access to VA Healthcare: How Easy is it for Veterans—Addressing the Gaps" held on April 18, 2007, I would appreciate it if you could answer the enclosed hearing question by the close of business on June 5, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Sincerely,

MICHAEL H. MICHAUD  
*Chairman*

---

**Question from Hon. Phil Hare, Subcommittee on  
Health, to Maurice Huguley, Legislative Analyst, Office of  
Deputy Assistant Secretary for Legislation for Human Services  
U.S. Department of Health and Human Services**

**Question:** I represent a congressional district with a lot of rural areas. You were talking about transportation, and you mentioned in your testimony that there are significant transportation barriers that affect the coordination of services. I wonder if you could maybe elaborate on that and what has HHS done to address the issue of providing transportation to rural patients?

**Response:** The Department recognizes the special barriers rural residents face in obtaining needed services and addresses transportation issues in a variety of ways within its programs. Within HRSA, the Bureau of Primary Healthcare (BPHC) funds the Health Centers Program. Health centers address the transportation issue in various ways, including: providing rides to/from the health center in center-owned vans; providing clients with public transportation vouchers; and/or providing clients with cab fare from a "taxi fund." Health centers are required to provide transportation services as part of the center's "enabling services." Specifically, the enabling services section of the health center authorizing legislation includes transportation within the definition of "required primary health services." HRSA also administers the Ryan White Program. Parts A, B, and C of the Ryan White Program provide funding for "support services." The legislation defines support services as those services "needed for individuals with HIV/AIDS to achieve their medical outcomes (such as respite care, outreach services, medical transportation, and linguistic services)."

To assure collaboration and coordination across the Department's Agencies and among other Federal Departments, HHS is part of the workgroup working on the United We Ride project. Other Departments in the workgroup include the Department of Transportation, Department of Interior, Department of Labor, Department of Education, Department of Veterans Affairs and Department of Agriculture. Within HHS, there is participation from HRSA, Centers for Medicare and Medicaid Services, Administration on Aging, Substance Abuse and Mental Health Services, and the Administration for Children and Families. The link to the website is <http://www.unitedweride.gov/>.

---

**Responses to Questions from Hon. Michael H. Michaud, Chairman,  
Subcommittee on Health, to Maggie Elehwany, Government Affairs and  
Policy President, National Rural Health Association**

National Rural Health Association  
Alexandria, VA  
*June 5, 2007*

The Honorable Michael H. Michaud, Chairman  
The Honorable Phil Hare  
Subcommittee on Health  
Committee on Veterans' Affairs  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Michaud and Representative Hare:

Once again, I appreciated the opportunity to testify to the Subcommittee during an oversight hearing on the topic of "Access to VA Healthcare: How Easy is it for Veterans—Addressing the Gaps" on April 17, 2007. On behalf of the National Rural Health Association (NRHA), a national nonprofit membership organization with approximately 15,000 members that provides leadership on rural health issues, I thank you both for your leadership in addressing the needs of our rural veterans.

My letter today responds to the followup questions submitted to me on May 2, 2007. The questions and answers follow.

**Question 1: *Increase Access Points.*** Difficulty obtaining reliable transportation is a common concern. Effective, timely, inexpensive transportation is a pervasive problem in the rural areas. There are significant transportation barriers that affect coordination of services and providers in the rural setting.

**Question 1(a):** Do you have any recommendations to address the time and distance issues as it relates to veterans getting to a facility?

**Response:** Distance of travel to VA facilities is a significant concern of the NRHA. During much of my testimony, I spoke of increasing access points in rural communities. Two ways to increase access points that have been successfully utilized in rural communities to a limited extent are the use of Community-Based Outpatient Clinics and the use of collaborative models with rural health facilities that are already in the community, such as Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics. We believe the expansion of services into the community in which the veterans live is the preferred method of providing care.

The NRHA acknowledges that it may not always be possible to have care provided in every community. A number of new innovative approaches are currently being tried that would help limit the need for transport. Some of these, such as telehealth and distance medicine, are the products of new technology. Others, such as the direction of care through a family physician and linking payment with Medicare monies, are simply new ways of thinking. But again, this may not provide care for every beneficiary.

It is essential, then, that during VA outreach the issue of transportation be raised. Through experience with other rural populations we have found that transportation can be the biggest barrier to care and can lead to the largest gap in patient-provider compliance. One approach that has been successful in improving this gap is to consider transportation from the moment the provider, in this case the VA, contacts a patient. By asking simple questions—such as how do you plan to get to the VA facility; do you have reliable transportation; will someone be driving you; and are you able to afford the transportation costs—the facility can get a much better sense of the needs of that particular patient. In asking these questions and considering their responses, the VA should be prepared to help pay this transportation cost.

The VA Office of Rural Affairs will need to monitor this transportation and access point question. While new collaborations and telehealth approaches sound promising and the NRHA strongly supports them, we can not be assured that these interventions are working without sound research. This type of followup research must be a part of any plan to overcome the lack of access points in rural communities.

**Question 2: *Traumatic Brain Injury Care.*** Given that TBI is the “signature wound” of OEF/OIF and that 44 percent of our returning veterans come from rural areas:

**Question 2(a):** You state that the number and location of TBI case managers is limited in coverage in States with high numbers of rural veterans. What is the scope of “expansion” of the TBI case manager network that your organization believes is needed to meet the needs of the rural TBI patient?

**Response:** Simply stated, it is not clear how much expansion is needed in the TBI case manager network to cover the needs of returning veterans in rural America. More research is needed to better understand TBI and the needs of those suffering from it. We strongly encourage that this research be ongoing, throughout the duration of care given to those returning from OEF/OIF.

We have learned from the experience of dealing with PTSD post-Vietnam War. As the severity of PTSD began to be realized, resources were poured into providing care. Like any new medical intervention, some worked while others did not. Had solid quantitative evidence been gathered from the start, perhaps less than the 15.2 percent of male veterans and 8.5 percent of females who served in Vietnam would currently be suffering from PTSD. Followup studies have shown more effective ways to treat PTSD and the VA has accepted these for veterans returning from future wars. However, when possible, research should be ongoing, especially in the case of TBI, where waiting for followup studies may mean leaving a generation of veterans with physical, cognitive, behavioral, emotional and social impairments.

The evidence shows that the TBI case manager network would be more effective in a ‘spoke-and-hub’ model that has more than one research and primary care center located across the Nation. By diffusing TBI care throughout the VA, every employee will see treating TBI as part of their core mission. Further, by using a spoke-and-hub model, more case managers will be available to rural veterans and will still have the support they need from larger research centers. We strongly encourage the expansion, testing, and decentralization of the TBI case managers to help provide rural veterans an avenue to recovery.

**Question 3: Office of Rural Veterans.** Your organization would like a national advisory committee on rural veterans established to provide information to policy-makers on the needs of this population as it ages.

**Question 3(a):** What does your organization believe is the number one issue that the advisory committee should take up if it is established?

**Response:** There are many things that the advisory committee on rural veterans could examine if it was established. Obviously, such a committee would have the opportunity to set its own priorities and may deal with issues that we have not even considered. However, we have identified a few issues that the advisory committee could take up immediately if established:

1. **Research Agenda.** Currently, there is not a specific rural research agenda for veterans' care, and rural research is not a priority of the general VA research projects. Since care in a rural environment is so different than in an urban community, the NRHA is very concerned about the lack of ongoing rural research. VA research must include rural specific issues, and an advisory committee could establish this priority and set the agenda.
2. **Special Population Status.** The VA has a long history of monitoring "special populations" and using the data for providing higher quality care. Such populations over time have included those with spine injuries and other difficult injuries, the homeless, and those of lower economic status. By monitoring those veterans living in rural communities, the VA may get a better sense on how to provide care to those furthest from VA facilities and better understand their health status and address barriers to care.
3. **Field-Based Operations.** Currently, the Office of Rural Veterans is located in one central office. For the information the Office collects and develops to spread throughout the VA, a more diffused network of offices may be needed. In addition, having field offices located in VA centers across the country that serve rural veterans may be helpful in understanding their specific needs.

**Question 3(b):** What would an advisory committee offer to the VA and veterans that is not currently being provided?

**Response:** In a different venue, the NRHA has a long history of working with the Federal Office of Rural Health Policy and the National Advisory Committee on Rural Health and Human Service. We know from experience that the National Advisory Committee is an important player in making sure that the Office of Rural Health is meeting its goals and identifying gaps in Federal programs. Further, the National Advisory Committee has helped set the agenda for a priority on rural issues within the Department of Health and Human Services.

We expect a rural advisory committee for the VA to do the same. While the Office of Rural Veterans is a strong advocate within the agency, an outside voice and independent review is needed. Unfortunately, as we all know, internal agency politics can play a role in determining the priorities of any single office. In addition, offices can be hamstrung by set policies or internal procedures. The advisory committee would be able to think outside of this internal paradigm and articulate a vision of what the office and the entire VA should be doing for rural veterans. In addition, such a committee can help focus attention on the good things that the VA is currently doing on behalf of rural veterans without the inherent bias that comes with any self promotion. We expect that an independent voice on rural issues would be helpful to the VA, and provide rural veterans with another needed advocate for the highest possible quality of care.

Mr. Chairman and Mr. Hare, thank you for this opportunity to respond to your questions on rural veterans' access to VA care. If you are in need of further followup or clarification, please contact Maggie Elehwany, NRHA Vice President for Government Affairs and Policy (703-519-7910 or elehwany@NRHArural.org).

Sincerely,

Andy Behrman  
Chair, NRHA Rural Health Policy Board



**Responses to Questions from Hon. Michael H. Michaud, Chairman,  
Subcommittee on Health, to Steve Robertson, Director, National Legislative  
Commission, The American Legion**

American Legion  
Washington, DC  
November 28, 2007

The Honorable Michael H. Michaud, Chairman  
Subcommittee on Health  
Committee on Veterans' Affairs  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Michaud:

Thank you for allowing The American Legion to participate in the Committee hearing on the President's budget request on April 18, 2007. I am pleased to respond to your specific questions concerning that hearing.

**Question 1: *Community Health Clinics.*** The Veterans Millennium Healthcare and Benefits Act (P.L. 106-117) encouraged collaborations between the Community Health Centers, that serve millions of rural Americans, and the VA.

**Question 1(a):** Does your organization support these collaborative efforts?

**Response:** The American Legion supports collaborative efforts between Community Health Centers and VA to provide services to rural veterans when VA is not capable of providing that care. In areas where there is very limited access to VA healthcare, it is in the best interest of veterans residing in rural areas that local care be made available to them. Some of these veterans have physical limitations due to age or service-connected injuries, or suffer from conditions that make extensive travel dangerous. Many veterans have expressed concerns/frustrations about their limited financial resources prohibiting travel—citing the disparity caused by long travel distances, the rising cost of gas, the limitations of the mileage reimbursement rate, and the need to pay for overnight accommodations as huge obstacles. Weather and geographic obstacles are also considerations.

Providing contracted care in rural communities—when VA healthcare services are not possible—would alleviate the unwarranted hardships that these veterans encounter when seeking access to VA healthcare.

**Question 2: *Level of Care.*** What are your organization's expectations regarding the level of care VA should provide in the rural community?

**Response:** The American Legion believes that veterans residing in rural communities deserve the same level of healthcare and timely access to care as veterans residing anywhere else.

**Question 2(a):** Do you believe the VA's presence in the rural health community should be expanded?

**Response:** Yes, when doing so would improve access to care and decrease travel time for veterans who travel hundreds of miles for care.

- If so, should the VA accomplish this by expanding partnerships or providing its own system of care?

**Response:** Determining whether VA should accomplish this by expanding partnerships or providing its own system of care should be based on the healthcare needs of the veterans in the rural area it is considering, services available through the rural health community, and the number of veterans who would benefit from VA providing its own system of care in that rural area. It would be VA's responsibility to determine if there are any trends in needed services in particular rural communities, especially for specialized care.

Many veterans move or return to rural areas following military service. If the services available through community health providers are not able to address the rehabilitative needs of those returning to these rural communities with traumatic brain injuries, other blast trauma injuries, or other service-related ailments, VA has a duty to make these services available. It would be ideal if—realizing that those requiring specialized services probably would have difficulty traveling and coordinating care—VA would make these services as easily accessible as possible.

Another indication that VA needs to bring its services more local would be if a number of veterans are traveling hundreds of miles from a specific geographic area

to receive services from the VA that they cannot receive in their communities due to lack of availability of those services.

If needed services are available in local communities, those traveling hundreds of miles for care would probably benefit from an expansion of partnerships.

**Question 2(b):** What do you believe would be an effective approach to providing returning veterans with the types of specialized services they need such as TBI rehabilitation and mental health services?

**Response:** An effective approach to providing returning veterans with the types of specialized services they need could be providing more facilities, nationwide, where veterans can access these service, and/or developing partnerships with community providers in rural communities.

**Question 3: *Women Veterans and Rural Health.*** Women are a growing population within the armed forces. By 2010 it is estimated that they will exceed 10 percent of the veteran population and 15 percent of the armed forces. Unlike their fellow female veterans from previous conflicts, this current cohort of female veterans is routinely exposed to combat in Operations Enduring Freedom and Iraqi Freedom.

**Question 3(a):** Does your organization have any recommendations as to how to address the growing need for specialized services for women who have experienced combat?

**Response:** Most importantly, we need to make sure we understand what specialized services these veterans will need. Outreach to women veterans is an important mechanism in identifying the specialized services women veterans will require. They will need to know where they can voice their needs and what services are available to them.

Also, comprehensive research on women veterans needs to be updated to consider the health effects of combat on women veterans that address long-term physical, as well as mental effects. Information gathered from research would also facilitate addressing their need for specialized services.

**Question 4: *Healthcare System of the 21st.*** The face of healthcare is changing. VA has an Advisory Committee on Genomic Medicine. The use of telemedicine programs is growing. Technology is advancing rapidly. The delivery of healthcare is going to change over the next 10, 20, 30 years.

**Question 4(a):** What does your organization believe VA should be focusing on in the future regarding the direction of the VA healthcare system?

**Response:** The American Legion believes that the VA needs mandatory funding to ensure that its healthcare system can adequately address the needs of all veterans. VA should be focusing on improving access to care and timely delivery of care.

Thank you once again for all of the courtesies provided by you and your capable staff. The American Legion welcomes the opportunity to work with you and your colleagues on many issues facing veterans and their families throughout this Congress.

Sincerely,

Steve Robertson  
*Director, National Legislative Commission*

---

Committee on Veterans' Affairs  
Subcommittee on Health  
Washington, DC  
May 2, 2007

Joe Violante  
National Legislative Director  
Disabled American Veterans  
Washington, DC 20024-2410

Dear Mr. Violante:

In reference to our Subcommittee on Health hearing "Access to VA Healthcare: How Easy is it for Veterans—Addressing the Gaps" held on April 18, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 5, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Sincerely,

MICHAEL H. MICHAUD  
*Chairman*  
*Subcommittee on Health*

---

**Questions from Hon. Michael H. Michaud, Chairman, Subcommittee on Health, to Joe Violante, National Legislative Director Disabled American Veterans**

**Question: *Community Health Clinics.*** The Veterans Millennium Healthcare and Benefits Act (P.L. 106–117) encouraged collaboration between Community Health Centers, that serve millions of rural Americans, and the VA.

a. Does your organization support these collaborative efforts?

**Answer:** After review of P.L. 106–117, the Veterans Millennium Healthcare and Benefits Act, we were unable to find any language addressing the question of collaboration with Community Health Centers.

**Question: *Level of Care.*** What are your organization's expectations regarding the level of care VA should provide in the rural community?

a. Do you believe the VA's presence in the rural health community should be expanded? If so, should the VA accomplish this by expanding partnerships or providing its own system of care?

**Answer:** We believe Congress should provide VA the additional resources it needs to expand its presence in rural areas. As we have often stated, veterans' healthcare is a continuing cost of war. After serving their country, veterans should not have their healthcare needs neglected by the VA because they choose to live in rural and remote areas far from major VA healthcare facilities particularly when Congress and the Administration have been aware that about 44 percent of today's active duty military servicemembers and tomorrow's veteran population list rural communities as their homes of record.

VA's medical benefits package is the embodiment of a continuum of care which allows veteran patients to be clinically matched to the appropriate level of care in order to maximize the care they receive and the quality of life they lead. When providing medical care in rural and remote areas, there are consequences to sick and disabled veterans, the VA healthcare system, and the cost of such care when the appropriate level of care is provided based on other than medical need.

As a direct provider of care, the VA has established and is operating over 700 CBOCs, of which 100 are located in areas considered by the VA to be rural or highly rural; however, we remain concerned that the VA receives no Congressional appropriation dedicated to support establishment of rural CBOCs but must manage those additional expenses from within the available Medical Services appropriation provided by Congress. The DAV believes that given current circumstances, VA cannot cost-effectively justify establishing additional remote facilities in areas with sparse veteran populations, and therefore urges Congress to act on the report it has required VA to provide in section 212(b) of P.L. 109–461 regarding CBOCs and additional access points identified in the May 2004 CARES decision.

Recognizing the diversity of rural areas, the DAV does not believe that requiring VA to provide needed medical care in rural areas should be done solely as a direct provider or solely through expanding partnerships. We believe the VA's ability to provide such care should be given proper latitude, particularly as VA is establishing an Office of Rural Health and is designating an individual at each Veterans Integrated Service Network (VISN) to promulgate policies, best practices, and innovations to improve healthcare services to veterans who reside in rural areas.

**Question:**

b. What do you believe would be an effective approach to providing returning veterans with the types of specialized services they need such as TBI rehabilitation and mental health services?

**Answer:** The current conflicts in which our Nation is engaged are producing a significant number of veterans suffering from polytraumatic injuries, amputations, brain injuries, blindness, burns, spinal cord injuries, and post-traumatic stress disorder (PTSD). The DAV believes reforming VA's healthcare budget is of primary importance in order for the Veterans Health Administration (VHA) to continue to provide these severely disabled veterans with the lifetime of specialized healthcare services they will require. To its credit, VA has taken progressive steps to address the specialized needs of our newest disabled veterans and is working to provide the highest quality care possible. We believe VA should be given every opportunity to capitalize on its successes without the fiscal uncertainties that have prevented the best management of VA healthcare. Timely and adequate funding would make the management of veterans' healthcare more dependable, and stable, and with proper oversight would make VA's high quality medical care and specialized services more cost-effective and efficient.

In an era of funding government programs through continuing resolutions or increased funding levels provided months into the fiscal year, VA facilities have had to restrict services provided to veterans, delay hiring of new clinical staff, institute local and regional freelance policies to restrict eligibility and care, and impose a variety of questionable—and potentially hazardous—cost-cutting measures just to make ends meet. It is clear that VA operates in a state of management paralysis, planning chaos, and structural financial crisis as a direct consequence of the discretionary budget process. We do not believe this is an effective approach to providing returning veterans with the types of specialized services they need such as TBI rehabilitation and mental health services.

In addition to reforming the budget process, we believe the direction taken by VA to use the effective hub-and-spoke model of its spinal cord injury service serves as a good first step to deliver coordinated care for our returning servicemembers. As you are aware, the VA established four Level I Polytrauma Rehabilitation Centers (PRCs) at the Defense and Veterans Brain Injury Center's (DVBIC) designated VA sites, Level II PRCs at each of the 21 regional Veterans Integrated Service Networks, as well as a multitude of local Level III and IV PRCs across the Nation. These new Level II centers will better assist VA to raise awareness of TBI issues, and the Level III and IV sites will provide increased access points for TBI veterans and allow VA to develop a systemwide screening tool for clinicians to use to assess TBI patients. Furthermore, clinicians and researchers are evaluating several approaches to ensure more effective healthcare delivery, such as standardizing patients' records from two distinct healthcare systems and treatment plans. We believe these efforts will provide a model of proactive care for patients with TBI and polytrauma and enhance standards of practice within the VA and non-VA healthcare systems.

Finally, the VA needs clear guidance from Congress on how to proceed with new programs for the latest generation of wounded and disabled veterans. A number of bills have been introduced dealing with polytrauma, brain injury, and mental health; however, none have become law at this time. We ask the Committee to consult with the veterans service organizations as you begin to fashion these bills into law.

**Question: *Women Veterans and Rural Health.*** Women are a growing population within the armed forces. By 2010 it is estimated that they will exceed 10 percent of the veteran population and 15 percent of the armed forces. Unlike their fellow female veterans from previous conflicts, this current cohort of female veterans is routinely exposed to combat in Operations Enduring Freedom and Iraqi Freedom.

**a.** Does your organization have any recommendations as to how to address the growing need for specialized services for women who have experienced combat?

**Answer:** With increasing numbers of women serving in the military, and with more women veterans seeking VA healthcare following military service, it is essential that the VA be responsive to the unique demographics of this veteran population cohort. As we see growth in the number of women veterans using VA healthcare services, we also expect to see increased VA healthcare expenditures for women's health programs.

At a recent VA National Conference: Evolving Paradigms—Providing Healthcare to Transitioning Combat Veterans—one track focused on women veterans who served in Iraq. A panel discussion by those women was very revealing about their unique experiences in the military and the impact of that service on their physical and mental health, as well as their existing impressions of access to VA services post-deployment. The women who participated in this panel, as well as other women who have served in combat theaters, could offer the Subcommittee greater insight

on the impact of military experience on this new generation of women veterans. We understand that VA had planned to convene a focus group of approximately 50 women veterans of the wars in Iraq and Afghanistan to examine gaps in service and how VA could better meet the needs of this group. It is not clear whether VA still plans to convene such a group, but DAV believes this could stimulate an effective policy debate within VA and likely benefit this new generation of women veterans.

We recommend that the Subcommittee hold a hearing on women veterans issues and invite women veterans from Operations Iraqi and Enduring Freedom (OIF/OEF), the newly appointed Acting Chief Consultant of the VA's Women Veterans Health Strategic Healthcare Group and a representative from the National Center for Post-Traumatic Stress Disorder, to discuss how the Department is currently addressing the unique healthcare needs of women veterans who have served recently in combat theaters.

The National Center notes that anecdotal reports from OEF/OIF veterans suggest a number of unique concerns that have a more direct impact on women than their male counterparts returning from combat theaters, including lack of privacy in living, sleeping, and shower areas; lack of gynecological healthcare; impact of women choosing to stop their menstrual cycle; gender-specific differences in urinating leading to health concerns for women, including dehydration and urinary tract infection. There are also reported findings that suggest distinct differences at homecoming including that women may be less likely to have their military service recognized or appreciated; possible differential access to treatment services; and possible increased parenting and financial stress. Additionally, preliminary reports suggest that women may be more likely to seek help for psychological difficulties.

The National Center is looking at gender differences in mental health, military sexual trauma (MST) in the war zone, and gender differences in other stressors associated with OEF/OIF service and homecoming. A number of research initiatives/projects are focused on treatment of PTSD in women, enhancing sensitivity toward and knowledge of women veterans and their healthcare needs among Reserve components of the armed forces. Testimony from principal investigators in these studies would also be of assistance to the Subcommittee in fashioning effective policy to meet the needs of women veterans.

Finally, some women serving in the military may suffer the dual burden of combat exposure and MST. While the DoD has established an office to deal with the incidence of sexual trauma, the conditions of a combat theater, quartering and lack of personal security offer special threats to women serving. VA and DoD need to better coordinate policies and treatment for transitioning women veterans who suffer readjustment issues related to combat exposure and/or have suffered MST.

**Question: *Healthcare System of the 21st.*** The face of healthcare is changing. VA has an Advisory Committee on Genomic Medicine. The use of telemedicine programs is growing. Technology is advancing rapidly. The delivery of healthcare is going to change over the next 10, 20, 30 years.

- a. What does your organization believe the VA should be focusing on in the future regarding the direction of the VA healthcare system?

**Answer:** Over the last decade, the VA has dramatically transformed the delivery of veterans' healthcare and moved to the forefront of the healthcare industry in areas such as patient safety, health promotion and disease prevention, quality improvement, use of computerized patient records, telemedicine, and biomedical and health services research. Therefore, we believe that VA is appropriately focused to meet the future needs of veterans and increasing demands on its healthcare system.

As the VA continues making advances in medicine to address chronic diseases and disabilities that are prominent in and specific to the veteran patient population such as diabetes, cardiovascular diseases, cancer, amputations, spinal cord injuries, poly-traumatic injuries and other similar conditions, VA must be mindful of the ever closer association of medicine with science and technology, which presents a dilemma where the latter broadens the former in helping the patient, yet may undervalue the caring or "art of medicine." We must ensure the VA finds a proper balance between the promising possibilities of modern, high-technology medicine and the actual "high touching" care of patients.

Moreover, VA must remain sensitive to the limitations and capabilities of biotechnology, genetic technology, and genomics. Rapid technological changes occurring in the field of biotechnology coupled with genetics, genomics, and links between the two, proffer a tremendous shift in how healthcare will be provided in the future. The possible effects would include a change from the current population-based medicine to personalized medicine, such as tailor-made drug treatment for the individual patient (pharmacogenetics) as well as the redefinition of the concept of "disease."

As medical care becomes more individualized, VA's *Health-E-Vet* automated record offers patients an opportunity to actively participate in their health decisions with a focus on prevention, empowerment, wellness and satisfaction. Since the newest generation of veterans tends to be more technologically inclined than veterans of prior wars, but will rely on the VA for their medical care for decades to come, VA should remain committed to this initiative.

The changes in VHA have been profound, and the benefits have been and continue to be recognized by the veteran, medical, academic and private sector communities. VA provides better care to our Nation's veterans, care closer to their homes, and uses the latest technology in delivering safe care. VA must continue to provide the right services, at the right time, in the right place to our Nation's veterans in the future. However, we currently face significant challenges, which we must address to assure that our Nation maintains a comprehensive, integrated healthcare system able to respond to the unique problems that are associated with the military combat experience. In addition to the most important new developments in the diagnosis and therapy of the most common diseases, the VA must focus on how medicine in the future can successfully combine high-tech and high-touch, and how the emphasis can be placed more on the individual person, with his or her physical, emotional and mental health needs—an aspect that, to the detriment of patients, all too often is neglected in the day-to-day practice of high-technology medicine.

A final concern is one that we have discussed previously in the *Independent Budget* for fiscal year 2008: the future of VA capital assets. The VA healthcare system operates over 1,400 centers of care, of which a number of the more significant VA Medical Centers were constructed in relatively brief periods following World Wars I and II, and the Korean and Vietnam Wars. Thus, aging physical plant facilities is a major issue for the future of VA healthcare. While it is difficult to make firm predictions about VA's capital infrastructure needs over the next 30 years, the existing trends of emphasis on ambulatory, outpatient care over acute and chronic inpatient hospitalization would seem to predict the need for smaller inpatient facilities in the future, treating a higher acuity of case mix for shorter periods, alongside significantly enlarged outpatient facilities, including those promoting primary care, preventative care, ambulatory surgeries, and other therapies that can be delivered in a same-day service setting. This trend coupled with the underfunding of VA's construction budget heightens our concern over the impact this may have on sick and disabled veterans needing specialized programs such as blind rehabilitation, spinal cord injury care, prosthetics services, and mental health services.

The agency strategic and clinical planning, budget formulation and Congressional appropriations processes create obstacles that cause years, at times decades, of lag time between conception and construction. DAV believes that Congress should provide additional oversight to VA's construction and capital-facilities replacement policies to improve their performance, and to help prepare for the future of a very challenging issue. Also, we continue to question whether VA's capital decisions are still consonant with the Capital Asset Realignment for Enhanced Services (CARES) process that was concluded in 2004. The CARES process was designed by VA to provide a clear, market oriented roadmap for VA capital planning needs for the next several decades, but in the intervening time we have been witness to facility construction decisions that seem inconsistent with the CARES decision memorandum of a prior VA Secretary. We ask the Committee to provide sharper oversight of VA capital programs to ensure they are consistent with CARES.

