

SERVING VIRGINIA'S RURAL VETERANS

FIELD HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION

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JULY 19, 2010
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SERVING VIRGINIA'S RURAL VETERANS

MONDAY, FEBRUARY 14, 2010

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

The Subcommittee met, pursuant to notice, at 9:00 a.m., at the Bedford County Board of Supervisors Meeting Room, County Administration Building, 122 East Main Street, Bedford, Virginia, the Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud and Perriello.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I'll call the Subcommittee on Health of the Committee on Veterans' Affairs to order, and I'd ask the first panel to come up.

First of all, I'd like to thank everyone for attending this hearing, especially the veterans who are here with us today. I would also like to express my sincere gratitude to the Bedford County Board of Supervisors for their hospitality in hosting this hearing.

Today's hearing would not have been possible without Mr. Perriello's tireless advocacy for veterans living in Virginia. He is a welcomed Member of the Subcommittee on Health of the Committee on Veterans' Affairs. He also brings a new energy and enthusiasm for tackling the unique challenges facing veterans. I really got to know Mr. Perriello when we took a trip to Afghanistan together to learn more about the health care provided to the men and women who are wearing the uniform so proudly. And as Chairman of the Subcommittee and a representative of rural communities in the State of Maine, Mr. Perriello and I share an interest in making sure our rural veterans receive the care they deserve.

Our veterans, whether they live in rural Maine or rural Virginia, face common challenges. Most notably, access to care is an issue for veterans living many miles or hours away from the closest U.S. Department of Veterans Affairs (VA) medical facility. Given these challenges, it is important that our rural veterans have access to health care.

When you look at access to health care, there are many tools out there that can help, such as telemedicine, telehealth and VA's new pilot program that provides enhanced contract care.

This year we held several important hearings focused on rural health. For example, this past April we held a hearing on VA's implementation of the Enhanced Contract Care Pilot Program. To our

surprise, we learned the VA planned to create pilot programs within the Veterans Integrated Service Networks (VISNs), that were selected under the original legislation, VISNs 1, 6, 15, 18 and 19.

At this hearing in April, we made it clear that Congress's intent was to have VA implement this pilot program VISN-wide within those VISNs. And when you look at the scoring that was provided by VA to the Congressional Budget Office (CBO) on how many veterans would be affected by that program, these scores indicated that it would be VISN-wide.

Unfortunately, we just were informed a few days ago that VA does not plan on honoring Congress's intent and will only be implementing a pilot program in selected locations within the VISNs. I'm deeply concerned about this recent development and look forward to hearing from the VA today on this very important issue.

Next, in June of this year we held a hearing on innovation of wireless health technology solutions as a way to help overcome rural health care challenges. At this hearing, we heard from the Director of Rural Network Development in the University of Virginia Health System, who provided testimony on the unique needs of veterans of the Appalachia and the importance of innovation in telemedicine and wireless mobile health applications.

Again, I want to thank Mr. Perriello for inviting us here today, and I appreciate this opportunity to hear directly from the veterans of Central and Southern Virginia about their local health care needs. I look forward to the testimony of the different panels we have here today.

Once again, I want to thank Mr. Perriello for all that you have done and are doing for our veterans across this Nation and in your State of Virginia. I would now turn it over to you for your opening statement and also to introduce the first panel.

[The prepared statement of Chairman Michaud appears on p. 53.]

OPENING STATEMENT OF HON. THOMAS S.P. PERRIELLO

Mr. PERRIELLO. Thank you very much, Mr. Chairman. I really appreciate the sacrifices you've made to come down here and be part of this, and also to the Committee counsel, both the Democratic and Republican Committee counsel present. The four of us did travel together to Afghanistan, not only to look at the security situation, but to look at the seamless transition or how to create a more seamless transition from the forward operating bases through our holding hospitals and back into the VA system. Far too many are lost within those seams, as we all know.

We've made dramatic advances in battlefield medicine since the Vietnam and prior ages, which means we're able to keep a lot of soldiers and airmen alive that would not have survived before. That also means we're seeing a complexity of physical and emotional issues back on the home front once they have returned.

And one of the things that I want to thank in particular—and the community here across Central and Southern Virginia has been great on this—is that in previous eras sometimes within the veteran service organization community, we have seen generational battles, one set of veterans against another. We have seen an unbelievable unity of veterans of—to make sure that we are doing ev-

everything we can with our returning Office of Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) vets, and I think it's a testimony to the veterans service organization (VSO) community and the unity across generations that we have been able to respond in such a dramatic way, still much more to be done, to make sure that those folks, as they're coming back, are getting the best care that they can. And again, I think everyone here up in diocese has been interested in understanding that.

As Mr. Michaud noted, he and I both represent quite rural districts with high degrees of patriotism and service through our armed forces. And one of the things that he and I both advocate heavily is trying to get more of the health care to the veteran instead of just the veteran to the health care, ways that through telemedicine, through primary care within our communities, which we'll hear a lot about today, through community-based outpatient clinics (CBOCs), and other ways we can try to get services to veterans instead of putting the burden on them.

This hearing in many ways is another example of that. We want to get out in the field to make sure that we're making it as easy as possible to bring the Committee's processes to the veterans instead of veterans always having to come up to Washington to do so, though many of you have given up your time on that front. So we wanted this hearing—I wanted this hearing here in Bedford because, of course, no community has given more in terms of sacrifice. The great tradition of the Bedford Boys and the wonderful D-Day memorial that's here, even with the controversy that's unfortunately going on, remains just an unbelievable statement of the—of the events of Normandy and D-Day that should never be forgotten and continue to inspire.

I remember one of the first programs that I attended up there—I believe it was a July 4th ceremony—hearing the story of a mother who had just lost her son in Iraq, who that son had grown up visiting Bedford and then eventually D-Day Memorial, and that had inspired him to enlist and continue that tradition that we have seen. So there's so much to be proud of here in Bedford. But we also see the challenges of course in the system.

Now, this Subcommittee is on Health. I just want to make one brief comment about the Economic Opportunity Subcommittee of the Veterans' Affairs Committee that I also serve on, which is simply that the unemployment levels for our returning veterans right now is astronomical. Some put it at or above 20 percent unemployment.

So of course as people are coming back, not only might they be facing, say, a foreclosure on their home, their job is not there, challenges in their marriage, because we know what a strain that these extended deployments can put on our military families, perhaps physical and mental challenges as well in the health sector, to also be in an environment where we see not only general unemployment, but we see employers actually resisting hiring veterans. We hear the tragic stories of a veteran saying they won't even put their service on their resume because employers are concerned whether it's perceptions of post-traumatic stress disorder (PTSD) or perceptions of how quickly people are getting called back up, or seeing

various hurdles to veterans getting employment when they should be the first in line.

So we are working on a number of proposals on that Subcommittee as well, which won't be the immediate focus of this panel, that includes not only the most rapid implementation of Senator—of the GI Bill, modern GI Bill that our own Senator and many others on this Committee fought for, to modernize access to 4-year colleges, but we're also hearing from a lot of veterans that, you know, a 4-year college isn't for me right now, I need to get 12 months of vocational and skills training so I can get a decent wage and support my family, and trying to expand and streamline some of the vocational skills, training programs, some of the hiring programs, to make it more appealing for businesses to hire veterans and other issues. So those are things we continue to fight on there.

Here in this Committee again, we are particularly focused today on issues of rural health, and I have been very blessed by the expertise of the people sitting in front of me and many others to talk on a daily basis about the issues that we face in terms of access to care, access to specialty care, costs involved and other things.

And with that I want us to move to the first panel, and first introduce Major General Carroll Thackston who, in addition to being a former Adjutant General of the Virginia Army National Guard, is also the Mayor of South Boston, Virginia. He has been a tremendous servant both in uniform and also in the community. And along with him we have Dr. Roger Browne and Colonel Ted Daniel, both retired military. Dr. Browne is a general practice doctor in the South Boston area. Ted Daniel is the Town Manager. We've also worked together.

These three gentlemen are tremendous public servants in every sense of the word, and we have worked together extensively on what I think is one of the most appealing, competitive proposals for offering primary care through local facilities. It's a project that has been painstakingly put together, has tremendous support both from the local medical community, the hospital community, the elected officials and the veterans community, African American, white, young and old in the area, and I think it exemplifies so much what this Committee set out to do with this pilot project, and I'm looking forward to them speaking.

We also have joining us Howard Chapman, the Executive Director of Southwest Virginia Community Health System and the Virginia Community Health Care Association, to talk some about their experiences, as well as Kevin Trexler, who's the Division Vice President for DaVita, who is going to talk some about dialysis and a number of other issues and ways that some of our private contractors are interacting with the VA system.

So, with that, I will have more to say in response, but I really appreciate all of our panelists being here to participate, all the work that went into your opening statements and look forward to what you have to say this morning. I yield back to the Chairman.

Mr. MICHAUD. We'll start with General Thackston.

STATEMENTS OF MAJOR GENERAL CARROLL THACKSTON, USA (RET.), MAYOR, SOUTH BOSTON, VA, AND FORMER ADJUTANT GENERAL, VIRGINIA ARMY NATIONAL GUARD; ACCOMPANIED BY ROGER BROWNE, M.D., USA (RET.), SOUTH BOSTON, VA (INTERNAL MEDICINE PHYSICIAN); COLONEL TED DANIEL, USA (RET.), TOWN MANAGER, SOUTH BOSTON, VA; HOWARD CHAPMAN, EXECUTIVE DIRECTOR, SOUTHWEST VIRGINIA COMMUNITY HEALTH SYSTEMS, INC., AND MEMBER, VIRGINIA COMMUNITY HEALTHCARE ASSOCIATION; AND KEVIN TREXLER, DIVISION VICE PRESIDENT, DAVITA, INC.

STATEMENT OF MAJOR GENERAL CARROLL THACKSTON, USA (RET.)

General THACKSTON. Thank you, Congressman Perriello, Mr. Chairman. Good morning, ladies and gentlemen. I'm Carroll Thackston and the Mayor of South Boston, as Mr. Perriello so said. I have served over 10 years, both as Vice Mayor and Mayor of our town, which numbers about 8,500 in population.

I'm also a retired Major General of the United States Army, having spent over 40 years, the last 4½ years as the Adjutant General of the Virginia National Guard. I served on active duty for about 6 years, spent 35 years in the National Guard. And so with this background I have a good understanding of the National Guard operations, their goals and objectives and the problems, current and future, facing the National Guard. So my main focus this morning will be about the National Guard and its varying components and its probable impact on the Department of Veterans Affairs.

As I'm sure you are all aware, the Total Force Policy has been in effect since post-Vietnam and treats the three components of the Army and Air Force, that is, the regular forces, the National Guard and the Reserves, as a single force. Unlike the impact of Vietnam veterans on the VA system, this total integration and increased reliance on combat and combat support units of the National Guard throughout the 1990s, and the war on terror creates a whole new dynamic for Veterans Affairs.

So before I discuss some of my concerns about the Guard and increasing impact on the VA, I would like to tell you about our local effort to help veterans of Halifax County and the immediate nearby counties. For the past 3 years several of us have worked with a small group of local Halifax veterans, primarily Vietnam veterans. We have worked to establish a primary care facility in South Boston to serve local area veterans. We have met many times, and we have travelled many miles in pursuit of our goal.

At this point, we are aggressively seeking designation as a rural locality under the VA's Enhanced Contract Care Pilot Program. If successful, Halifax Regional Hospital's new primary care facility located in South Boston will serve as a pilot project for contract care within VISN 6. Our group has also met numerous times with Congressman Perriello, his staff and VA representatives. We have travelled to Washington and were able to meet with Secretary Shinseki. And most recently participated in a lengthy teleconference that included Deputy Assistant Under Secretary Vandenberg and numerous VA staffers.

In January of this year, Dr. Roger Browne, a member of our group, testified during Roundtable discussions of the Committee on Veterans' Affairs on "Meeting the Unique Health Care Needs of Rural Veterans." Dr. Browne is credentialed as a specialist in internal medicine. He's treated Halifax County veterans for over 30 years, and has personal experience as a brigade surgeon for the 198th Light Infantry Brigade in Vietnam in 1968 and has provided our group with the leadership and the credibility to clearly identify the quality of primary health care our veterans need and deserve.

At the finish line we hope to have a new and modern primary care center in South Boston operating as a VA primary care contractor, providing all Halifax County veterans, both old and young, regular forces, Guard and Reserve, with the quality primary care, medical care that they have earned and are entitled to, both legally and morally.

There were 1,127 veterans in Halifax County enrolled in the VA system at the end of fiscal year 2009. There are 2,954 civilian veterans in Halifax County according to the most recent census data. We want all of them participating in the VA health system, and we want a local facility that is convenient for them and their families. We want to ensure that our growing population of veterans that are returning from current tours of active duty, are assimilated back into their home communities with the assurance that convenient quality VA medical care is there for them.

Now, as a former Adjutant General of the Virginia National Guard from June 1994 to October of 1998, I have some deep concerns about the coming impacts of the VA system as a result of the extensive use of National Guard combat and combat support units during Operation Iraqi Freedom and Operation Enduring Freedom in Afghanistan.

During my tenure as the Adjutant General, in spite of actively seeking overseas operations for our 10 National Guard divisions, the National Guard was more or less relegated to homeland security and domestic crises. As I'm sure you are aware, this is not the situation the Guard finds itself in post 9/11.

Let me give you some examples. In Virginia, we have 7,838 members currently assigned to the Army National Guard, which is 102 percent of our authorized strength. Since 9/11, 8,862 Army Guard personnel and over 700 Air National Guard personnel have been deployed, 81 Purple Hearts have been awarded to Virginia Guardsmen, and ten of our men and women have been killed in action. There are currently 630 Virginia National Guard and Virginia Air National Guard men and women on active duty.

If we go to the national scene, the total number currently on active duty from the Army National Guard and the Army Reserve is 90,144. The Navy Reserve is 6,354, excuse me, the—the Air National Guard and Air Force Reserve, 14,457, Marine Corps Reserve, 4,917, and the Coast Guard Reserve, 787. This brings the total number of National Guard and Reserve personnel currently activated to 118,659, including both units and individual augmentees. These figures are current as of July 13. And when you consider the continuing participation of the war effort since 2001, the total number of National Guard and Reserve numbers is substantial.

So in conclusion, when we consider the huge influx of citizen soldier veterans created by the increase of Guard and Reserve forces under the Total Concept Policy, and the prosecution of the extensive combat operations in the Middle East, there is an enormous workload headed for the Department of Veterans Affairs. When you also consider the demands being placed on the Department of Veterans Affairs by the intense combat environment and multiple tours of duty, combined with the efforts to increase VA medical care eligibility for veterans, I believe that the VA will have to expand its network of health care facilities to meet these increased demands.

News reports last week indicate that the VA is adopting new rules regarding post-traumatic stress disorder that will, in my opinion, drastically increase the clinical workload for the VA. Reports in this newspaper article cite a 2009 Rand Corporation estimate that nearly 20 percent of the returning veterans, or 300,000, have symptoms of PTSD or major depression. It will be interesting to see how these estimates are updated to reflect the new rules announced last week.

The education our group has received in pursuing a contract primary care facility for Halifax County has clearly enlightened us on the tremendous strides that the VA has made since the mid-1990s with the establishment of the VISN and the CBOCs, community-based outreach clinics, but we are absolutely convinced that the VA will need to rely on the numerous professional and highly qualified private sector medical facilities to meet the incoming demands for VA medical health care.

Expanding the CBOC system may be prudent and wise, but the full utilization of contract medical facilities such as the one in South Boston will be essential to meeting these demands, both on time and on cost. Our research has shown considerable savings in time and fuel by veterans using more convenient and accessible primary care locations. Only through an aggressive primary care program that is structured to include all qualified veterans will the VA be able to cultivate a climate of preventive medicine and early detection for serious illnesses.

The VA Medical Center will always be the bedrock of VA medical care to take care of the most serious medical problems of our veterans and the VISN/CBOC system is a proven winner, in our opinion. But we still believe that contract primary care using existing private-sector facilities is going to be critical to the VA. So we in South Boston, in Halifax County, are prepared to lead the way.

And that concludes my—do we get a chance later on to answer questions?

Mr. MICHAUD. Yes.

General THACKSTON. Again, we thank you very much for the opportunity to be here today.

[The prepared statement of General Thackston appears on p. 53.]

Mr. MICHAUD. Thank you very much, Major General, for your testimony. And we're looking forward to working with you as we move forward in addressing the concerns that we have heard about veterans access to applicable health care services in rural areas. Thank you very much for your service to this great Nation.

Mr. Chapman.

STATEMENT OF HOWARD CHAPMAN

Mr. CHAPMAN. I'm Howard Chapman. I'm the Executive Director for the Southwest Virginia Community Health Systems. We're Federally-funded health centers, community health centers (CHCs) that receive Federal support located across the Commonwealth of Virginia. There are approximately 24 organizations with just over 110 sites.

Southwest Virginia Community Health Systems offers primary care and preventive services, but in addition, we have provisions for an integrated model of mental health in a primary care setting, which works well with depression and even substance abuse. It's a collaboration between the primary care doctor as well as the mental health provider.

We provide some degree of medication assistance through the Federal Drug Pricing Program and 340B. We also have a medication assistance program that uses the patient assistance programs through the different pharmaceutical companies. We have worked to provide some limited transportation, and all this in regard to trying to deliver good primary care services in rural areas and knock down the barriers.

One of the groups that do have a lot of barriers in their way are the veterans in our area. So we very much try to take advantage of being able to provide them the same level of services that we do the rest of the community.

We have been a CBOC operation, and our contract was terminated in May of 2009. We had actually been working in that capacity since 2005 and had built—we had just over 800 patients enrolled within our CBOC operation. We actually had been one of the first CBOCs in the Nation. Back during President Reagan's Administration, in the early 1990s, Secretary Sullivan made the announcement on the Capitol steps. And much along the line of, again, trying to develop and extend health care services to veterans, they actually tied the program to a program in Tuskegee, Alabama, that was looking to serve nonveterans in a VA hospital. And various veterans organizations, they take back full Congress and asked to appeal before we ever saw the first patient. But what we had done was been able to work with our local veterans that were anticipating having these services in their community and directly affecting their lives.

We worked for probably another 10 years or so to actually get those services started back, and it was going very well. We were very pleased with it. We did have some issues with the Veterans Administration in how they actually had set up some of the process. Rather than a direct link in using the VistA system that they have as their medical record, we were given sort of a dial-type virtual private network (VPN), which was extremely slow, really dragged out the length of the appointment for the veterans. And, you know, even in assessing things like that, we needed to do the preventive measures that—that they had in their process, it's really cumbersome to work your way through this system. It could have been made a whole lot easier through an integrated medical record that would have allowed us to use our existing electronic medical record (EMR) and dumped information into their system.

All of the technology things that happen, you know, it seems the veterans administration are behind on doing a lot of that. VistA is old technology, and I know they've talked about moving into a Web-based system, but, you know, it needs to be upgraded as we are moving toward this whole area of health information exchange and that type of thing.

I just want to close by telling you that at the close of our—our CBOC contract, the Veterans Administration announced the meeting in February, and the morning that they had that meeting, the temperatures were down in the single digits. They had done the melding on Wednesday. Most of the veterans did not get their announcement until Friday or Saturday. And they had asked us for space to accommodate 50 to 60 veterans. They had more than 250 that showed up. So again, the concern about veterans and the health care that they receive is really, you know, tremendous, a tremendous effort.

We have maintained and kept a lot of those patients just because it's an hour and a half, either to the Salem VA or the Mountain Home VA in Johnson City, and again they have set up a couple of VA staff, CBOC in Bristol. There's actually one in Atkins. And all of this has a considerable amount of cost in regard that they don't own the building but lease the space. And the renovations and things that they have had to do have been again money that's sort of lost in regard to VA paying for renovations and constructions that, you know, we can as Community Health Systems across the State of Virginia provide pretty much immediate access through a contracted arrangement to at least 110 sites across the State of Virginia. Most of the centers are Joint Commission on Accreditation of Health care Organizations (JCAHO), accredited. They meet high quality standards, and we're very willing to work with the Veterans Administration to see that happen.

One other thing I would note is that we do have a Statewide contract for TRICARE that allows service to military families. And the other benefit behind using a community health center is not only for the veteran and the services through the VA, but we have a sliding fee scale for the families and children and spouses of these veterans, that we can offer the same level of service based on their ability to pay by total family income and total family size.

So we think it's a great benefit for the veterans. I think it opens up immediate access for the veterans and their families, and we would very much like to see the CBOC continue and be back in line to be able to serve the veterans in our community.

[The prepared statement of Mr. Chapman appears on p. 55.]

Mr. MICHAUD. Thank you very much, Mr. Chapman, for your testimony. I look forward to asking the questions that we will have for you.

STATEMENT OF KEVIN TREXLER

Mr. TREXLER. Mr. Chairman, distinguished Members of the Subcommittee, I'm grateful for the opportunity to provide testimony on behalf of DaVita. I manage more than 80 clinics in Virginia, DC, and Maryland. I am also a veteran. I served as a naval officer 6 years on an attack submarine. At this time, I will summarize my

written statement and look forward to responding to any questions you may have.

DaVita is a leading provider of dialysis services in the United States. It provides treatment to more than 117,000 patients each week in more than 1,500 centers, and represents nearly one-third of all patients with end-stage renal disease or ESRD. We are also a recognized leader in achieving excellent clinical outcomes, consistently demonstrating outcomes that are among the best when compared to national averages. Our testimony today addresses the Subcommittee's interest in understanding the quality of and access to dialysis care provided to veterans in rural and underserved areas.

DaVita is privileged to care for more than 2,000 of our Nation's veterans in our dialysis clinics across the country. Our dialysis providers deliver dialysis treatment in veterans' communities when the VA cannot provide reasonable access or lacks in-house capability to provide this life-saving treatment.

More than 20 percent of veterans with ESRD in rural Virginia have no treatment options within 20 miles of their home. We consider ourselves a partner with the VA and are committed to providing excellent quality, exceptional clinical performance and outstanding customer service to all these veterans whom we serve.

Veterans receiving dialysis treatment are frail patients often with multiple illnesses and cannot survive without dialysis or kidney transplant. Thus patient access to care is critical. Patients receive three treatments per week, every week of the year, often 4 hours at a time. Both provision of the treatment and the financial aspects of the dialysis treatment are unique. Dialysis and all it entails is expensive, but in fact it is only about a third of the total cost for unmanaged end-stage renal disease patients. I will address both of these issues and suggest a way to improve the health status for these extremely sick veterans and the VA's desire to reduce total costs of purchased care. DaVita recognizes and supports the VA's goal for standardizing reimbursement for the purchase of non-VA provided health care services and reduce costs in a way that—that will ensure that we can continue to provide care for all of our veterans in rural areas. I'd like to share two ways that dialysis providers and the VA can have win-win approach to these issues.

First, here in Virginia we provide care to veterans through VA established existing negotiated contracts. These contracts, if continued, will continue to provide mutually agreed upon sustainable reimbursement.

Second, we propose to the VA that they implement a patient-centered, integrative care management dialysis program for the ESRD veterans. Results of this would be improved clinical care for the patients and lower total costs to this system. In Medicare demonstration projects, we have been able to improve clinical outcomes and reduce hospitalizations. Dialysis is only about a third of the cost for end-stage renal disease patients. The majority of the costs come from emergency room visits and hospital stays.

An integrated care program would focus on all the clinical needs of the veteran, and would provide lab, pharmacy, medication therapy management, vascular access care, vaccination, case management and access to diet and nutrition counselors and nephrologists.

The VA currently does not receive any clinical data about its dialysis patients. In the integrated care model, we fix that in the system, but would provide an interface between our extensive databases and our integration systems.

In response to the VA's request for dialysis care innovation, DaVita will also submit a proposal that reflects our expertise in providing and remotely monitoring dialysis care in the patient's home that would be of particular benefit to patients in rural areas.

On behalf of DaVita, I'd like to thank you again for your interest in the care we provide to our veterans and commitment to ensuring that veterans in rural areas continue to receive the quality of and access to care that they have earned. We're grateful to the Subcommittee for its leadership in seeking new ways to promote quality care for all veterans and especially the unique population of veterans with kidney disease whom we serve. I'd be happy to answer any questions you may have.

[The prepared statement of Mr. Trexler appears on p. 61.]

Mr. MICHAUD. Thank you very much.

Once again I want to thank the panel for testimony this morning and I look forward to working with you as we move forward.

Major General Thackston, I have a quick question. As you heard, both Mr. Perriello and myself are very concerned about access to health care for veterans who live in rural America. Rural health care issues are extremely important and over and over again we continue to get legislation that contracts out VA services.

At the same time we have heard some concerns from the VSO community. And as a Major General and a former Adjutant General of the Virginia National Guard, are you concerned that we might no longer need the VA medical facilities, or do you feel there always will be a need for the larger medical facilities.

General THACKSTON. Yes, sir, I certainly feel there will always be a need for that. What we are concerned with—like yesterday I ran into a lady and I told her where I was going this morning. She said, "Oh, thank goodness." She lived down in Clarksville. She said, "My father is a World War II veteran, and he has to have somebody drive him to the VA Medical Center in Richmond." So there's literally hundreds of people like that in rural areas, as I'm sure you know.

The other thing we're quite concerned with is the relaxation of the criteria that will qualify veterans for the PTSD as well as—Dr. Browne, if you take a minute, wants to explain a little something about how the criteria for heart disease has been expanded, which will cover a number of Vietnam veterans. Have we got time for that?

Mr. MICHAUD. Yes, we will. Before we turn over to Dr. Browne, when you look at, for instance, community health centers and other qualified health care clinics and hospitals in rural areas, and where they're currently located using Federal dollars, in a lot of cases, they're in the same area as access points recommended in the Capital Asset Realignment for Enhanced Services Process in 2004.

Do you feel that veterans will be less likely to visit community health clinics versus a VA facility, or do you think they'll be more likely to use a community health clinic since it's in their community.

General THACKSTON. You mean community health clinics?

Mr. MICHAUD. Yes.

General THACKSTON. Yes, sir, I feel like they'll be more likely, because, for example, this new primary health care center we have in South Boston, we have had all kinds of people that are qualified to go there, but our veterans can't unless they pay, and they have to go to Richmond, Salem, or Durham. So I feel like if we have this expanded network, they will certainly be used to a great extent. And we have done a rather exhaustive study to talk about the costs and reimbursement for travel that VA pays for many of these veterans who go to McGuire and Durham. And we have these clinics that will certainly save the VA money, and it will save our veterans time. You know, a lot of them have to take a day off from work, and a lot of them have to get somebody to drive them.

But to answer your question, for serious illnesses and all, they will still go to the major VA centers, but we'd like to think this community-based, the CBOCs as well as what we are trying to establish, will serve an important need.

Mr. MICHAUD. Dr. Browne.

Dr. BROWNE. Well, I agree. I got started in this because I've practiced medicine down there for a long time. I would like to point out to the Subcommittee that this is a moving target. When I go to the barbershop, I wonder whose head they're cutting when I see all that silver stuff falling on the sheet. I used to be young and strong. Nobody knew when we were in Vietnam what was going to happen with this Agent Orange business, which is a massively expanded load. Who knows about all these other issues.

Plus, if a veteran becomes 30-percent disabled from a service-connected illness, then he becomes or she becomes enabled to go for any illness, and people age and they get problems. So we think, like the rest of the country, as the veteran population ages, their demand for services will increase. And that's been my experience. In internal medicine, most of the patients are elderly, and many, many, many of them are veterans.

So we see this as a way to integrate to—also to minimize the number of unnecessary visits to the mother center. If people get chest pain, where do they go? What is it? Well, it could be nothing. Somebody needs to sort of triage these people. And we see this as a way to improve the quality of health care, to intervene with simple measures, to get one-on-one treatment, and to improve the quality of referrals to the VA center, to utilize those physicians better.

As you know, there's going to be a shortage in this country, not only of primary care doctors, but there may be of other doctors and nurses. There's going to be a competition between the VA systems and other health systems for qualified people. This is a way for the VA to immediately expand its staff by incorporating CBOCs and—and willing other participants and treat, splint them where they lie, treat them forward.

Mr. MICHAUD. Thank you.

Mr. Chapman, what have you found to be the biggest barrier to working collaboratively with the VA system in the Community Health Care Centers.

Mr. CHAPMAN. I think working in the VistA system with the restraints that we had by using the dial-up. Had it been pretty much a live connection, where our providers could have done that real-time would have definitely speeded the process. Again even further to have had the ability to use our own electronic health record and then download the information or send it to the VistA system—we're not taking anything out of their system. We're actually adding information to their system—it would have greatly enhanced the ability for us to have been able to have done those services.

You know, if I could follow up on maybe a couple of the questions in regard to rural America. You know, again, in rural Virginia, by the 2000 census data, we have some communities in Southwest Virginia that 14 percent of the householders do not have vehicular transportation. So that trip, an hour and a half to the nearest VA hospital is almost impossible for some of these veterans.

You know, 12 percent of the households lack basic telephone service. So while we all take for granted that we carry cell phones, a lot of people out there just don't have that, that ability. And so, you know, we think there are a lot of barriers to serving the veterans and making these services accessible in the communities and the places that they live really is a great benefit for the veterans.

The VA hospital uses the, I think, all open-access scheduling. Everyone is given the 8:00 appointment. And again, these veterans do go and they sit all day, primarily, before they're seen. And that gets to be a real hindrance, to be able to ask a friend or a relative or a neighbor to take you to the VA hospital and, you know, and be there for a day.

We've actually used the same scheduling with the veterans that we did for our regular patients. They were given a 2:00 appointment, and they were seen on or around 2:00. They may have been delayed somewhat, but again it did allow the veterans to be able to take advantage of sort of scheduling their time and knowing what they could do and not wasting a day for health conditions.

Mr. MICHAUD. You mentioned, I think, in 2005 to 2009 that you took care of 800 VA patients.

Mr. CHAPMAN. We have never done any marketing. We've sort of just let word spread about the program itself. And again, we had some degree of existing capacity that we were able to enroll about those 800 veterans. We were actually moving toward probably having two or three providers that would just have been able to serve the veterans themselves rather than just fall to spreading it across all of our medical providers, and we think that would have worked out a little better for the arrangement. It would have given us access for, on heavy days, some of the other providers. All of them would have been potential, but we would have had two or three primary providers that would have been just serving the veterans. And we think that would have made a little better situation than what we had.

Mr. MICHAUD. Have you looked at the cost of providing health care services? Since you no longer, I understand, have the 800 veterans, has the cost per patient gone up.

The second question, relates to quality of care. Is it fair to assume that some of those 800 veterans are no longer getting VA health care because of the travel distance? What were some of the

comments from the veterans who might have stayed there or gone to VA and then ultimately quit?

Mr. CHAPMAN. We did actually maintain a lot of those veterans, primarily because again the CBOC-VA staff/CBOC in Bristol, which again, you know, it's 40 miles away. And some of the comments we got from the veterans is, if I've got to drive 40 miles, I'll drive the other half-hour and go to the VA hospital anyway, because if I need other testing, things like that done.

You know, probably in October or November of 2009, one of the veterans had commented that they were backlogged, and I think it was by about 1,200 patients or more, that they were having to schedule appointments, try to get enrolled in the VA system at the Bristol CBOC.

You know, they've built three others from some of what they took away from the community health centers, and the VA staff models now, again with the extensive amount of money going into renovation and things, the facilities that the VA did not own, and the—and bring their own providers in. The one in Marion or Atkins, Virginia, I think the last count I had, they were open maybe 2 days a week, and last count I had, they were about 6 months behind on—on a wait list of about 6 months to get a veteran enrolled in that program. So there's still a lot of access issues from the standpoint of the VA.

The VA hospital in Johnson City and in Salem are extremely busy. They don't have the capacity to be able to take these. When you see waiting lists of 6 months or more in getting a veteran enrolled, it really indicates that there is a need for more services out in some of these rural communities.

Mr. MICHAUD. Thank you.

Mr. Trexler, in your testimony you talked about the capabilities of remotely monitoring the patient in their home. Can you explain to the Subcommittee what type of technology veterans might need in their home to be able to be monitored properly?

Mr. TREXLER. It would be telephonic, just by phone or also video conferencing.

And there's another part of this program I want to stress that particularly applies to rural locations. We would provide predialysis education to all the patients, and our research shows that patients who are educated choose what's called a home modality, the ability to receive dialysis treatment in their home 30 percent of the time versus an uneducated patient will only choose it six percent of the time. So this would be another component of the program that would help veterans have access. They won't have to travel three times a week far away to receive this treatment. They can do it in the comforts of their home.

In addition to that, we also have a program to provide medications to be delivered directly from the center to the patient's home, once again reducing the number of times these veterans would have to go to the pharmacy, oftentimes have to go to multiple pharmacies to get all of their medications they require for dialysis, and also improve the adherence because we'll get a report that will alert us when the patient runs out of medication or when they should run out, so we can remind them to refill that and also check to see if they've used all of their medication.

And a third major component of this is by providing better education, we reduce the number of crashes into our hospitals, so the patients have a gradual transition into dialysis as opposed to having an acute illness that causes them to go in the hospital, and the benefits of this are reduced total costs and improved outcomes and mortality in the first year of dialysis.

Mr. MICHAUD. And my last question is—and I know this is an important issue for Medicare/Medicaid patients, and an issue the Committee is somewhat familiar with—about dialysis reimbursement rates. VA is looking at adopting the Centers for Medicare and Medicaid Services reimbursement rates. In Maine, we have the oldest population per capita in the country. We're number one for the loser on Medicare. We're number two for the loser on Medicaid. Sixteen percent of our population, near the top among States. We're near the top. We're a rural State. For reimbursement rates, we're second from the bottom for Medicare. And that's actually a concern, making sure that providers will be able to adequately take care of their patients. And one of the reasons why we're near the top for high insurance premiums is because there's a lot of cost shifting that's occurring because of low reimbursement rates.

Do you have a brief comment on reimbursement rates for dialysis treatment and what might that do for some of the facilities that are in rural areas, which tend to have higher numbers of Medicare/Medicaid patients.

Mr. TRELXER. I want to focus my testimony on what would we would do to provide access for rural veterans and also to improve the quality. We've submitted other testimony that provides more extensive comments about any proposed changes of reimbursement. I'll just briefly summarize them by saying that any change could have unintended consequences, and it could be negatively affecting the access of care in the rural communities for all the reasons that you mentioned. But I'd just urge the Committee to make sure you are researching that, because no one wants to see any reduction in the access to care for our veterans. They've certainly earned it, and I thank the Committee for your support, asking the questions and doing the research.

Mr. MICHAUD. Mr. Perriello.

Mr. PERRIELLO. Thank you very much, Mr. Chairman.

Thank you again to all the panelists. A few questions to run through.

First, just so I understand, for General Thackston and Dr. Browne, right now with the existing facilities, someone with private insurance, Medicare/Medicaid, could attend, but a veteran could not; is that correct.

General THACKSTON. Correct.

Mr. PERRIELLO. And to what extent have you and Mr. Chapman, to the extent you all are still serving some of those veterans, are you already seeing a change in or any trend lines in the amount of care or upticks that you're seeing, or is this something 5 years off or 10 years off in terms what you're expecting for some of the changes that you have predicted.

General THACKSTON. You want to answer that?

Dr. BROWNE. Well, I can't answer that question at this point. We don't have the information. As you know, we have researched ev-

everything pretty well, and I can't answer that, don't have enough data for that. But I expect that if—if you read what's in the various literature, General Shinseki's decision to include certain new illnesses with Agent Orange, that alone is going to massively impact the Veterans Administration. I don't see how they'll be able to cope with it, frankly. But that alone will clog up the system beyond belief, in my opinion.

Mr. PERRIELLO. One of the concerns we've heard in the past is the issue or issues that arise when you handle both a veteran and a nonveteran population in the same physical area. To what extent did you see that, Mr. Chapman, and to what extent has that been thought through or considered in the South Boston context?

Mr. CHAPMAN. Again, we basically were using the existing providers we had in working through the—pretty much the excessive stacking and had some degree or capacity to observe those. We really think it would probably have been better to have had more or less a provider or two. Now, I don't think there's a difference between, you know, a veteran and a nonveteran in the same facility. I think, again, we would have been better off to have a couple providers that would have been just dedicated to serving the veterans, and then, you know, in high demand times we could have had the other providers serve as backup to those staff. But we do extended hours, again real convenient for the veterans and that type thing, and we didn't see a problem with that.

I think, again, you know, veterans were appreciative of the services. Again, they were appreciative of being able to come in and appointed a time slot and really great patient satisfaction from the veterans in regard to services that they were receiving.

Mr. PERRIELLO. One of the things that I have been so excited about with the project you all have put together is not just the, you know, the level of detail and the community engagement with it, but it seems to me one of the reasons to support the pilot program is just to try different things. What we know is we are going to see a different world than we saw 20 years ago in terms of the scale, in terms of the types of problems, the complexity, and so it seems like part of the goal of this Committee, both before I joined it and now, is to say we have to try some different things.

So if you are saying to a group of people here's what we are going to test by the South Boston facility, by the primary care facility, and if it works, we will know X, if it doesn't work, we know Y, what do you say for us who have to look at this across the country that we could learn from what you all are putting forward?

Dr. BROWNE. Well, one of the things, if we get this far, if you grant us permission, is we intend to have a board, made up of consumers, veterans, who will meet quarterly and they will assess the performance of this. And we would invite representatives from the VA to serve on that, and these veterans would make a decision about how this clinic is working and to meet their needs. And if you met some of the people that we'll put on that, on that small group of five, seven people so it can function, and periodically review that and make a report to the VA or to you, whoever you wish, and then we'll assess how things go on as a pilot program.

As far as the veterans are concerned, I took care of plenty of those. They came in my office. They didn't wear a veterans t-shirt.

They were amongst the people out there. We treated them the same. The only difference in my office was sometimes we had a huge difference in insurances. It was a matter of processing the patient.

In view of whether you put this clinic here, if you want a separate entranceway, we can accomplish that, or separate person to deal with that. As you know, Mr. Loftis is interested in getting a couple of disabled veterans to work in this clinic and provide computer access and to process these veterans. We even think that we should be able to enlist veterans at these local clinics. A lot of them won't go to Richmond. So who knows. I think it's a moving target.

Colonel DANIEL. I'd like to add that, as the General pointed out in his presentation, we know we have some 1,100, 1,200 veterans that are currently enrolled. We know we have close to 3,000. And from the beginning we have said, why aren't all eligible veterans taken care of? We have some younger veterans that are sitting back. They're not getting the primary care. They aren't getting educated. That's going to result in long range costs to the VA if they have ailment, diseases.

As far as evaluating the effectiveness of our program in South Boston, we're going to be very closely monitoring the increase in the number of people who are going to step forward and enter the system to take advantage of it. So we'll see an increase.

South Boston is situated where we are more or less equal distance between Salem, Richmond, and just a little bit closer to Durham. Most of our veterans historically have gone to Durham and Richmond as opposed to Salem. The CBOC that's over in Danville of course is in the VISN system where its primary medical center is Salem. The amount of Halifax veterans that are currently going to that CBOC, we don't see any change in that. They're convenient to it. They're enrolled in it. We see them go there. But we see the increasing workload that will be coming as a result of more veterans qualifying and coming into South Boston. We see an increase in primary care, primarily in the area of preventive maintenance, follow-up.

Again, the Chairman's question was what is the future of the VA centers. My personal opinion is that it is solid. There will always be a requirement for it. Our veterans love the centers. They prefer a center to go to. And the CBOC system is fantastic, and the whole VISN. But our position is that the increasing workload is going to require taking advantage of every asset you have, and local community primary care centers like in South Boston will be able to provide tremendous advantages to the veterans and to the VA, and that's why we're looking forward to be participating in the pilot program. We think we can prove that.

General THACKSTON. Mr. Perriello, you were there when the ribbon was cut on the facility we are talking about. It's an ultra-modern building. We feel like there will be no cost overhead, this type thing, when veterans use it. So, while the CBOCs do a great job, we're talking about something totally different. We are talking about a clinic that's run by the Halifax primary, Halifax Regional Hospital, and no overhead to worry about. We put a couple of volunteers in there with computer connections to the VA centers in

Richmond, Durham and Salem, and we just see it as win-win situation along with the CBOCs.

Mr. PERRIELLO. Let me ask one with question of you all. Then we'll wrap this up pretty quickly.

Mental health capacity, what capacity do you have in South Boston? And related to that, one of the things that we found in the CHC system is we have been doing more mental health work through telemedicine, and somewhat surprisingly we actually have a higher show rate for mental health appointments through telemedicine than through going in. Some of that is obviously it's easier access to it.

To what extent is there either the capacity in South Boston or the technological capacity to do, to be connecting up with mental health experts in the VA system?

Dr. BROWNE. From a technological standpoint our little hospital is on the cutting edge of computer technology, in fact, probably ahead of the VA.

As far as psychiatric care, there are two psychiatrists with a large support staff and a mental health group that's in there. So I don't anticipate any problem. Many people who have experience in combat know about PTSD. It's no stranger. So a lot of other physicians with a small amount of education could easily take care of identifying.

And of course this is a way to integrate between the VA—we don't see this as two separate issues. We see this as supporting the VA, following their guidelines, giving them support, but yes, we have the staff to deal—and that's who I've sent a lot of people that have PTSD who weren't in the military. We use the psychiatrist.

Mr. PERRIELLO. Well, I really see this as being one of those demands that's going to grow tremendously, and creating capacity there both in the CHC community, but particularly the veterans community, that's going to be crucial.

When my brother was being recruited very heavily as a high school athlete, his coach told him, "Go where you're wanted the most because they'll find a way to make it work for you." And I think in this case, as we look at the pilot programs we'd be hard pressed to find a place around the country that has done more work saying we want this to happen here, we want to prove it can work here. I think the work you all have done to put this together is tremendous, and I appreciate that.

And I have some questions for Mr. Trexler, but I'll ask those off-line about quantitative numbers. We have gone back and forth with dialysis from assuming it was better to do it in the home to bringing people to the clinics, back to the home. The upfront costs tends to, of course, be higher to prepare it in the home, but we're starting to see that being something that pays off over time. So I'm going to want to run through some numbers with you both in the Medicare context as well as the VA context, which we can do off line.

But, again, I just want to thank all the panelists for their work in the community. Thank you very much.

Mr. MICHAUD. I, too, want to thank the panel.

I have just one more quick question for Mr. Chapman. With the community health clinics, is your primary bulk funding from the Federal Government?

Mr. CHAPMAN. Community Health Centers in general are about a third Federal Government. The other two-thirds we generate through contracts and people service arrangements with patients. So virtually it's about a third of our operating budget comes from Federal sources.

Mr. MICHAUD. And your fee for the services, is that usually on a sliding fee scale?

Mr. CHAPMAN. It is based on a sliding fee scale. We're limited to what the insurance companies will pay and contract arrangements and that type of thing, so it's much like the physician's office down the street.

Mr. MICHAUD. How does a contract with the VA system work? Is it more lucrative for you, or if you look at a veteran who might go in if you were paying on a sliding fee scale, is he paying more because you have a contract with the VA system, or is it about the same or—

Mr. CHAPMAN. Well, actually ours is on—in Southwest Virginia we don't have a lot of managed care. And the VA contract was on a capitative basis. So once we had done the physical and had them enrolled, we assumed responsibility for their primary care. That was probably in the neighborhood of about \$30 per member per month, and that assumed, you know, taking care of pretty much the whole round of services that we deliver through primary care.

Mr. MICHAUD. Great.

Once again, I'd like to thank the panel for your testimony this morning as well as for answering questions. We'll probably have some additional questions which we'll provide in writing. So, once again, thank you very much. You've been very helpful.

General THACKSTON. Thank you for the opportunity.

Mr. MICHAUD. I'd like to invite the second panel up, and I'll turn it over to Mr. Perriello to once again introduce the second panel.

Mr. PERRIELLO. Thank you very much, Mr. Chairman.

Before I introduce the panel, I want to introduce Martha Woody from my staff.

Martha, if you'll stand up.

Any veterans that are here today to talk about a specific case of theirs, Martha does our casework. She's based out of the Martinsville office and previously worked with the VA, so she understands the inside of the system as well as the veterans. So if anybody wants to grab her, I may ask her to just stand outside for a few minutes. So anyone who came because they're having a particular issue with the VA, I want to be sure that you have a chance to talk to Martha.

I'll introduce Ericke Cage, my legislative counsel from Halifax County who handles my Veterans Affairs' Committee work on the policy side. So if it's a policy question, obviously you're welcome to talk to me about both case and policy work, but I want to be sure that you understood that our team was here and can be pulled aside, because these hearings will go on for a while, so if you want to grab him at any point.

With that, I'll invite the second panel to come up: Michael Mitrione, Commander, Department of Virginia, for the American Legion, and thank him for his tremendous leadership with the Legion.

Dan Boyer from the National Legislative Committee, Past Commander, Department of Virginia for the VFW, for the Veterans of Foreign Wars of the United States. Again we've really enjoyed working with the VFW staff on some of the vocational skills training and employment issues as well as on the health issues.

Clarence Woods, the Commander for the Department of Virginia for Disabled American Veterans (DAV), who—several of these men made quite a trek today to get here and were commenting on just how beautiful our area is. So it's always nice to show off a little bit the beauty of the Blue Ridge and the community.

And I particularly want to thank Lynn Tucker for her participation. She'll talk as a veteran caregiver the amount that her sons have sacrificed, that she has sacrificed. As you will hear, it is just tremendous. And rather than just focus on making sure that her family is getting the care they deserve, she's also made sure that she wants to speak out for others who are going through a similar process.

And one of the things that we know is that unlike in, say, the Vietnam era where most fighters were going over as single individuals and quite young, we're seeing people go over now where it's an entire family that's involved, particularly extended deployments. An older fighting force is more likely to be married. I think Ms. Tucker's words about the experience in military families and caregivers is one that you will particularly want to hear.

Again, I want to thank all the panelists.

Mr. Mitrione, if you can get us started.

STATEMENTS OF MICHAEL F. MITIRONE, COMMANDER, DEPARTMENT OF VIRGINIA, AMERICAN LEGION; DANIEL BOYER, POST COMMANDER, GRAYSON POST 7726, VFW PAST STATE COMMANDER, VETERANS OF FOREIGN WARS OF THE UNITED STATES; CLARENCE WOODS, COMMANDER, DEPARTMENT OF VIRGINIA, DISABLED AMERICAN VETERANS; AND LYNN TUCKER, MUSEVILLE, VA (VETERAN CAREGIVER)

STATEMENT OF MICHAEL F. MITIRONE

Dr. MITRIONE. Mr. Chairman, Members of the Subcommittee, thank you for giving me the opportunity to address the issue of concern to many of the 750,000 veteran families living in Virginia. The American Legion greatly appreciates and salutes your efforts on behalf of the residents of Virginia. In my next article to our members I will be mentioning the efforts of your Committee to address the availability of VA care in our outlying areas.

A written copy of my testimony was provided as requested. However, given the short time to prepare, it covers these topics from a general perspective. I used the intervening time to discuss the subject with many of the members directly impacted by your issue of interest, and we'll use the time available to me this morning to provide a more focused viewpoint. Boiled down to its essence, the issue can be expressed in three words: "time and distance." Fortu-

nately, emergency care is not an issue since the VA has provisions for covering expenses and life-threatening situations. The issue is in outpatient care.

Virginia houses three VA medical centers, two outpatient clinics, and 10 CBOCs. However, as might be expected economy of scale dictates that these scarce resources be placed in areas of high density population. This naturally tends to exclude a large percentage of our population who choose to live various distances from these population centers. To reach adequate medical care facilities, therefore, hours can be spent travelling to and from their homes. In many cases this involves the time not only of the veterans themselves but, as we have heard, the availability of volunteers willing to spend their time transporting them. In times of adverse weather conditions, these time frames can be more than double or triple.

Not only do eligible veterans have to travel long distances to obtain medical care, but sometimes artificial boundaries make that travel distance even longer. For example, a Legion member advised me there is a VA clinic 19 miles from his house, but because of some artificial line of demarcation he's required to travel 56 miles to another care facility. That of course raises the question why such boundaries exist. Active-duty military can obtain care from any military facility. It would, therefore, seem logical that if a veteran has a valid VA card, medical care should be available from whatever facility is available.

The American Legion realizes that the government has limited resources and cannot be expected to build and staff an extensive network of CBOCs across the landscape. As part of the American Legion's efforts on behalf of the veterans, we make it part of our mission to conduct site visits to VA medical facilities across the country under our National System Worth Saving Program in order to assess the quality of VA care. In fact, one such visit is scheduled in Virginia for next year, and special attention needs to be paid to rural areas due in part to the fact that many Reserve and Guard units from rural areas have been called up to support war efforts in the Middle East.

In addition, thousands of volunteer hours are spent by concerned Legion members in VA facilities across the State. Their interaction with veterans within the VA systems provides valuable insight and allows us to develop resolutions provided to our Congressional representatives. Discussions with a number of members represent—result in a recommendation that might provide an easier and more cost-effective solution to the problem of accessibility to medical care and worthy of the study by the VA or other appropriate agency.

Senior citizens and retired military now have the option of being treated by doctors instead of clinics of their choice. If the VA had a system of issuing medical cards to eligible veterans that could be honored by health care providers, it would appear that geographical locations would no longer be an issue. Company sponsored health plans provide a list of health care professionals authorized to provide services. The VA might be able to do likewise.

The American Legion welcomes the opportunity to work with this Committee, veterans of VA and rural health care providers to improve timely access to quality primary and specialty health care

services for veterans living in rural areas. Mr. Chairman and Subcommittee, I wish to thank you again for your time.

[The prepared statement of Mr. Mitrione appears on p. 63.]

Mr. MICHAUD. Thank you. Mr. Boyer.

STATEMENT OF DANIEL BOYER

Mr. BOYER. Mr. Chairman and Members of the Subcommittee, I am honored to be here today to represent members of the Veterans of Foreign Wars of the United States here in Bedford and around our wonderful State of Virginia.

I come before you with profound gratitude for what the VA is striving to achieve on behalf of our veterans. No agency or department is perfect. And yet I know that with the support of the Congress and this Committee, the VA is making strides forward and is working diligently to care for all generations of veterans. With these thoughts in mind, I would like to address the rural health care challenges we are facing here in Southwest Virginia.

Access to VA services in rural areas is always a primary concern, and that is no different in our region. From my hometown of Galax, Virginia, we have the Salem VA Hospital that is approximately 100 miles to the northeast. Also located in our region is the Johnson City, Tennessee, VA Hospital, and that is approximately 125 miles to the west.

Either of these can be quite a journey, particularly when a veteran has two noncontiguous appointments. It can be a frustrating process for veterans to travel long distances for multiple appointments spread throughout the day. Thus, we are very thankful for our community-based outpatient clinic or CBOC in Hillsville, Virginia, and we believe that the addition of a second CBOC in Marion, Virginia, although limited to 3 days a week, will provide even greater assistance.

There is clearly a need for the VA to open more clinics in rural areas. And the onus is on the VA to find solutions for our veterans, whether it be through additional private contracting, private and public partnerships, collaboration at multiple levels of government, or other creative means to make sure veterans are getting the care they deserve.

Another area that will potentially improve access to care is telehealth. The VFW believes that this is a major opportunity to improve health care outcomes, particularly in rural communities. Though there are privacy issues and technological limitations that must be addressed, they should not delay any expansion of telehealth services. This Subcommittee held a hearing that spent considerable time discussing rural broadband and wireless expansion, and we encourage the Committee to continue expanding the body of evidence that clearly supports a robust telecommunications infrastructure in our rural communities.

We're also concerned that many cases of traumatic brain injury (TBI) are not being properly diagnosed. We are obviously playing catch-up in our understanding of TBI, and access to medical professionals who can properly diagnose TBI is a problem nationwide. As you might imagine, veterans living in rural communities are especially vulnerable to misdiagnoses and ill-suited treatment. And the VA needs to make sure a sufficient network of doctors is in place

to take what we are learning and put it to use in these communities. Moreover, post-diagnosis treatment can be time-consuming and can hinder efforts to treat rural veterans suffering with TBI. This is a serious issue that the VA and this Committee need to tackle head on.

Closely tied to TBI is our concern for proper diagnosis and treatment of mental health conditions. We applaud VA for raising awareness on mental health issues and for working to reduce the stigma attached to seeking mental health treatment. We urge the Congress to provide continuous oversight of VA mental health programs to assure that the need for counseling and other types of treatment is being met here and in all the rural areas of the country. At the Salem, Virginia, facility alone, nearly 2,500 veterans have received diagnoses that may be caused by PTSD.

One concrete step that can be taken to ensure all veterans who struggle with mental health conditions receive timely and professional care is to staff our rural CBOCs to provide inpatient mental health counseling among other specialty services. Specifically strong outreach and education programs will be necessary to help eliminate the stigma of mental illness and other barriers that dissuade many from seeking care. We also need meaningful post-deployment health assessments that will incentivize servicemen and women to provide honest responses so they can receive appropriate types of care and secure benefits, which they have earned.

Routine examinations should include mental health assessments. VA staff should be fully competent to identify warning signs, should be aware of all available programs and should fully utilize them. We all know that suicide among our veterans is higher in rural communities. The VA suicide hotline is an effective tool for those who call. But we should work to ensure every veteran who is at the end of his or her rope knows there is a helping hand.

Again it comes back to outreach. These programs must be visible in the everyday lives of veterans. We know this is especially challenging in highly rural areas, and we hope the VA will redouble their efforts with regard to rural outreach, not only for the suicide prevention hotline, but for all their programs.

One way the VA is reaching out to address these and other issues is through Mobile Vet Centers (MVCs) that are literally going to where our rural vets live and work, ensuring access to services is provided where it is needed. However, it is with some dismay that I tell you I have not seen or heard of one being in our community. With that in mind, the VFW hopes that the VA is devoting proper time and attention to evaluating successes of MVCs and considering additional resources, if there is a demand for more Mobile Vet Centers.

In rural areas, simple word of mouth is still one of the primary ways information is distributed. The VA should not overlook hometown newspapers, local VSO chapters and other means tailored to our older veterans. Though they should employ e-mail alerts, social media and other electronic means to reach out, they should not expect these to reach every generation of veterans. We want to be a resource for the VA to reach rural veterans, and the potential to boost outreach by using VFW posts and those of other veteran service organizations cannot be overstated.

Another helpful opportunity for collaboration would be to use local VFW posts to conduct local screenings and wellness events. Just because a Mobile Vet Center is not available, that shouldn't mean the VA can't send a doctor or medical professionals to a rural area. Speaking on behalf of the VFW here in Virginia, if the VA sends us a doctor, we can supply the patients and the physical space needed to screen for mental illness and TBI along with other physical conditions such as glaucoma, hearing, diabetes and other illnesses. Such opportunities would provide a platform for further collaboration and would be a positive contact with rural communities where there is no VA presence. Everyone benefits when mutually interested parties work together. We hope that the VA would take seriously the many benefits of increased cooperation with the VSO community.

The Independent Budget said it best when it stated that, "Health workforce shortages and recruitment and retention of health care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care." The VA must aggressively train future clinicians to meet the unique challenges rural veterans face. The VA already has existing partnerships with over 100 schools of medicine in the United States. Not to apply them or expand upon them if needed would essentially squander this vast resource. We cannot allow that to happen.

The VFW is also concerned that the men and woman who serve in our Guard and Reserve are not fully utilizing VA benefits that they have earned. Demobilizing members of the Reserve component or the Guard are often so preoccupied with thoughts of family and home that they fail to even mention existing health conditions, not to mention ones that will certainly develop down the road as a result of their service. Local VFW posts often fund and facilitate going away and coming home parties for Guard and Reserve units. We have successfully used these events to offer assistance with their VA paperwork through the Virginia Department of Veterans Services, and we will continue to support our returning warriors through events and other outreach efforts.

Finally, I would like to bring attention to the success of our Virginia Wounded Warrior Program. Rural veterans are a primary target population of the Virginia Wounded Warrior Program. I hear and know of very positive things about this program, and we hope that the VA will continue to look at this hallmark State program and redouble their efforts to work with all layers of government, local, State and other Federal entities to provide integrated total solutions for not just our wounded warriors, but for all who have served and their families.

Mr. Chairman, I again thank you for the honor of presenting our priorities to you. I would be happy to try to answer any questions that you or the Members of the Subcommittee may have.

[The prepared statement of Mr. Boyer appears on p. 65.]

STATEMENT OF CLARENCE WOODS

Mr. WOODS. Mr. Chairman, Ranking Member Brown and Members of the Subcommittee, thank you for inviting the Disabled American Veterans Department of Virginia to testify at this oversight hearing of the Subcommittee focused on the Department of

Veterans Affairs and the health care needs of rural veterans in the Commonwealth of Virginia.

As an organization of 1.2 million service-disabled war veterans with 38,000 members and 59 chapters located throughout the Commonwealth, rural health is an extremely important topic for DAV, and we value the opportunity to be here today.

Mr. Chairman, our former VISN statements were provided to the Subcommittee on July 15th. That testimony details a number of positions that we have taken by our national DAV organization on rural health issues, and I have been told that most of those positions are well known to you. So I will not focus or remark on those points. However, the DAV Department of Virginia subscribes to all those positions, and they are backed by the national resolution adopted by our leadership in the DAV 2009 National Convention in Colorado.

Virginia's specific concerns as requested by Mr. Perriello's office, we wanted to provide the Subcommittee our local and regional perspectives and concerns on rural health care in the Commonwealth of Virginia.

In our Veterans Integrated Service Network, VISN, the rural health initiatives are centrally funded for only 2 years. The DAV Department of Virginia is concerned that the VA medical center directors will not continue to support these initiatives once this protected and fenced funding ends, and that they might be tempted to rob Peter to pay Paul within the medical centers by utilizing funds needed by other VA programs and applying them to the rural initiatives. We believe that the rural initiatives should remain centrally funded and not be made to compete with other VA health care programs or the cause of a reduction in medical center programs.

Sick and disabled veterans in Virginia have been waiting patiently for many years to see new Virginia Community Based Outpatient Clinics or CBOCs, as they're called, to be opened in the rural areas of our State. Currently we have approved two CBOC projects that are taking far too long. Each of these CBOCs is now more than a year overdue in opening. It is our opinion that efforts are not being made to open new CBOCs expeditiously, and projected opening dates are usually delayed by a bureaucratic system that we believe can be improved. Also for those that are open in Alexandria, Bristol, Charlottesville, Danville, Fredericksburg, Harrisonburg, Hillsville, Lynchburg, Norton, Tazewell, Virginia Beach and Winchester, VA space planning is needed and should be improved.

In our experience VA space configuration does not include making space available for the occasional visiting clinician, but only provides space for authorized permanent employees. When visiting clinicians come to provide services to our rural veterans in mental health, podiatry and other specialties, they either have nowhere to see their patients or space for them is very cramped.

VA space planners need to do a better job of providing for itinerant providers within CBOC space configurations. Allowing more space than needed by permanent VA staff also provide us an opportunity in future years to expand services sooner than having

to wait additional years for clinic construction projects after the need is identified.

We believe the CBOCs need to provide more services on site in order to obviate to veterans needing to travel long distances to major VA Medical Centers for services that they cannot receive in the CBOCs. The DAV, Department of Virginia, believes this problem can be solved by VA building what's called super CBOCs or larger and more extensive outpatient facilities in rural areas. This should not come at the expense of reducing service at our major VA Medical Centers.

Over the past year, we have noted that Veterans Health Administration (VHA) is now working on system redesign, reforming the VHA as the new patient-focused medical home. We believe this kind of logic could also be applied to VHA-Veterans Benefits Administration (VBA) system redesign. We believe that there are many opportunities between VHA and VBA to work together in both the health and benefit area, but they are being missed because of lack of coordination between the two systems.

Mr. Chairman, this concludes my testimony, and I'll be happy to answer any questions from you or any other Member of the Subcommittee.

[The prepared statement of Mr. Woods appears on p. 67.]

Mr. MICHAUD. Thank you very much for your testimony.

Ms. Tucker, I want to thank you very much as well for coming here today, and I'm looking forward to your testimony this morning.

STATEMENT OF LYNN TUCKER

Ms. TUCKER. Thank you for having me. I'm glad to be here. My name is Lynn Tucker, and I'm here to testify on behalf of my son, Private First Class Benjamin Tucker, a lifelong resident of the rural community of Museville and the Fifth Congressional District of Virginia.

Ben enlisted in the United States Marines in May 2004. Ben served for 22 months before tragedy struck in the form of a dirt bike accident, leaving him with a traumatic brain injury. Ben is classified by the Veterans Administration as 100-percent disabled.

I am here to testify on behalf of Ben's two brothers, Corporal Jonathan Tucker and Lance Corporal Clayton Tucker, who served two tours as Marines in Iraq. They suffer from the effects of repeated IED (improvised explosive device) and RPG (rocket-propelled grenade) blasts and the deaths of many friends. I am also here to testify on behalf of all veterans needing care from the VA.

My testimony today is based as a caregiver to Ben who lives at home in Museville. Ben's story reveals what should be our concerns for all veterans, particularly those representing rural areas. The concerns are access to primary and specialty care, effective and efficient communication within the VA, approval and remittance of payments from the VA for medically-related items and services.

Problems in any of these areas affect rural veterans like Ben, Jonathan and Clay by limiting medical choices, causing travel hardships and contributing to an overall breakdown in the quality of care and life. What we need to remember here is that these indi-

viduals and all veterans made a commitment to serve and to protect our liberties without the knowledge of the ultimate outcome.

Access to primary and specialty care is imperative for all veterans and especially difficult for rural veterans. For Ben, who requires frequent specialized care, this is quite a challenge. Ben lives 45 minutes from the Danville CBOC, 1 hour and 15 minutes from the Salem VA, and 3 hours from the Richmond VA. Only the Richmond VA can provide all the different types of care Ben needs and is the least accessible.

In October 2006, Ben returned home after almost a year in hospitals and was totally dependent for all his care, as he had no voluntary movement and was fed by a gastric tube. He was eligible for 15 hours weekly with the VA home health aid program. Due to his rural location, locating and retaining certified nursing assistants (CNAs) with the selected VA vendor was often impossible. Months would pass with no nursing help and no help from the VA in locating a vendor with nurses willing to drive the extra distance for a rural client.

Just this last year we were able to retain a reliable, caring nurse through the VA when a new vendor was selected. With Ben's monthly VA disability payments, another CNA was employed after a period of 4 months with no nursing help. Overall, low payroll compensation, with the added expense of the additional driving, discourages CNAs from accepting rural clients.

Ben has a Codman shunt in his brain to drain excess fluid and requires care from a neurosurgeon. The Salem VA does not have a neurosurgeon. Therefore, Ben has continued to see a Roanoke neurosurgeon practicing with Carilion Hospitals. Getting approvals for appointments is so time-consuming we have stopped applying for approval of routine visits and use Ben's Medicare insurance and pay the balance. This is not an appropriate solution for veterans and conveys that the VA does not have an appropriate system in place to care for their own.

Many veterans' families that our family is associated with express concerns about waiting for approval and appointments with primary care doctors and specialists. Per two VA clinic staffers in Salem with the intake of more veterans from Iraq and Afghanistan, the situation is growing worse by the day. Do VA administrators understand the situation? Effective communication is a barrier for veterans seeking care and necessary assistive equipment. Communication between VA staffers within the administration often results in long delays or unnecessary denial.

During the summer of 2006, Ben applied for a grant to help pay for custom wheelchair van. This request was submitted to the Roanoke Regional VA office. The form was passed along through the VA from person to person until somewhere a copy was made and the copy was passed along instead of the original. After several weeks inquiries were made of the VA on Ben's behalf with no results. It was not until the family actually traced the path of the grant form, with the help of Kay Austin of the Paralyzed Veterans of America, that it was determined the form was in fact on the desk of a VA employee where it had laid for 2 months. The employees stated the original was needed, but had not tried to locate the original or call for a new original. Ms. Austin faxed a new form,

and a second completed copy was delivered personally to the VA employee.

Veterans often have to wait for needed medications to be refilled. Just this past month Ben needed renewal on a medication that took over 12 days to resolve. The CBOC in Danville received my request by fax and the receipt was confirmed by a nurse. Three of the medications arrived in the mail, but the one in question was not on Ben's prescription list in My HealthVet. I called the CBOC and left a message on the nurse line. No one called. Inquiries confirmed that the message was retrieved off the voice mail but no action was taken.

Finally, the nurse called to say we need to contact Richmond for approval. In all it took 12 days for the CBOC to tell me to call Richmond. Consider this: If you needed medication for your hypertension, would you be willing to forgo that for 12 days? Is that not harmful to your health.

Living in a rural area, with the nearest pharmacy 30 minutes away and the nearest VA pharmacy an hour and 15 minutes away, this problem is compounded. Simple communication would have alleviated the waste of time, energy and driving to fill this prescription.

In September 2008, a back sling was requested for Ben by the Richmond VA Physical Therapy Department to the Richmond VA Prosthetics Department. A picture and an Internet link were provided to the employee. After months, many phone calls, e-mails with the link again, three improper slings were delivered.

Calls were made to the Guldmann vendor in Texas for the sling, attempting to provide Ben with the needed equipment. After calling the Guldmann headquarters and being given the information for Guldmann Mid-Atlantic, on March 4, 2009, the correct bath sling was delivered overnight for free by Guldmann Mid-Atlantic after hearing the difficulty of trying to procure the sling for Ben.

A veteran in a rural location cannot easily travel to a VA center and resolve issues in person. VA employees must respond to e-mails and calls and act appropriately to resolve the issue of payment. Veterans should not spend days, weeks, or months waiting by the phone.

During 2008, a recumbent stepper was requested to Salem VA by a physical therapist for Ben. Ben was taken to the Salem VA and evaluated by a doctor who approved the request. After months, calls were made about the equipment and found the request had never reached the prosthetics department. Shortly, the Salem VA called, explaining that Ben needed the evaluation he had already completed. The doctor never entered the evaluation into the computer and never forwarded the request to the prosthetics department.

Once this issue was resolved and several months passed, calls were made again, checking the progress of the request and again it was denied. The Danville CBOC was notified but no one notified us. Efforts were made to begin tracking the documentation to determine why the request was denied. The VA employee who denied the request was very exasperated and actually said, "Why am I in the middle of this?" The employee could not grasp why he had to

defend his decision nor could he present procedural or policy issues related to the denial.

After a lengthy discussion debating the need for the equipment due to Ben's rural location and his physical condition, the request was approved and the equipment was delivered.

Payments from the VA for medical services or equipment outside the VA system are slow to nonexistent, and this traps the veterans between the VA and the outside vendor. After Ben's van was delivered in November of 2006, the VA owed a payment to the dealer it had already approved. After several weeks the dealer contacted his family asking for help in obtaining the payment from the VA. Phone calls were made seeking this payment to no avail. Several weeks later the dealer requested the payment from Ben. The payment for the van finally reached the dealer on February 20, 2007, 3 months after the delivery of the van to Ben.

The van is not the only example of poor payment practices. Ben currently has collections against him for medical bills the VA agreed to pay. At first we paid some of the bills ourselves until realizing this wasn't an exception, but the norm. A great deal of time has been spent tracking many payments with the hospital and the VA not willing to communicate with each other. Currently all collection calls are referred to the VA.

Ben was referred to physical therapy at the Carilion Clinic in Rocky Mount. During one of his appointments I was called to the front desk because the center did not have the authorization number to pay for his therapy. It was necessary to contact the VA from the front desk of the facility in order that Ben could complete his appointment. Otherwise Ben or his family would have had to agree to pay for the therapy.

Ben spent almost 5 months in 2006 at Craig Hospital in Colorado after we paid over \$14,000 to have him flown back. On his return trip home, the VA agreed to pay for the flight because it was necessary for him to be evaluated by the Salem VA before returning home. On the day before the flight, the air ambulance company asked for a credit card number because the VA could not locate or approve payment for the flight. Once again many phone calls were made, adding to an already tense situation.

In May 2006, my husband and I sat in a meeting with the Richmond VA after Ben was discharged by the Marines in April. Ben was an active-duty Marine for 22 months, 2 months short of eligibility for VA coverage, with no TRICARE insurance and his VA claim not processed. The VA employee wanted to know how the bill of approximately \$40,000 a month was to be paid if Ben continued to stay in the polytrauma unit. With no help from the VA, we investigated and obtained COBRA insurance with TRICARE for Ben, and the VA was paid.

As a taxpayer and citizen of the United States of America, it is striking how we take for granted the lives of those who voluntarily put theirs on the line. Ben, Jonathan, Clay and all veterans enlisted without knowledge of the outcome. They made a commitment to their country. Where is their country now? Where will our country be when all veterans return from Iraq and Afghanistan? Will they, too, be burdened with forms, phone calls, red tape and

delays? Will they, too, be turned away and not cared for? We cared to send them.

Thank you for allowing me to come today.

[The prepared statement of Ms. Tucker appears on p. 74.]

Mr. MICHAUD. Thank you very much, Ms. Tucker, for sharing your story with the Subcommittee. And we also want to thank your sons for their service to this great Nation of ours.

Mr. Perriello.

Mr. PERRIELLO. Thank you, Chairman.

Ms. TUCKER, how many hours do you think you've spent processing, appealing the cases involving your sons.

Ms. TUCKER. It's countless hours, especially in the very beginning, getting his VA claim processed, dealing with the van, dealing with getting nursing care. At one point I was noting, you know, how much time I was spending, and, you know, it was just totaling up. It was making me very frustrated because at that time I needed to be taking care of Ben, not being on the phone, arguing with one person after another or sitting, simply sitting on hold.

Once you call into the regional office, sometimes you can just sit there on hold for 20 minutes waiting for a person to answer. And that's just too many hours. It shouldn't happen. It shouldn't happen. It shouldn't happen to do it that way at all.

Mr. PERRIELLO. And in terms of most of these claims, are they going through the Roanoke office, benefits claims.

Ms. TUCKER. As you can see, they went through different offices. Salem's currently—I mean, Ben is currently under the Salem VA, so we deal with them a lot. But there are some things coming from Richmond because of the situation. We were going to the Danville CBOC, but what happened in that situation was we started getting bounced between the three in a triangle sometimes, just trying to get care. It was hard to figure out who do I call.

So as of this past month, I disenrolled Ben from the Danville CBOC and started taking him back to Salem. That way we'll only have two places to deal with instead of three.

Mr. PERRIELLO. As you know, there was a much needed investigation, Inspector General investigation into the Roanoke office, which has a very bad track record on claims. Many people working there are great people who are putting in countless hours to help veterans. There were both systemic failures and personal failures there.

Have you seen any improvement of late? Are you seeing the same pattern of behavior with the various claims you are fighting.

Ms. TUCKER. I don't see any improvement over the last 4 years. Like my testimony said, we're coming up on the fifth anniversary of when Ben was injured. And over that time period, I do not see any improvement in communication with the VA. And I know at the beginning, when I was trying to file some claims, I was talking to someone on the phone with the regional office, and I was saying, "If I have it overnighted would that help?" And he said, "Not really. The mailroom is about 3 weeks behind." So once it hits the building, that's where you get the problem.

Mr. PERRIELLO. As you have gone through this, have you had apologies from people in the system for the delays and the mistakes or not.

Ms. TUCKER. Sometimes, yes, you know, I have had apologies. I have met some people who are very helpful. Some people I know I can call on to help me to get through some things. I have also run into some people that were, quite frankly, incompetent and should not have been in that position. I had worked for some people who simply just were lackadaisical and just cannot get back with me.

Mr. PERRIELLO. With the processes that are going forward, what are some of the—aside from dealing with the VA itself, as a veteran caregiver, what are some of the challenges you have faced over that time period besides the obvious pain and frustration of the delays and bureaucracy that we have talked about that you face as a caregiver.

Ms. TUCKER. Well, of course, as Ben's mother, and our family, all our family, you know, it is traumatic to see someone you love so much be hurt. And through that time he has had global aphasia and he cannot communicate to us. He does not understand language, I'm being told. He cannot even answer "yes" or "no." So it's very frustrating for him and for us, trying to keep him comfortable and happy. When he does get upset and frustrated, we have to keep trying things, much as you would a small infant, trying to figure out what is he upset about, until we, you know, can find out how—how to make him comfortable and not so frustrated.

Mr. PERRIELLO. I have met your son, and I know what he goes through, but I also know what you go through. And, you know, a mother's love is tireless, but it's really incredible what you have done, again, not just to take care of him, but also keep an eye on his brothers and to speak up for so many veterans.

One of the things we have done—and Chairman Michaud has worked on this, as well—is trying to get more supportive caregivers, whether that's extending training benefits or health benefits, other things to caregivers who so often, whether it's a spouse or a mother or, you know, parent, may have to leave a job just to be taking care full-time and knowing that, in many cases, that's a higher quality of care and a more 24-7 service and where we can help get some medical training to the family members and benefits with the family member.

We have had some strides in that area, but we'll continue to work obviously with your specific case as well as trying to look at where we allow those gaps that families fall through, and of course for those who have been willing to make the ultimate sacrifice or at least put themselves in a position where that might happen.

We're also seeing in general that because again, as I mentioned earlier, these great advances in battlefield medicine—I know in Ben's case it was not battlefield, but we are seeing people come back who are very young, and we're looking at not a couple years of care, but we're talking about a lifetime of care. So we need to be incredibly caring but also creative about how we think about ensuring not just a minimum standard of living but a high quality of life for veterans and their family members, and we'll continue to work with you, with you on that.

A couple of questions for the others on the panel. One of the things that many of you touched on is while we do have a long way

to go in terms of access to care for our rural veterans, we have also made some strides in recent years.

And one of the things that I would like to ask that Mr. Boyer commented on is what's working in terms of getting information out. I do believe that the vans, the rural vans are parked out back. I came in the front, so I didn't see them.

What's working? What do we need to do more of to make sure that veterans know what benefits already exist as well as trying to fill those gaps.

Mr. BOYER. Continued outreach and all means of communication.

In my particular case, my VSO is constantly contacted by mostly elderly veterans, inquiring about what they're eligible for. You know, this is just my observation. I think that World War II veterans and, to a degree, Korean War veterans, when they were demobilized, made a promise to themselves to never get involved again. Mostly for their working lives they did not do that, and now in their declining years and limited resources and no other insurance, they want to know, well, what am I eligible for in the VA, and they're at a loss. When you tell them and show them what they're eligible for and they look at the paperwork, what they have to fill out, you know, their eyes tend to glaze over.

So we in the VSO community have to be helpful. The Virginia Department of Veterans' Services has some 28 field agents around the State whose primary purpose is to help the veterans fill out the paperwork. Since they are semi-experts, if they do the paperwork, it has a chance to be evaluated successfully. I just would encourage—you know, in rural areas word of mouth is still the—the primary issue, not only for elderly veterans, but also for the National Guard and the Reserve, fellows who have been demobilized and come back to their rural communities, they face the same problem the elderly veterans do but for a different reason. They're just not aware of what is available although it may have been discussed when they were demobilizing.

For example, there's a program called Benefits Delivery at Discharge. But they're just not concentrating. They have their minds on other things. We have to continue to try to reach out through all the means of communication.

Dr. MITRIONE. In asking that kind of question, what kind of services, satisfaction factor, I kind of, like, looked out in the south-western tip, because I thought that was probably one of the more remote areas, and I got very good vibrations, very good reports from the—the Hills people, that went out to the Hillsville, the Tazewell, the Norton, people down in South Hill who were very satisfied with the RV that came down, provided services down there.

I think in some cases you see that we have a system that's being swamped by requests for services. I think veterans organizations such as the VFW, I know that in—in American Legion, we're putting a lot of emphasis on our service officer program. We have started training sessions across the State, trying to get qualified people, trying to reach out to veterans who can come to these—these specialists, and these specialists take the—their claims. They try and marshal them through the system. I think that the—the veterans organizations provide a very valuable service in that respect.

But, again, it's an organization just like any other, not only government, but I think, in many cases, corporate, where there are inefficiencies that need to be addressed, and there are people who maybe aren't the best. They aren't suited for the job they're in, and those people need to be sought out and told if you are not happy here, you can get a job somewhere else and be happy.

Mr. PERRIELLO. Well, we certainly will have a zero tolerance policy, but we also want to build on the successes.

One of the ones that you mentioned, Mr. Boyer, and I'll head back to you, is the Virginia Wounded Warrior Project. And I certainly have been very impressed by their work, and in particular their ability to engage some of the younger veterans who have shied away in some cases from some of the traditional outlets. What lessons can we learn from them that might be something we could take to scale?

Mr. BOYER. Collaboration. The Wounded Warrior Program is beginning its third year with the General Assembly providing \$2 million per year and supported by \$150,000 or so per year in private funds. We have an executive director, but it's administered through—we have five regional consortia where we have a regional director, and the services are implemented through community service boards, which are already in existence.

It's a collaborative effort. We have partnered with the VA. The VISN 6 Director sits on the Wounded Warrior Executive Board. The rural health teams in VISN 6 have made contacts with our regional directors and attended a couple events. They are looking for ways to join together to provide the services that particularly rural veterans, National Guardsmen and Reservists are not aware of, and many of them, you know, need them desperately.

Mr. WOODS. One of the things that we are doing in the DAV is for the Guard and the troops coming back, we have meetings in Richmond, meet with them when they come back, give them hand-outs, let them know what's available to them. A lot of the kids come back and they really don't realize what kind of benefits are available. So before they get out in the outlying areas, we try to catch them and do a brief—we give them some booklets, give them some phone numbers, say if they have any problems, contact us so we can get somebody within your area. Because in the outlying areas we have, in the DAV, they can assist them, so they don't have to worry about traveling when they get the information they need.

Mr. PERRIELLO. The good news is we have increased funding for the VA in general significantly over the last couple years, and one of the areas is rural health where we have been able to see this. But just like the primary care facility we talked about earlier, I think now has to be a time of some experimentation as well, because we are dealing with so many new factors, whether it's the new veterans coming in or, as you said, a generation reaching a different type of need, Korean/Vietnam vets hitting into that aging level where some who were not enlisting before are coming in.

So I think one of the things we want the capacity to do is to try different outreach efforts, try different collaboration efforts, try work with, you know, different VSOs as partners. And the more we can get rapid feedback from you as you have gone out and done re-

peatedly and say, hey, this is a program we're getting good feedback on—the CBOC is an example of that, where we have got overwhelmingly positive feedback from CBOC.

So there's some real concerns, not just Ms. Tucker's, but in one case we have lost someone who was doing a lot of the mental health work, and that just sets you back in a tremendous way. Sometimes that's just a person needing to move on, and in some case that's a systemic failure. But overall people seem to be pleased with the direction we are going with the CBOCs. The same way with outreach. I just hope you will continue to do the diligent job you have done in letting us know in real-time, hey, this isn't working, we like the idea of the vans, but we haven't seen the vans here.

One of the things that we spent a lot of time on last year was the implementation of the new Post-9/11 GI Bill, and that was a substantial new investment in our veterans, but it was also complicated because we were doing it for the first time. In working with the VSOs, we were able to take what could have been a real logistical nightmare in terms of payments and other things, and I think we were able to implement that relatively smoothly and now have about 250,000 veterans enrolled in the new GI Bill.

So in the same way as we roll out some of the new rural health proposals and outreach, I just really appreciate the real-time feedback we're getting and hope to build on that and see areas that we need to do it and again have a zero tolerant strategy for those who are vigilant with our veterans.

With that, I yield back.

Mr. MICHAUD. Ms. Tucker, once again, thank you for sharing your story.

I am concerned about the daily challenges that you face as a mother caring for your son, Ben. VA is supposed to have a case manager to help families maneuver through the VA health care system. Did your family have a case manager assigned? And if so, do you have any recommendations of how we can have case managers do a better job?

Ms. TUCKER. Okay. Over the years we did have several different social workers that were there to help us. At the very beginning, I became aware that the social worker that was trying to help us just could not handle what I needed her to do. So when we were in the Richmond VA, on Mondays, Ben and I, I would put him in his wheelchair, and we'd walk the halls looking for help, people to tell me just what do I do, because I had no idea. I was overwhelmed. You know, like others had mentioned the forms. You look at them, and you do—our eyes glaze over, because you don't know how you're ever going to fill in all those blanks, pull all of that information together.

So I did occasionally, you know, run across someone that could really help me. Now I have two people in the VA I know I can go to, that can point me in the right direction, like Rhonda Fletcher at the Salem VA is one person, Kamisha Thornton at the Richmond VA another one. Those two people have been able to help me.

One of the people that couldn't help me, in the beginning actually, when I went back to the Richmond VA, they put her in a management position. And I do not understand how, when she could

not help me on a lower level, why she is now in a management position. You know, that's one of the problems with the VA. Supervision needs to be able to see that their workers are getting their cases handled, their jobs done.

Mr. MICHAUD. You said you had several——

Ms. TUCKER. Yes, because we have moved around so much. We were in the Richmond VA. We dealt with Salem VA. And we've dealt with the Hampton VA. And every time we go to a different VA, you end up with a different social worker following you around. It's not just one person. And so sometimes you run into people that just cannot help you, and you know that pretty quickly.

One thing that has saved me is the fact that I am a certified public accountant. I was chief financial officer of a company before I left my job to care for Ben. So I was used to negotiating, you know, complicated forms and organizations and different things like that.

One of the horrors that I thought of as I've gone along is like with aging veterans that are standing there that may be 70 years old, 80 years old, and they need help, and how are they going to get the help, you know, if they're not able to push for it, they're not able to write the payments? If they end up hitting a caseworker like some that I've gotten, that absolutely do not do their job, then they will be dead before they get help.

Mr. MICHAUD. Other than probably simplifying the forms, when you did actually get Ben to the VA system, were there waiting times, for instance, you coming in at 10:00, and waiting until 2:00 or 3:00? Or were they pretty prompt in that area?

Ms. TUCKER. That I haven't run into, extreme waiting times. I haven't in the clinics. You know, sometimes they have to put appointments off. Like I said, with Ben, sometimes the Salem VA cannot provide his care. I then would have to go outside to get it. But waiting time for appointments has not been a huge problem. I've usually always had, like, a 2:00 or 11:00, not just a "come in 8:00 in the morning" type of situation.

Mr. MICHAUD. Mr. Woods, in your testimony you noted the system between the VHA and the VBA should be redesigned. You further stated that there are many opportunities for VHA and VBA to work together. Could you expand upon that point? What are the missing opportunities between the VHA and VBA?

Mr. WOODS. We feel that they are missing the opportunity to work together. You know, even though one is providing the benefit and the other is providing the administrative part, if they can link those two things together and not have a disconnect where one has to get the paperwork and the other one has to take out a medical evaluation, if they could work together, pull those two things together, it would cut down the lead time where a veteran has to wait to get the claim back.

We don't feel they're working close enough together. This person has to have it in so many days, and they have to work it before they get it to the other area. If they were connected together, we feel that would cut down a lot of the lead time, something they need to look at. Just our thoughts. We feel they need to look at that.

Mr. MICHAUD. Okay. As was stated earlier on the first panel, and you have touched upon it, if you look within the VA system, with

the new rules as it relates to Agent Orange, as it relates to post-traumatic stress disorder, look at actually increasing access to health care for veterans that are Priority 8 veterans, you look at the fact that this Administration is sending more troops to Afghanistan, clearly there's going to be more of a burden upon the VA system to be able to handle this all at once, and on top of that, a process where we're hearing a lot of complaints about delays in getting, you know, veterans' paperwork processed in a timely manner, has any of the VSOs in your organizations looked at ways that the VA might be able to streamline the process to make it more efficient and—but haven't actually moved forward in that regard?

Mr. BOYER. If I may address that, the VFW strongly believes that the administration is not going to make improvement in processing paperwork as long as that system is using pencils. If they go to electronic records processing with a link between the U.S. Department of Defense (DoD) and the VA, until they do that, they're not going to make headway in processing all these benefit claims.

In the State of Virginia we have an automated electronic data processing system. It's been demonstrated. We're finishing the demonstration this year. We have discussed it with the VA. I've talked to our Congressional delegation in Virginia about the need for electronic data processing. Everybody agrees there's no momentum, nothing is happening concretely. It's talk, agreement, no action.

Mr. MITRIONE. We believe that this is a technology that's here. I mean, I know that if an individual fails to include a 1099 miscellaneous on his income tax, the Internal Revenue Service definitely knows about it regardless of where it came from. So from the VA system, why they cannot take care of or at least incorporate this same kind of technology—you know, they may be moving in that direction. They may not be moving fast enough to get it done.

Mr. MICHAUD. On the subject of collaboration to let our veterans know what they're entitled to, how closely do the VSOs work with the State? We've actually invited the Virginia Department of Veterans' Services to come testify today. They chose not to. Disappointing in that fact.

But I think we could learn a lot from the State, and in other field hearings that we've had the State has testified. How do you feel that the State is doing as far as helping veterans move forward with their issues?

Mr. WOODS. What we have is we have 130 service officers throughout the Commonwealth dealing in our different chapters that work the cases, veterans come through. They get certified once a year so they know how to fill out the claims and what they need to send them forward. The ball is being dropped someplace within the system. After you send the information in, it's not being processed in a timely manner. We feel the backlog is causing that.

But the service officers are really doing what they're taught to do, what information they need on the form, how to fill the forms out. There are so many different forms that you've got to go through, you've got to know how to fill them out. If you fill the forms out wrong, it's going to get kicked out. It's going to be frustrating. By having a service officer filling it out, you eliminate that.

I think if we continue that process, the VSO starts doing what they're supposed to do, we're going to limit some of this backlog.

Mr. BOYER. Mr. Chairman, if I might address that question, as Chairman of the Joint Leadership Council of the Veterans Service Organizations, I worked directly with the Virginia Department of Veterans' Services. And I would like to say that the Department of Veterans' Services has a very comprehensive program. We have 28 field agents scattered around the State whose primary purpose is to work with veterans and help them access the VA system. We would like to have more, but, you know, funding, funding is an issue.

The Department of Veterans' Services manages the Virginia Wounded Warrior Program. The Executive Director works for the Virginia Department of Veterans' Services. And that is an effort that they have been pushing very, very strongly. There is a concerted effort within the Department to increase the outreach to veterans, and it's only limited by the amount of funds available.

Ms. TUCKER. I was just going to say that the VBA has been so helpful with Ben's case. If I hadn't been directed toward them when I did, I would have been very buried under the forms. It's a shame that we have so many that you have to have service organizations like that to help you.

And one of my sons is currently switching to the VBA because the service organizations, the State that it was using, you know, just didn't seem to help at all, didn't seem to advocate on his behalf. So the VBA is going to take over his case now.

Mr. MICHAUD. Once again, I want to thank all of you for coming this morning. I really appreciate your willingness to inform the Subcommittee on what's happening in Virginia on rural health care for our veterans.

And once again, Ms. Tucker, I want to thank you for telling us your story, and it definitely has not fallen on deaf ears in this Subcommittee. I really appreciate your willingness to come out. I know it can't be easy. I know at times it is extremely frustrating being in your position, trying to take care of Ben. But it's always extremely frustrating on this side when we provide the VA with what we think are adequate resources, but we're still continuing to hear problems veterans have to go through. Hopefully, we'll be able to eventually have a system where, when the veterans need help, they'll get it, and they'll get it in a timely way.

So once again, I want to thank this panel's willingness to come out this morning.

Mr. PERRIELLO. Thank you all.

Mr. MICHAUD. We'll invite the third panel to come forward.

Mr. PERRIELLO. Thank you, Mr. Chairman.

If the third panel will come up.

Assistant Deputy Under Secretary for Policy and Planning, Patricia Vandenberg, who I have had the pleasure of meeting with by phone, but we were meeting in person earlier today for the first time, and we'll continue to talk with her. She is the Acting Director of the Office of Rural Health for the Veterans Health Administration, U.S. Department of Veterans Affairs. We are happy to have her down in the district today.

We also have Daniel Hoffman with us, who is the Network Director of VISN 6, Veterans Health Administration, U.S. Department of Veterans Affairs; as well as Carol Bogedain, the Interim Director of the Salem VA Medical Center (VAMC), which I have had the pleasure of touring before and hope to get back to again, and which services many, many of the veterans in Central and Southern Virginia. We do split some with Richmond and Durham, but again, probably the bulk of the Salem area, and we have generally heard very positive reviews of everything going on over at Salem.

So we appreciate the three of them being here today and look forward to your testimony.

STATEMENTS OF PATRICIA VANDENBERG, MHA, BS, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND PLANNING, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DANIEL F. HOFFMAN, FACHE, NETWORK DIRECTOR, VETERANS AFFAIRS MID-ATLANTIC HEALTH CARE NETWORK, VETERANS INTEGRATED SERVICES NETWORK 6, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CAROL BOGEDAIN, MS, RD, CPHQ, FACHE, INTERIM MEDICAL CENTER DIRECTOR, SALEM VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF PATRICIA VANDENBERG, MHA, BS

Ms. VANDENBERG. Thank you.

For the record, I would like to acknowledge that we have a Director at the Office of Rural Health, Dr. Mary Beth Skupien. She began her service to the VA on July 6. She is coming to us from the Indian Health Service, where she has served both as a care provider and nurse practitioner, as well as in a variety of administrative positions. She had a nursing practice and has a doctorate in public health from Johns Hopkins. So I'm delighted to have her on the team.

I will continue to be actively involved in all matters pertaining to the Office of Rural Health and, most particularly, the implementation of Section 403. So we decided that it is most appropriate for me to be here today to address the Subcommittee.

We appreciate this opportunity of you inviting us here today to discuss the progress the Department of Veterans Affairs has made in implementing Section 403 of Public Law 110-387, as well as the VA's efforts to increase access to quality health care for veterans living in rural and highly rural communities in Virginia.

I'm accompanied today by Mr. Daniel Hoffman, the Network Director, and Ms. Carol Bogedain, Interim Director of the Salem VA.

Mr. PERRIELLO. If you could move the microphone closer, there are some hands going up in the back.

Ms. VANDENBERG. As you know, the VA is required to conduct a pilot program to provide health care services to eligible veterans through contractual arrangements with non-VA providers. This statute directs that the pilot program be conducted in at least five VISNs. The VA has determined that VISNs 1, 6, 15, 18, and 19 meet the statute's requirements. This program will explore oppor-

tunities for collaboration with non-VA providers to examine innovative ways to provide health care for veterans in remote areas.

Immediately after Public Law 110-387 was enacted, the VA established a cross-functional workgroup with a wide range of representatives from various offices as well as VISN representatives to identify issues and develop an implementation plan. The VA soon realized that the pilot program could not be responsibly commenced within 120 days of the laws enactment as required. In March and June of 2009, VA officials briefed Congressional staff on these implementation issues.

VA has made notable strides in preparing for the implementation of Section 403 with the goal of having the pilot program operational in late 2010 or early 2011. Specifically, VA has developed an implementation plan, which contains recommendations made by the workgroup, analyzed our driving distances for each enrollee to identify eligible veterans and reconfigured our data systems, provided eligible enrollee distribution maps to each participating VISN to aid in planning for potential pilot sites, developed an internal request for proposals that was disseminated to the five VISNs, asking for proposals on potential pilot sites, developed an application form that will be used for veterans participating in the pilot program. And we have taken action to leverage lessons learned from the Healthcare Effectiveness through Resource Optimization pilot program, HERO, and adapt it for purposes of this pilot program.

VA has assembled an evaluation team of subject matter experts to review the proposals from the five VISNs regarding potential implementation. This team will then recommend specific locations for approval by the Under Secretary of Health. We anticipate this process will be completed this summer.

After sites have been selected, VA will begin the acquisitions process. Since this process depends to some degree on the willingness of non-VA providers to participate, VA is unable to provide a definitive timeline for completion, but we're making every effort to have these contracts in place by the fall. This would allow VA to begin the pilot program in late 2010 or early 2011.

VA is developing information materials for veterans participating in the pilot program for non-VA providers and for VA employees and other affected populations so that when the pilot is implemented all parties will have the information they need to fully utilize these services. VA is committed to implementing the program directed by Congress and to maintain the quality of the care veterans receive.

Other issues such as securing the exchange of medical information, which was referred to several times this morning, as well as verifying veterans' eligibility for this pilot program, coordinating care, and evaluating the success of the pilot program are also important priorities. And we are working to ensure that there is appropriate implementation in the pilot program.

As was referenced by Mr. Thackston and his colleagues, I appreciated the opportunity to meet with Congressman Perriello and his staff and interested stakeholders several weeks ago. The prior panels this morning have addressed important issues facing veterans in rural communities, and I value the opportunity to hear their

perspectives and will take insights learned back to the implementation of this pilot.

Thank you again for the opportunity to discuss the status of the pilot program with you today.

[The prepared statement of Ms. Vandenberg appears on p. 76.]

STATEMENT OF DANIEL F. HOFFMAN, FACHE

Mr. HOFFMAN. Good morning, Mr. Chairman and Congressman Perriello. Thank you for the opportunity to share what we in VA's Mid-Atlantic Health Care Network are doing to reach out to veterans in our rural areas.

Increasing access for veterans is one of the Secretary's top priorities for the Department. This has several components immediately relevant to rural veterans. It means bringing care closer to home, sometimes even into the veteran's home. It means increasing the quality in the care we deliver, and it means providing veterans-centered care in a time and manner that is convenient to our veterans.

It's my responsibility to increase access for veterans in North Carolina, Virginia and the southeastern portion of West Virginia. VISN 6 encompasses more than 88,000 square miles, 53 percent of which is rural or highly rural. The veteran population for our area is in excess of 1.5 million, and between October 1, 2009, and June 30, 2010, we have cared for more than 319,000 veterans.

To meet the growing demand for health care, we have aggressively worked to increase capacity, we have added to or enhanced each of our eight medical centers, and we have grown from two community-based outpatient clinics less than 10 years ago to a current total of 17. Our plan calls for 11 more to be added by the end of fiscal year 2013. In all, over the next 3 years, VISN 6 will add more than 1.5 million square feet of health care space for veterans. With these additional sites of care, more than 90 percent of our veteran population will be within 60 minutes of a VA health care facility.

However, our efforts to care for veterans living in rural areas go beyond bricks and mortar. Our rural health teams are working diligently to find new and better ways to affect care in the rural areas. In May of 2009, VISN 6 began laying the foundation for what is now our rural health program. In July of 2009, clinicians, staff and medical center directors developed a strategy to bring together the many resources which contribute to enhancing and integrating our rural health efforts.

We created eight teams of professionals based out of each of our eight medical centers made up of pharmacists, nurses, social workers and others whose focus is to make VA care available closer to veterans' homes, and sometimes even into our veterans' homes. These teams are now fully staffed and are now currently developing and deploying strategies to enhance care, specifically focusing on areas they serve.

Three of the teams representing Virginia—from Salem, Richmond, and Hampton—are set up outside today for veterans to visit. We're also reaching out to partner with and leverage the many programs already in existence. Our teams are working closely with the Virginia Wounded Warrior Program, and we are meeting with universities like Old Dominion, the Eastern Virginia Medical School

and the University of Virginia and Via Osteopathic School to share the knowledge they have accumulated. Additionally, we are working with the Indian Health Service and local tribal councils to provide for our veterans of Native American heritage.

VISN 6 has reached out to Native American veterans through the use of a mobile van based clinic you can see and tour outside. Operating out of this mobile clinic, five VA staffers provide primary care on five Native American reservations located in Virginia. Each month the clinic visits the Chickahominy Tribe, Eastern Chickahominy Tribe, Pamunkey Tribe, Upper Mattaponi Tribe, and the Rappahannock Tribe.

In line with VA's efforts in other rural areas, we are also leveraging technology to strengthen our telehealth program designed to close the geographic gap between providers, specialists and patients. Currently all of our CBOCs are equipped with telemedicine, to bring additional services closer to where our veterans reside.

One of our great success stories is the use of teleretinal imaging for diabetic retinopathy. This system is now up and running in 22 sites, and because early detection allows for early treatment, we have saved many veterans from going blind. We have also enhanced our telemental health services based out of the Salem VAMC. This program currently provides telemental health to veterans in Tazewell, Hillsville, Danville and Lynchburg. It will be expanded to serve the new Wytheville and Staunton clinics when they open. This program has served more than 330 veterans by offering medication evaluation and management, substance abuse evaluation and treatment and treatment for both combat and other military trauma.

In our efforts to become the provider of choice for our women veterans, we have hired a women's health coordinator for the VISN, one for each State and one in each hospital. They are overseeing our progress in developing a women-friendly atmosphere and are working hard to get the message out that this is not just your grandfather's VA. We have been and will continue to make huge leaps forward on providing gender specific care in safe and comfortable environments.

Beyond the use of telemedicine and mobile clinics we are also using low-tech methods like direct mail. As a trial in June, we mailed letters to 10,000 women veterans in West Virginia, inviting them to consider using the VA for their primary and gender specific care.

The bottom line is that throughout VISN 6 we're working hard to live up to our motto: "Excellent service, earned by veterans, delivered here." Thank you again for the opportunity to share what the men and woman of VISN 6 are doing to help improve the lives of veterans. I look forward to responding to any of your questions.

STATEMENT OF CAROL BOGEDAIN, MS, RD, CPHQ, FACHE

Ms. BOGEDAIN. Good morning, Mr. Chairman, Congressman Perriello. Thank you for inviting me here today to discuss the programs at the Salem VA Medical Center with respect to outreach and care for rural veterans.

The Salem VA Medical Center is part of VISN 6 and serves veterans throughout Virginia for psychiatric care and Southwestern Virginia for medical and surgical care. We have community-based outpatient clinics in Lynchburg, Danville, Tazewell and we have a site of care at Hillsville. And we plan to open VA staffed CBOC in Wytheville and Staunton in January of 2011. As a side note, we're having the groundbreaking for the Wytheville CBOC today. The Vet Center in Roanoke provides services to our CBOC and support counseling groups in consultation, and they do travel to other areas.

The Salem VA Medical Center has several programs that provide services to rural veterans. Our rural health team in Salem began serving veterans in our catchment areas in May of 2010, and we have 14 staff members who support this initiative, including both clinical and nonclinical employees. The team works closely with many of our other outreach programs such as home-based primary care, telemedicine, our women's health program, mental health, the OEF/OIF, and other services to address the needs of rural veterans. The team educates veterans on eligibility and enrollment and disease specific issues. They offer pharmacy consultations, provide blood pressure and body mass index screening and promotes My HealtheVet, which is the VA's personal electronic health record.

We use visual aids, models and presentations and videos to educate the veterans for their needs. We're reaching out to veterans at VA, Community, VSO and other events and organizations. To date approximately 40 events or visits have occurred. There's 15 more that have been confirmed and scheduled and we continue to outreach.

As part of our outreach, the team helps veterans in rural and VA health care. Veterans have the option of enrolling either face-to-face with VA staff or filling out a 10-10EZ Health Application Enrollment Form. We are focusing our outreach efforts on women, women veterans, and OEF/OIF veterans in particular. The rural health team is coordinating with our Veterans Health Clinic to educate women in rural areas.

We have already completed training of our providers in gender specific care, and we'll also have additional training provided at the Salem VAMC for the rural health nurses by the Eastern Virginia Medical School. The rural health team has attended pre- and post-deployment events in collaboration with our OEF/OIF program coordinator.

Salem VA Medical Center supports the Volunteer Transportation Network that runs each Thursday from Martinsville for veterans who have scheduled appointments at the Salem Medical Center. We have also recently recruited a volunteer driver who will operate a shuttle van from the Danville CBOC to meet the Martinsville van. Between October and mid-May, the Martinsville van travelled 4,285 miles and transported 112 veterans during 28 trips to the Salem VA Medical Center. We have ordered an additional van to be based in Danville to transport even more veterans.

We also offer a range of specialty programs. Home-based primary care delivers primary health care in the veteran's home through an interdisciplinary team of VA specialists. Another program, tele-mental health, which we discussed earlier, is currently used in con-

junction with comprehensive on-site services at are CBOCs to offer specialty mental health services. We currently offer telemental health care at the Tazewell, Hillsville, Danville and Lynchburg CBOCs and plan to provide these services at the new CBOCs in Wytheville and Staunton.

The Salem VA Medical Center has provided Care Coordination Home Telehealth to veterans since 2005. This program utilizes an in-home device to help VA and veterans monitor their health status on a daily basis.

Congressman Perriello, in conclusion I'd like to address some of the concerns that you and others have raised in a conversation that we had last week on our conference call. We appreciate the opportunity to speak with you and your staff and to better communicate with our veterans.

We are sending a letter to all of our veterans who use the Danville CBOC to explain that they can choose a medical home and identify which hospital they would prefer to use for services the clinic cannot provide. We will also work to ensure all Danville providers have the necessary credentialing and privileging at the Salem, Durham, and Richmond VA Medical Centers to allow our doctors to order tests, consultations, medications and any other services our veterans need, and that process has started. We will also do a better job communicating with the local VSOs to explain these policies and what we're doing to improve the care, particularly in Danville.

Thank you for the opportunity to present the many programs we offer to the veterans in the Salem rural areas, and I look forward to answering any questions you may have.

Mr. MICHAUD. Thank you, all three of you, for your testimony this morning. I appreciate your coming forward.

Mr. HOFFMAN, you quoted the slogan that you go by. Could you repeat the motto again?

Mr. HOFFMAN. What we decided—

Mr. MICHAUD. No. Could you read your motto—

Mr. HOFFMAN. Sure.

Mr. MICHAUD [continuing]. Once again? I didn't know if I missed it or not.

Mr. HOFFMAN. Starting from we created eight teams—

Mr. MICHAUD. No. You said you have a motto.

Mr. HOFFMAN. Oh, the motto. I'm sorry. I thought you said the "model."

Mr. MICHAUD. No.

Mr. HOFFMAN. "Excellent service earned by veterans delivered here."

Mr. MICHAUD. You heard the testimony of the two previous panels. You heard Ms. Tucker's concern with her son. If I was evaluating based upon what you stated, I probably would have to fail the VA for not living up to the motto. What seems to be the problem.

Words are cheap. Action is what counts. In my opinion, you did not live up to that motto. And as I heard from other veterans earlier as well, there's concern here. So what are you doing to live up to that motto? What resources do you need? Where has the VA failed you as a VISN Director? Do you want to respond?

Mr. HOFFMAN. First, I would agree with you, we failed Ms. Tucker. And I would not hold that out as my example of good VA care. We would hope and in fact we have done very, very good things in the VA in a lot of cases, but that one I cannot be proud of. And I'm sure the people that have worked on her would not be proud of that as well.

One of the things that I have heard in focus groups and other venues that we're taking much more seriously is—and what I heard from Ms. Tucker and others, is that we do have case managers, but we don't have just one. And you were very perceptive in your question, who is your case manager, and Ms. Tucker mentioned at least two and others over her last 5 years.

One of the comments that came out of the focus group that struck me as being critical in all of this is who manages the case managers on behalf of veterans. I think that's something we need to do much better. It is, frankly, something that our whole medical home concept that has been recently implemented I think will help. We're still in the implementation stages on that, but essentially it sets up within the medical home, the medical home chosen by the veteran and their family to increase case management services on behalf of that veteran.

So, to make invisible the very complex system which is VA, not just VHA but VBA and all of the other issues, I'd like to think that the money that we have received already for rural health will also help in that regard, just being able to make contact with these folks, getting them enrolled in our system and then being able to have the opportunity to case manage we'll also adopt.

I think you also heard issues related to our information technology functions, and it's something that I think we think is very important—I know we think is very important from our leadership point of view, to move as quickly and with alacrity as possible to not only upgrade our current system which was a leader for a long period of time in health care, but to synchronize that with DoD and with the private community.

We're actually engaged in this VISN in a pilot to do just that in our Hampton facility. Hampton is teaming up with DoD in Portsmouth and with the Bon Secours Health Care System and with the State of Virginia who has experience in this area. Hopefully that will move the process forward to pilot these things.

Mr. MICHAUD. To give you an example, I'm going to add to that. Then I'll ask you a specific question. In Maine, a mill that I worked at filed bankruptcy, and they shut the mill down in East Millinocket. I did know that the different drug companies offered either no- or low-cost prescription drugs for people who qualify. What I didn't know is that there were over 385 different types of programs within all the drug agents and drug companies. People had to fill out seven or eight pages in applications to see if they qualified for any of these specific programs. When Senator Snowe and I approached Pharmaceutical Research and Manufacturers of America (PhRMA), we asked them if they could simplify that. They did. The process boiled down to four simple questions, and the computer did the rest of the work.

We heard earlier today about filling out paperwork after paperwork, getting denied, encountering delays. They're using pencils. What have you done as a VISN Director to streamline that process.

I'll be asking the same question of Ms. Vandenberg as well. It's more than just money. It's about trying to make the process smoother, more efficient. Have you done anything to simplify the process by collaborating between VHA and VBA?

Mr. HOFFMAN. Well, we do work closely with VBA. But I think both of us—I'm speaking for VBA and I probably shouldn't. But I think we both feel a little behind the technology curve. One of the analogies was we feel like we're digging the Panama Canal with a teaspoon. And all of the comments that have to do with upgrading our system so that we can automate and share records more transparently between VBA and VHA would all be welcomed. We can't really do that independently of the entire system. But we actively adopt all of the systems that are made available to us.

Mr. MICHAUD. Even within VHA I've heard several complaints on setting up an appointment for a veteran. Once they get there, they have to wait there all day. In some cases, they still can't see the doctor. That's concerning, especially when they have to travel in Maine, for instance, 4 or 5 hours. So it's not only between VBA and VHA. It's within VHA as well.

So what are you doing to make sure that veterans are not wasting their time to get adequate health care? Have you streamlined that process, or is it not a problem within VISN 6.

Mr. HOFFMAN. No, I would not be so bold as to say it's not a problem in VISN 6. It is a problem, multiservice scheduling, and it's one that's frankly been brought up through our national leadership board to VA, national VA.

Centralizing, coordinating scheduling is something that's vital for our future. We have tried our own manual work-arounds, and it's basically a case management issue at this point where if a given veteran we know needs two or more appointments at a given location, we will try our best to try to get those appointments grouped in a tighter time frame, so if they come in the morning they don't have to stay the whole day. They can return home by noon.

We don't always succeed in that, and it's not always easy, because we're doing it manually. You know, it's our case manager calling the various appointment people and trying to get those appointments rather than having to collate and neatly put together in the most economic time, economic fashion for our veterans.

Mr. MICHAUD. Have you ever run into the situation, in contracting out care, where a veteran would have to travel some distance to get health care?

First of all, I'll use an example I heard this past weekend, where a veteran had to travel 4 hours for a 15-minute hearing exam and ultimately couldn't get that hearing exam, and had to travel another 4 hours back.

When you make your decision to contract out care for a veteran, are you considering the time it takes a veteran to actually travel to the VA facility?

Mr. HOFFMAN. Yes, in short. We consider time, the acuity of the patient's condition—they just may flat not be able to travel because of distances that a healthy veteran may be able to travel—and the

type of exam. You know, we fee out, for example, numerous exams, ophthalmology exams, hearing exams in various locations. We have even piloted and are piloting a teleaudiology concept which may have promise for us in the future for actually doing some of these exams out of our CBOCs so that we can give one closer to our veterans.

Mr. MICHAUD. My next question is on the Veterans Equitable Resource Allocation model. We heard at one of our hearings from a former VISN director who made reference to the mothership, the Central Office, not giving adequate funding to the other medical facilities within the VISN.

I'll use Maine again as an example. When Congress increased the boundary reimbursement for our veterans, what it cost VA Togus for reimbursement rates is anywhere between \$5 million and \$6 million. However, they received from the mothership about \$1.5 million. So therefore, they're running in the red.

So the problem I have, and my question to you is, are you providing the adequate resources for the different facilities within VISN 6, or are you forcing them to live within their means, meaning that ultimately they cannot hire nurses or must restrict what services they can provide, whether that is contracting out care or other services.

Mr. HOFFMAN. That's a great question. There's probably not a network director or a director that would say that they have all the resources that they need. So, by definition, we live within constrained resources. Both at the VISN level and the medical center level, if you ask any one of my directors, I think they would confess that they have to watch their budgets very, very carefully and make tough choices. And whether that's—it will never be with any travel. That's a given. But it will be somewhere in the whole continuum of health care services. We do our best to allocate appropriately to each facility based on where the veterans are and their acuity of care needed.

Mr. MICHAUD. Ms. Vandenberg, I have several questions for you as well. I think you remember that Congress is very lenient anytime there's a new Secretary onboard. Because they're new, we give them the flexibility to grow into the position.

Secretary Shinseki has been there a year and a half, and I think it's important for the VA and for the Secretary to start delivering services. And my concern, as you can imagine, is going to be about the pilot program, which I will ask you a specific question about. I will be reading a quote that you gave us when you testified before our Committee. As I said earlier, it's more than money. It's about doing things in a way that provides better services. We heard from panel two about the need for VHA and VBA to work more collaboratively together. I gave you an example of a cumbersome process with a lot of different drug companies.

What is VHA doing to help streamline that process so it will help with the delays? I agree with what the Secretary is doing on Agent Orange, PTSD, and increasing access for priority veterans. The President is escalating the war in Afghanistan by sending more troops over there. Therefore, they're going to come back and need more services. My big concern is that the workload is going to increase exponentially within VHA and VBA.

What are you doing to help streamline that process? Is there a way you can simplify it similar to what PhRMA did with the prescription drug issue?

Ms. VANDENBERG. Thank you for that question. As you are no doubt aware, we have had a very systematic approach to system redesign within the Veterans Health Administration for a number of years now, and I think we can demonstrate very significant progress in improving throughput in our clinics as well as enhancing efficiency in our inpatient services.

Recently, we have begun to team up with VBA to look at processes where we interface with VBA, in particular the whole set of steps that it takes to do compensation and pension exams and the Disability Evaluation System pilot in particular. So we have a high level commitment at this point to collaborate systematically with VBA to look at select processes and attempt to streamline them.

I'd be happy to give you further information on the record. To follow up, I didn't come prepared today to talk about this extensively, but I can tell you unequivocally that we are collaborating with VBA in bringing the vast network of tools and resources that we have used within VHA to enhance efficiency and streamline the processes.

With regard to Section 403 implementation, after our April hearing we went back and reviewed the law, and the interpretation that came from that is that the law reads, and I quote, that "the pilot be carried out within areas selected by the Secretary for the purposes of the pilot program in at least five Veteran Integrated Service Networks." We interpreted this statutory language to mean that it was permissible for VA to implement the pilot program within specific areas.

I understand that that continues to be a concern to you, sir, and I look forward to the opportunity to brief you and other Members of the Subcommittee and other Members of Congress and your staff in more detail as to the analysis that we have conducted with regard to the requirements that we would face if the pilot program is implemented on a VISN-wide basis.

Mr. MICHAUD. The CBO requested from the VA certain information when the legislation was passed. One of the questions that they asked was the number of total patients within those VISNs who are going to be affected by this legislation. For VISN 6, 267,189 is the number of total patients that were going to be affected by this legislation. When they did the fiscal note, they came up with the estimate. I believe it was \$100 million. The intent was for full VISN participation.

When you were before the Subcommittee earlier, I want to quote your comments in regards to that. You stated, and I quote, "So I'm just wanting to acknowledge that I hear you. I further appreciate the intent and just practically speaking obviously we are going to honor the intent. We are obviously going to go back and apprise the Under Secretary of Health of the need for us to think more broadly and make whatever adjustments are necessary then in the next steps of the process." So in looking out for fiscal year 2011 we expected, as I mentioned earlier, to spend at least \$100 million on this pilot. Now that we are going to go back and reset our parameters, we may need to amend that estimate.

I guess my question then is, when did the VA reach the decision that the implementation of the pilot program is only going to be in selected areas? When was that decision made? Since, clearly, your testimony at the last hearing indicates you were going to go back and reassess it, and you would probably have to come up with a different estimate for cost. When did you make that decision?

Ms. VANDENBERG. That decision—

Mr. MICHAUD. Who made that decision, as well? When and who?

Ms. VANDENBERG. That decision is still pending in the Department at this point. We have revisited the requirements of the law. We have reevaluated the implications of VISN-wide implementation both from an economic standpoint as well as from the contracting standpoint, and that decision is still under consideration.

Mr. MICHAUD. Well, my other question is all about access to quality care. We heard earlier today from Mr. Chapman from Southwest Virginia Community Health Systems. If you look at the needs of our veterans in rural areas, in a lot of areas community health centers are located, where we need that help.

What is the VA doing to focus on contracting with community health centers that want to participate, or accommodate veterans in those regions who want to participate? What are you doing to reach out to them?

I can see a huge problem when you look at Agent Orange, PTSD, Priority 8 veterans, escalation of the war in Afghanistan. It's not going to get easier for the VA, it's actually going to get harder. And, quite frankly, those that are going to take the brunt of the frustration over VA not being able to provide adequate services in a timely fashion to our veterans in rural areas, will be the VA employees in those regions. And that's very unfortunate, because I think in the past, VA employees have taken a lot of criticism primarily because they have not received adequate funding from our previous administration or Congress.

This Committee and Congress have been very generous in trying to meet the needs of VA, but we can't meet the needs of VA if we're not given the proper information or if VA is not implementing the laws as they are intended to be implemented. And I can go into the nursing home issue, as well, where VA did something totally different from the intent of the law on reimbursement for nursing homes.

Ms. VANDENBERG. With regard to community health centers in particular, in our VA planning process we have identified the location of those resources and have communicated that information as part of the planning process to the network directors in the annual planning exercise. Our planning approach is a top-down, bottom-up. And, therefore, we have afforded the network directors the opportunity to identify what resources within their VISN would optimally meet the requirements that they have for providing care to veterans, and so there have been a number of collaborative efforts.

The situation that was cited earlier is one that I am somewhat familiar with, having convened our Veterans Rural Health Advisory Committee in Johnson City. And we heard during the course of that recent meeting in March a review of that circumstance.

So there is no prohibition to using community health centers at this point in time, and your observation that we might need to do

something more systematic is one that I will take back to the Under Secretary.

Mr. MICHAUD. There might be no prohibition, but the prohibition is going to come when Mr. Hoffman has to live within his budgetary needs. I want to make sure that Mr. Hoffman and other VISN directors and medical facility directors are able to provide the services that they need for their veterans. And that's where the problem is going to be.

If we have to provide more resources, that's one issue, but if we are not told of what's out there, the problem that we are facing as elected officials with jurisdiction over VA is to see how we can change the system to make it work for our veterans so that we will not have to hear stories from Ms. Tucker about, going through what she had to go through with Ben. That's what we are all here for, and I know that's what you're here for, as well.

The other issue is to make sure that what legislation we do pass is implemented in the way that it was intended to be implemented. If it isn't, then we're going to hear complaints from veterans.

We want to work with you. We want to make sure that you have the resources available. But we also want you to work with us and let us know where I believe we can make changes. I'm getting to a point now where we might want to look at other ways to deliver services, such as asking the U.S. Department of Health and Human Services to bring forward a proposal where our veterans can go to them directly to access health care, because we're starting to hear more and more concerns within the VA system. And with the increased need for veterans' health care because of Agent Orange, PTSD, and expansion of Priority 8 enrollment, it's going to get worse and not better unless we can actually streamline that particular process.

We want to be able to take care of the problems before they become too severe. And, ultimately, when you look at the increase in the amount of suicides, not only within the veterans community but also within the active military, it is increasingly too great. We want to be able to provide Mr. Hoffman with the resources that he needs. He needs to have the resources so he can distribute them in a way that's fair and equitable, but also, streamlining the process is going to be, I think, extremely important as well.

Mr. Perriello.

Mr. PERRIELLO. Thank you, Mr. Chairman.

First, Ms. Bogedain, thank you for being on the call and for the responsiveness. We have, as you know, had a largely positive response to the CBOC in Danville. We've had an overwhelmingly positive response to Salem.

Again, we want a zero tolerance policy there for where problems arise. But one of the confusions as we do develop some of these new programs like the CBOC is the question of, does that mean that I have to switch my specialty care from one hospital to another? I think that has been a barrier for some people participating in what seems to be a step in the right direction.

So I just want to commend you for a rapid response, and we'll continue to follow up with you on that and other concerns that we hear about with the hospital, and again, we have been really enjoying a rapid response and open line of communication with you.

Ms. Vandenberg, you know, I was thinking about this old "Saturday Night Live" skit, while Chairman Michaud was talking, where Jon Lovitz is playing a movie agent advising an old war film actor, and the war film actor keeps saying, "Well, maybe I made too many of these war movies." And Jon Lovitz says, "I guess you have." He says, "Well, tell me what you really think." He says, "Well, you know, I think it's time to hang it up." He says, "What are the reviews saying?" "Well, the reviews say you're the worst actor I've ever seen, and now I get 10,000 letters a day saying the same." "So tell me where I stand really."

And I think that the point here is that sometimes there are two interpretations of a law, and sometimes it seems clear to me that there's just a breakdown of communication or something people don't want to hear.

In this case, through the multiple hearings that we've had, it seems clear to me—and I am new to politics—that the Committee feels very strongly that this is a pilot program that we want to test and test as broadly as possible to see and we believe that's coming from the grassroots up from communities. And it seems that the VA has taken every opportunity to try to crush, delay, and minimize this plan.

Now, this is a situation where the VA may be right and Congress may be wrong, and I offer you this proposal: There is no easier group to blame than Congress. So if this is something that goes forward and does not work, I think it will not be difficult for the VA to say it's Congress's fault. We're clearly on the record believing in this program. If, however, it succeeds, no one ever believes what we do works anyway, and the Administration, and more importantly, the VA will be able to claim very aggressively the success of this program.

I really do believe this is something where, again, we may be wrong, but I think our intent is very clear, which is that we believe it's right. We believe that accessing more primary care in these areas is a positive thing. What I feel like we've tried to do is put forward the most positive cases that we can find.

Now, I think that's often the case out of what you might call colloquial interest for Members of Congress, but out of all the communities that I could represent, I do my due diligence, and I look at the ones that I think can sustain it versus ones that are flash-in-the-pan ideas and have that response.

So I guess, you know, to play what's turning into a bit of a bad-cop, good-cop scenario, it seems like we're offering you an opportunity for something where the downsides can all fall on us, the upsides can go to the Administration. And the question is, you know, at the end of the day, what is the reason not to try a larger number of these within the VISNs that already qualify if—or try to run a pilot where the goal is to figure out if this works, not to figure out how to make the case against it? Why would we not try a broader set of data points to have in the study?

Ms. VANDENBERG. I'm glad to see the direction you took in the beginning when you were talking about the old actor. I thought, "Oh, goodness, we're getting very personal here."

Mr. PERRIELLO. No, I was not directing to you.

Ms. VANDENBERG. I'm just teasing.

All I can say today is that I hear you loud and clear, and I will take this message back to the Under Secretary and to the Secretary.

Last Thursday I was part of the team briefing the Secretary on a range of issues on access, was focused on access, and the work was done in my Office for Policy and Planning, and it's an issue that we are and will continue to give extensive consideration. So I hear you. I will take the message back tomorrow.

Mr. PERRIELLO. We appreciate that. I also want to commend Secretary Shinseki. I think the thing at the VA, first of all, there's obviously just a lot of day-to-day things going on with the uptick, not only the transition, but the uptick in demand. But I think what he has tried to do in his leadership style is, excuse me, to take big problems and try to check them off one—not one at a time, but definitely have a focus.

I know in the first year, getting the new GI Bill implemented and implemented well was a huge focus. And I think it was an unbelievable accomplishment, given how quickly that was implemented. People say, you know, that the public sector can't do that, but I think the fact that the—the general put so much into it—our Committee was following it—really was, again, a big accomplishment.

And I know that his focus has been the backlog since then, among other—veteran homelessness, jobs and other things. But the issue of the backlog—and we have tried to take a big chunk of that on, with moving Agent Orange funding forward and doing some of the investigations and other things.

I think when it comes to the issue of rural health, we already have a lot of pieces on the table that suggest we are already taking a big swing at the bat on this. When you look at the CBOC starting to take off, when you look at some of the things we have done in terms of telemedicine and other areas, I think, you know, if you start to put that together, you really are looking at something we can be really proud of looking back in a couple of years. I think there's so many people that want to do this right, and it's our belief that this can be a very significant component of that.

Again, we don't know at the outset for sure what's going to work. We believe that the new challenge is so big with the changing demographics of our veterans that we're going to need to try four or five things, what combination of telemedicine, CHC, primary care through private-sector vendors, CBOCs, bumping up our hospital care, what combination of those things will meet the challenge.

So I appreciate that you understand the intent as you did in the April hearing. We really hope that this is something that we can look at again and champion as a success and not just be up here, you know, expressing our frustration. But, again, it is something where we feel like our intent is clear. And I do have a place near and dear in my heart for the facility in South Boston. There's no question about it. My bias is clear. But I also think it's indicative of a larger issue, which is that we believe there are opportunities like that around, and that it would be a shame to delay or hold off on that.

So we appreciate your continuing conversation with us and look forward to hopefully have a very positive resolution to this specific and general case.

I yield back.

Mr. MICHAUD. Let me once again thank this panel for coming forward. I look forward to working with you.

Hopefully you heard loud and clear the concerns the two previous panels brought forward, and you can look at ways to work collaboratively to help streamline that process. I know a lot of the issues relate to the technology, but the bottom line, I know for me as a Member of Congress, is to make sure that our veterans get the health care that they need when they need it, and I know that's what the VA hopes to do as well. We look forward to working with you so we can do what's right for the men and women who serve in the military and put their lives on the line each and every day for this great Nation of ours.

So I want to thank Ms. Vandenberg, for coming forward today, and I look forward to working with you.

If there are no other questions, I will adjourn the hearing.

Thank you very much. I want to thank all the veterans and everybody in the audience for coming as well. Thank you.

[Whereupon, at 12:10 p.m., the Subcommittee was adjourned.]

A P P E N D I X

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

The Subcommittee on Health will now come to order. I would like to thank everyone for attending this hearing, especially the veterans who are with us today. I would also like to express my sincere gratitude to the Bedford County Board of Supervisors for their hospitality in hosting this hearing.

Today's hearing would not have been possible without Mr. Perriello's tireless advocacy for our veterans living in Virginia. He is a welcomed member of the Subcommittee on Health for Veterans' Affairs who brings new energy and enthusiasm for tackling the unique challenges facing our rural veterans.

As a Congressman who represents rural communities of Maine, Mr. Perriello and I have a shared interest in ensuring that our rural veterans receive the care that they deserve. Our veterans, whether they live in rural Maine or rural Virginia, face common challenges. Most notably, access to care is an issue where veterans live many miles and hours from the closest VA medical facility. Given this challenge, it is important that our rural veterans have access to such tools as telemedicine, telehealth, and the VA's new pilot program to provide enhanced contract care.

This year, we held several important hearings focused on rural health care. For example, this past April, we held a hearing on VA's implementation of the enhanced contract care pilot program. To our surprise, we learned of VA's plans to create a pilot within a pilot program, where only those veterans in select communities within VISNs 1, 6, 15, 18, and 19 would have access to enhanced contract care. At this hearing, we clearly conveyed Congress's intent for VA to implement this pilot program VISN-wide. Unfortunately, we were just informed a few days ago that VA does not plan on honoring Congress's intent and will only implement the pilot program in select locations within the five VISNs. I am deeply concerned by these recent developments and look forward to hearing from the VA today on this issue.

Next, in June of this year, we held a hearing on innovative wireless health technology solutions as a way to help overcome rural health care challenges. At this hearing, we heard from the Director of the Rural Development Network of the University of Virginia Health System, who provided poignant testimony on the unique needs of the veterans of Appalachia and the importance of innovations in telemedicine and wireless mobile health sensors and applications.

Again, I'd like to thank Mr. Perriello for inviting us here today and I appreciate this opportunity to hear directly from our veterans of central and southern Virginia about their local health care needs. I look forward to the testimonies of our witnesses today.

Prepared Statement of Major General Carroll Thackston, USA (Ret.), Mayor, South Boston, VA, and Former Adjutant General, Virginia Army National Guard

Good morning ladies and gentlemen. I am Carroll Thackston and I am the Mayor of South Boston, Virginia. I have served over ten years as both Vice-Mayor and Mayor of our town which numbers 8,500 in population. I am also a retired Major General, United States Army, having served for over 40 years, the last 4½ years as the Adjutant General of the Virginia National Guard.

I served on active duty for over six years, but spent 35 years in the National Guard. With this background, I have a good understanding of National Guard operations, goals and objectives, and the problems, current and future, facing the National Guard.

My main focus this morning will be about the National Guard and its probable impact on the Department of Veterans' Affairs. As you are aware, the Total Force Policy has been in effect since post-Vietnam and treats the three components of the

Army and Air Force—the Regular forces, the National Guard and the Reserves as a single force. Unlike the impact of Vietnam veterans on the VA system, the total integration and increased reliance on the combat and combat support units of the National Guard throughout the 90's and the War on Terror creates a whole new dynamic for Veterans' Affairs.

Before I discuss some of my concerns about the Guard and its increasing impact on the VA, I would like to tell you about our local efforts to help the veterans of Halifax County and immediate nearby counties. For the past three years several of us have worked with a small group of local Halifax veterans, primarily Vietnam veterans, to establish a primary care facility in South Boston to serve local area veterans. We have met many times and traveled many miles in pursuit of our goal. At this point, we are aggressively seeking designation as a rural locality under the VA's Enhanced Contract Care Pilot Program. If successful, the Halifax Regional Hospital's new Primary Care Facility located in South Boston will serve as a pilot project site for contract care within VISN 6. Our group has met numerous times with Congressman Perriello, his staff, and VA representatives. We traveled to Washington and were able to meet with Secretary Shinseki, and most recently participated in a lengthy teleconference that included Deputy Assistant Undersecretary Vandenberg and numerous VA staffers. In January of this year, Dr. Roger Browne, a member of our group, testified during the Roundtable Discussion of the Committee on Veterans' Affairs on "Meeting the Unique Health Care Needs of Rural Veterans." Dr. Browne's credentials as a specialist in internal medicine who has treated Halifax County veterans for over 30 years and his personal experience as Brigade Surgeon for the 198th Light Infantry Brigade in Vietnam in 1968 have provided our group with the leadership and credibility to clearly identify the quality primary health care our veterans need and deserve. At the finish line, we hope to have our new and modern Primary Care Center in South Boston operating as a VA primary care contractor providing all Halifax County veterans, both old and young, Regular forces or Guard and Reserve, with the quality primary medical care that they have earned and are entitled to, both legally and morally. There were 1,127 veterans in Halifax County enrolled in the VA system at the end of fiscal year 2009. There are 2,954 civilian veterans in Halifax County according to the most recent census data. We want all of them participating in the VA health system, and we want a local facility that is convenient for them and their families. And we want to insure that our growing population of veterans that are returning from current tours of active duty are assimilated back into their home communities with the assurance that convenient, quality VA medical care is there for them.

As a former Adjutant General of the Virginia National Guard, I have deep concerns about the coming impacts to the VA system as a result of the extensive use of National Guard combat and combat support units during Operations Iraqi Freedom and Operation Enduring Freedom in Afghanistan. During my tenure as Adjutant General, in spite of actively seeking overseas operations for our ten National Guard Divisions, the Guard was more or less relegated to Homeland Security and domestic crises. That is not the situation the Guard finds itself in post 9–11.

In Virginia, we have 7,838 members currently assigned to the Army National Guard which is 102% of its authorized strength. Since 9–11, 8,862 Army National Guard personnel and over 700 Air National Guard personnel have been deployed. Eighty-one (81) Purple Hearts have been awarded to Virginia Guardsmen and ten (10) Guardsmen have been killed in action. There are currently 630 Virginia Army National Guard and Virginia Air National Guard on active duty.

On the national scene, the total number currently on active duty from the Army National Guard and Army Reserve is 90,144; Navy Reserve, 6,354; Air National Guard and Air Force Reserve, 16,457; Marine Corps Reserve, 4,917; and the Coast Guard Reserve, 787. This brings the total National Guard and Reserve personnel currently activated to 118,659, including both units and individual augmentees (DoD News Release 7–14–10—National Guard (in Federal Status) and Reserve Activated as of July 13, 2010)

These figures are current as of July 13th. When you consider the continuing participation in the war efforts since 2001, the total number of National Guard and Reserve members is substantial.

So, in conclusion, when we consider the huge influx of citizen soldier veterans created by the integration of Guard and Reserve forces by the Total Concept Policy and the prosecution of extensive combat operations in the Middle East, there is an enormous workload headed for the Department of Veterans Affairs.

When you consider the demands being put on the Department of Veterans Affairs by that intense combat environment and multiple tours of duty, combined with the effort to increase VA medical care eligibility for veterans, I believe the VA will be required to expand its network of health care facilities to meet those increased de-

mands. News reports last week indicate that the VA is adopting new rules regarding post-traumatic stress disorder that will, in my opinion, drastically increase the clinical workload for the VA. Reports cite a 2009 Rand Corporation estimate that “nearly 20 percent of returning veterans, or 300,000, have symptoms of PTSD or major depression.” It will be interesting to see those estimates updated to reflect the new rules announced last week.

The education our group has received in pursuing a contract primary care facility for Halifax County has clearly enlightened us on the tremendous strides the VA has made since the mid-1990’s with the establishment of the VISN network and CBOCs, or Community Based Outreach Clinics.

We are absolutely convinced that the VA will need to rely on the numerous professional, and highly qualified, private-sector medical facilities to meet the coming demand for VA medical health care. Expanding the CBOC system may be prudent and wise, but the full utilization of contract medical facilities such as the one in South Boston will be essential to meeting those demands—both on-time and on-cost. Our research has shown considerable savings in time and fuel by veterans using more convenient and accessible primary care locations. Only through an aggressive primary care program that is structured to include all qualified veterans will the VA be able to cultivate a climate of preventive medicine and early detection of serious illnesses. The VA Medical Center will always be the bedrock of VA medical care to take care of the most serious medical problems of our veterans and the VISN/CBOC system is a proven winner in our opinion. Contract primary care using existing private sector facilities is going to be critical to the VA. We in South Boston and Halifax County are ready to show you the way.

Thank you. May I answer any questions.

**Prepared Statement of Howard Chapman, Executive
Director, Southwest Virginia Community Health Systems, Inc.,
and Member, Virginia Community Healthcare Association**

Utilizing Community Health Centers as a Vehicle for Increasing Access to Primary Care for Veterans Through the Rapid Activation of Community Based Outpatient Clinics (CBOCs)

EXECUTIVE SUMMARY

PROPOSAL: This paper proposes the use of individual community health centers, or organized networks of community health centers, to serve as a vehicle for increasing access to primary care for Veterans. In this model, community health centers would function as Community Based Outpatient Clinics (CBOCs) as defined by the Department of Veterans Affairs. This model is based on a strong collaborative relationship between the Health Resources and Services Administration’s Bureau of Primary Health Care and the Department of Veterans Affairs.

Summary Overview

In May 2004, the Department of Veterans Affairs issued its final version of its Capital Asset Realignment for Enhanced Services (CARES) Report. The CARES process was “initiated in 1998 to provide veterans, Congress and the American people with a 20-year plan to provide the infrastructure the VA will need to provide 21st Century veterans with 21st Century medical care.”¹

This Report calls for VA systemwide improvements in the use of vacant space, modernization, operating costs, as well as increasing access to primary care from 73 percent to 80 percent for all eligible² veterans. In addressing the need for increased access to primary care, the CARES Commission originally identified the addition of 250 Community Based Outpatient Clinics,³ which would be strategically located throughout the country. These CBOCs would be in addition to the existing inventory of both staff model and contracted CBOCs that have been operating since 1998.

The final Report prioritized 156 CBOCs out of the originally proposed 250 locations for activation by Calendar 2012.

¹ Chapter 1—Statement of Secretary, CARES Report, May 2004.

² According to the Veterans Administration Primary Care Access Guidelines.

³ CBOCs are outpatient primary care access points that are generally located in areas of high concentration of veterans populations, and are 1–2 hours driving time from regionally located VA Medical Centers.

A crossmatch analysis comparing the 156 prioritized CBOC locations with current⁴ BPHC grantees indicates that there are approximately 256 BPHC grantees that could potentially provide access to primary care to 100 percent of the 156 prioritized CBOC locations identified in the 2004 CARES Report.⁵

Rationale

There are a multitude of rationales supporting a community health center—VA CBOC collaboration in addition to the most compelling resource rationale given above:

- The goal of the CBOC program to increase access to primary care for its Veterans is consistent with the mission of community health centers and the President's Initiative.
- Community health centers offer the wide range of services that meet or exceed the VA's requirements for CBOCs including primary care, laboratory, radiology, mental health, and women's services.
- Veteran patient population health demographics are consistent with the patient health demographics of community health center patients and the program's efforts to further develop disease collaboratives.
- Community health centers are well suited to meet the CBOC Performance Measures, as established by the VA, in the areas of JCAHO accreditation, travel distance, mental health, patient satisfaction, etc.
- There is a growing community health center commitment to health information technology, high speed internet connectivity, and an electronic health record which is consistent with the Veterans Administration's commitment to the Computerized Patient Record System (CPRS).
- Community health centers are organized in BPHC/HRSA funded networks that can provide the infrastructure and expertise in information technology, contracting and care management.

The purpose of this document is to organize the experiences, requirements, capacities, and issues that could impact the successful use of community health centers in serving the primary care needs of our veterans.

Community Health Centers as Vehicles For Increased Access to Primary Care for Veterans

Background of the CBOC—VA Staffed vs. Contracted

From 1995 to 1998, the Department of Veterans Affairs approved more than 230 Community-Based Outpatient Clinics (CBOCs). By the end of FY 98, there were 139 CBOCs providing health care to veterans with the number of CBOCs per Veterans Integrated Service Network (VISN) ranging from one to 16.

The predominate staffing model for these early CBOCs was based on the use of VA employees who practiced in VA owned or leased facilities. During this development period, the VA also began issuing Request for Proposals on a competitive basis in order to contract with existing, community based primary care providers in private practice. Some of the early RFPs were actually awarded to academic medical centers that had concurrent contractual relationships with the regional VA Medical Center for graduate medical education training programs. By April 1998 only 26 of the existing 139 CBOCs were contracted CBOCs.

Current BPHC Grantees with CBOC Contracts

There are approximately 13 community health centers with CBOC agreements across the United States as of August 2004. Eleven of these agreements are direct agreements between the individual health center and the local VA Medical Center. Two of the Virginia health centers participate with the VA as CBOCs through a network master agreement with the statewide health center owned network. The use of organized networks as a contracting vehicle has broad applicability, especially in

⁴ Cross match conducted August 2004 and includes all BPHC Web site posted grantees including community health centers (CHC), migrant health centers (MHC), health center networks (ISDI), health care for the homeless (HCH), FQHC Look-a-Likes (FQHCLA), healthy communities access program (HCAP), and healthy schools healthy communities (HSHC) grantees.

⁵ Cross match analysis does not take into account any increase in community health centers as a result of President Bush's Initiatives I or II.

the areas of pricing, contracting, contract management, compliance, data collection, reporting, and quality improvement.

*Description of Need and Authority—2004 CARES Report*⁶

As recommended by the CARES Commission, the VA completed a rigorous re-examination of its forecasting Model by expanding the enrollment base period, completing a lower bound sensitivity analysis, and making Model improvements. These changes resulted in several recommendations regarding facilities, operating costs, and access to primary care, specifically as it concerns the Community Based Outpatient Clinic program.

[The following is excerpted from May 2004 CARES Report, Chapter 2. Pages 6–8.]

Commission Recommendations: The CARES Commission made several recommendations for enhanced access to veterans' health care through Community-Based Outpatient Clinics (CBOCs). Recognizing the need to apply uniform criteria and consistent national standards, the Commission reaffirmed that final decisions regarding the establishment of new CBOCs should remain under the purview of the Under Secretary for Health and the Secretary. Under that national framework, the Commission made several additional recommendations about how VA should prioritize CBOCs.

The Commission found that the prioritization methodology ... disproportionately disadvantaged veterans living in rural areas that are underserved and lack appropriate access to care. They also sought flexibility for VISNs to relieve space deficits at parent facilities by adding new sites of care. Finally, the Commission recommended VA improve the efficiency of operations at existing sites and supply basic mental health services at all CBOCs.

Secretary's Response and Implementation: The VA will continue its ongoing efforts to meet national standards or access to care for our Nation's veterans by establishing new sites of care through CBOCs. The Commission made several positive recommendations regarding CBOCs, and VA will act to ensure they are met. To that end, VA revised its national criteria for establishment of CBOCs to include emphasis on the importance of access to care for rural veterans, use of CARES travel guidelines to assess access to care, the availability of mental health services, and the flexibility for VISNs to relieve space deficits at crowded parent facilities by moving care to a nearby outpatient setting.

These actions complement existing CBOC criteria that include a focus on caring for Priority 1–6 veterans, ensuring that VISNs have necessary funds to operate new sites, developing well conceived business plans before implementing new sites, ensuring new CBOCs will increase access to care, and other factors. Further, VA will continue to explore opportunities to improve management of existing CBOCs through more effective staffing, expanding hours of operation, and examining opportunities to augment services where appropriate. VA will proceed with development of new CBOCs through CARES and will prioritize clinics that meet specific criteria.

Priority criteria include CBOCs that:

1. Are in markets that have large numbers of enrollees outside of access guidelines and are below VA national standards for primary care access;
2. Are in markets that are classified as rural or highly rural and are below VA national standards or primary care access;
3. Take advantage of VA/DoD sharing opportunities;
4. Are associated with the realignment of a major facility; and
5. Are required to address the workload in existing overcrowded facilities.

These priorities reflect determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options. They also reflect the Department's ongoing commitment to strengthening sharing opportunities with the Department of Defense.

The 156 priority CBOCs listed at the end of this response will be implemented by 2012 pending availability of resources and validation with the most current data available. This list reflects VA's priorities for planning based upon the most current information. As VA proceeds in implementing CARES and as it engages in future planning, the locations of these CBOCs may change, but the priorities will remain constant. VA will enhance access to care in underserved areas with large numbers of veterans outside of access guidelines and in rural and highly rural areas. VA also

⁶ Excerpted from May 2004 CARES Report, Chapter 2, pages 6–8

will enable overcrowded facilities to better serve veterans and will continue to support sharing with DoD. These principles will remain priorities even if management strategies to meet them evolve as new data and information becomes available. Recognizing that resources are not available to open all of these clinics immediately, VA will manage implementation of CBOCs by applying the revised CBOC criteria within the existing National CBOC Approval Process.

These priorities reflect determination to produce more equitable access to VA services across the country, particularly in rural and highly rural areas where there are often limited health care options, ensure a careful and considered implementation that mandates VISNs develop sound business plans, ensures national criteria are met, and that resources are available to provide the quality of care veterans expect from the Department. Resource requirements that must be in place to open new CBOCs include the capacity to manage specialty referrals and inpatient needs of new populations.

These priorities do not prohibit VISNs from pursuing other CBOC opportunities identified in the DNCP. VISNs will be able to propose any CBOC in the DNCP for activation; however, they must be able to demonstrate their ability to open priority clinics on schedule before they can open a clinic that is outside of the priority criteria. VISNs will immediately begin preparation of proposals for development of CBOCs for this year.

[End of excerpt.]

Testimony—Veterans Affairs Under Secretary for Health

In his testimony before the Subcommittee on Health, House Committee on Veterans Affairs on June 27, 2006, then VA Under Secretary of Health, Dr. Jonathan Perlin recognized the value of community health centers by acknowledging the potential for collaboration:

“The VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of health care for rural veterans . . . VA services are complemented by the services of community health centers (CHCs), which are local, non-profit, community-owned health care providers serving low income and medically underserved communities. For nearly forty years, this national network of health centers has provided primary care and preventive services to communities in need. Most centers try to arrange specialty care for clients with hospitals and individual health providers.

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

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

Basis for Collaboration

Community health centers are uniquely positioned to meet the needs of the Veterans Administration in providing increased access to primary care for its Veterans.

Current Collaboration between the Department of Health and Human Services (HHS) and Department of Veterans Affairs—On February 25, 2003, the Department of Health and Human Services and the Department of Veterans Affairs entered into a Memorandum of Understanding (MOU) to encourage cooperation and resource sharing between the Indian Health Service (IHS) and Veterans Health Administration (VHA). Five mutual goals were established in the MOU (www.vha.ihs.gov). There are current successful examples of increased access to health care under this MOU.

Available Inventory of Community Health Centers—The current inventory of community health center grantees within those programs supported by the Bureau of Primary Health Care are operating in all 156 priority locations identified in the CARES Report for CBOC activation. Activation of these 156 CBOCs would increase access to primary care for eligible Veterans to the 80 percent

level targeted by the Veterans Administration. Activation of additional CBOCs within BPHC grantee operations has the potential to exceed the 80 percent target levels for primary care access.

Compliance with VA Quality Standards—Community health centers are committed to becoming accredited by the Joint Commission and are supported by the Bureau of Primary Health Care in achieving this accreditation. This accreditation standard is consistent with the Veteran Administration Medical Centers' accreditation efforts.

Commitment to Information Technology—Community health centers are increasing their focus and capacity to acquire electronic health records, integrate disease registries, implement telemedicine solutions, and improve the overall quality of care provided to its patients through measurable outcomes. This growing commitment to information technology is being fueled by several factors including the successful acquisition, implementation and support of health information technology within a health center controlled network.

Experience as a Contracted CBOC—Although somewhat limited in number, there are specific, successful examples of existing community health centers acting as a CBOC through the competitive awarding of a CBOC contract. These contracts have been awarded to either individual health centers or to a health center controlled network. These community health center based CBOCs can provide real time information on the experiences in serving veterans in a CBOC model, financing, utilization of services, use of the VA's version of an electronic health record (CPRS), and overall contract compliance.

Veteran's Administration Commitment to Collaboration—The CARES Report clearly states the VA's commitment to collaborate with the Department of Defense in meeting the goals of the Report. This model is based on the assumption that the VA would extend their willingness to collaborate with community health centers as described in Dr. Perlin's testimony previously discussed, as well as allow for a similar collaboration as described in its MOU with the Indian Health Service.

Benefits to the Veterans Administration

1. Readily accessible facilities and staffing for the activation of planned CBOCs.
2. Simplified contracting processes which could decrease the activation costs of new CBOCs.
3. Improved patient care for veterans through existing community health center disease management programs and other enabling services.
4. Improved veteran patient satisfaction through the increased accessibility of primary care.
5. Improved veteran patient satisfaction through the ability of community health center CBOCs to serve not only the veteran, but the veteran's family members for primary care regardless of their ability to pay for services.
6. Improved veteran patient satisfaction with the provision of culturally sensitive health care services.
7. Decreased reliance on VA resources for support of information technology interfacing between community health centers and the CPRS system.

Benefits to the Community Health Centers

1. Increased patient base with an accompanying revenue source.
2. Improved provider satisfaction with the increased professional educational opportunities available to VA medical staff.
3. Contracting, disease management, information technology and financial management activities do not have to be developed and managed with new community health center resources, if these activities are housed within an existing health center network organization.
4. Improved standing in the community via increased interaction with veteran organizations such as VFW, AMVETS, etc.

Considerations for a Health Center—Department of Veterans Affairs CBOC Model

THE MODEL—The proposed "model" advocates for a high level of formalized collaboration between the Department of Health and Human Services and the Department of Veterans Affairs allowing community health centers to be considered the **"primary option"** for locating and activating a CBOC according to the requirements set forth by the Veterans Administration. This collaboration would include

an agreed upon process to allow “qualified and ready” BPHC grantee community health centers⁷ to be designated as CBOCs and provide those Scope of Services currently required by the Department of Veterans Affairs. Community health centers would have to meet all operating requirements of the CBOC program and be held to the same performance standards as existing contracted CBOCs.

There are numerous issues that would need to be addressed in order to successfully implement a community health center/Department of Veterans Affairs CBOC collaboration. Many of these issues concerning existing Federal contracting laws, acquisition rules, intergovernmental agency cooperation, Federal budgets, etc. are outside the scope of this document.

These issues notwithstanding, the following considerations could be explored based on current community health center CBOC experiences:

- Currently, CBOC RFPs and contracts are developed, issued, and awarded at the individual VA Medical Center or VISN level. The RFP system is fragmented and is based on individual VA Medical Center/VISN schedules and budgets. They are governed by a competitive bidding process. **Consideration:** *Create a collaborative contract environment that provides BPHC grantees first right of refusal for announced CBOCs. Only those community health centers that are deemed “ready” may participate in the contracting process (see below).*
- Contracts for CBOCs between VISNs may vary in Scope of Services, and other terms and conditions of an agreement. **Consideration:** *A national community health center CBOC RFP could be developed that would minimize the variability in contract documents and decrease the cost of contracting.*
- There are varying degrees of willingness within the VA system to accommodate an outside organization’s ability to interface with the CPRS system. **Consideration:** *A Memorandum of Agreement could be developed between HHS and Department of Veterans Affairs that lays the groundwork for ongoing cooperation in the area of information technology, or the CBOC program in general, similar to that of the IHS.*
- Community health centers may be willing to become a CBOC and become excited about the opportunity without a realistic assessment of their capacity to serve veterans. **Consideration:** *A standard readiness assessment could be developed and conducted at community health centers in order to properly prepare to accommodate veterans. This may require technical assistance resources.*
- Community health centers may not have the sophistication required to properly analyze the requirements of a CBOC RFP including the scope of services, financial management, contract compliance, etc. **Consideration:** *Technical assistance resources could be identified by the BPHC or NACHC to serve interested community health centers in support of these contracting and financial requirements in order to ensure success.*
- Mental health in the primary care setting is an important issue for both the VA and community health centers. Often times, there is an expectation for CBOCs to provide mental health services, although the actual Scope of Services re: mental health varies from filling out an assessment form to actual staffing requirements. In some instances, however, the VA has mental health resources that they are willing to provide in a CBOC facility to serve its veterans even though that facility is a contracted CBOC for primary care. **Consideration:** *In those contracted CBOC locations where the VA has a mental health resource available to see veterans, explore a “reverse contract” whereby the community health center can use that VA mental health resource for all of the patients being seen at the community health center. Adjust the contractual reimbursements accordingly.*
- The May 2004 CARES Report makes no reference to any alternative methodology for implementing CBOCs. The Report relies on existing VA policies and procedures for activating a CBOC and only references collaboration with the Department of Defense on a limited basis, mostly for facilities changes. **Consideration:** *Offer an Addendum to the CARES Report that is based on a broader view of collaboration with other Federal agencies that share a common purpose i.e. the BPHC’s mission of increasing access to primary care.*

⁷The reference throughout this paper to community health centers is based on current experience and does not imply that other federal grantee organizations could not serve as a CBOC site.

Conclusion

The purpose of this paper was to make an initial attempt at identifying the potential for increasing access to primary care for veterans through the use of community health center contracted CBOCs. It is not meant to be an all-inclusive discussion of the issues nor an attempt to limit the collaborative opportunities to one group of federally supported grantees.

Contact Information

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**Prepared Statement of Kevin Trexler,
Division Vice President, DaVita, Inc.**

Mr. Chairman and distinguished Members of the Subcommittee, I am grateful for the opportunity to provide testimony on behalf of DaVita. I am Kevin Trexler, Division VP of DaVita. I manage more than 80 dialysis clinics in Virginia, DC, and Maryland. My career path has also included six years as a deployed Navy-trained advanced degreed nuclear Submariner, working closely with various military and other intelligence agencies.

DaVita is a leading provider of dialysis services in the United States. We treat more than 117,000 patients each week in more than 1,500 centers, which represents nearly one-third of patients with End Stage Renal Disease—or ESRD—in the United States. We are also a recognized leader in achieving excellent clinical outcomes, consistently demonstrating outcomes that are among the best when compared to national averages. We have a proven track record of success in providing the best possible patient care through our innovative approach to collaborating with our many partners. At DaVita we also recognize the value in supporting the concept of community and especially those who serve and have served in the military. DaVita employs over 800 Veterans, as well as many active duty, guard and reserve troops. We have a long tradition of honoring those teammates at DaVita who have served, and are serving, as well as their families at our annual nationwide meeting.

DaVita is privileged to care for more than 2,000 of our nation's Veterans in our dialysis clinics across the country. Because VA's own network of dialysis facilities is not sufficient in capacity or geographic scope to care for many thousands of the Veterans with ESRD, we and other dialysis providers deliver dialysis treatments in Veterans' communities when VA cannot provide reasonable access or lacks the in-house capability to provide this life-saving treatment. More than 20 percent of those Veterans in rural Virginia have no alternative treatment options within 20 miles. We consider ourselves a partner of VA and are committed to providing excellent quality, exceptional clinical performance, and outstanding customer service to all these Veterans whom we serve.

Our testimony today addresses the Subcommittee's interest in understanding the quality of and access to dialysis care provided to Veterans in rural and underserved areas.

Veterans receiving dialysis treatment are frail patients often with multiple illnesses. They cannot survive without dialysis or kidney transplants. Thus, patient access to care is critical. Patients receive three treatments per week, every week of the year, each one requiring four hours of staff-assisted care. Moreover, the treatment requires a highly skilled workforce including a dietitian, a social worker, and other ancillary service providers, as well as the use of high tech medical equipment and supplies. Dialysis treatments are dependent on high-cost pharmaceuticals—including one key drug that is still under patent and has no generic, less expensive alternatives. Both the provision of the treatments and the financial aspects of dialysis treatments are unique.

Veterans with ESRD who live in rural or underserved areas often have no other treatment options within many miles. Any disruption to a Veteran's reasonable accessibility of a dialysis center will lead to longer travel times for their dialysis treatments, which, in turn, can have a significant impact on health outcomes. A study published in the April 2008 American Journal of Kidney Diseases found that patients traveling more than 60 minutes each way for dialysis treatments had significantly higher mortality levels and a lower health care quality of life.

Like many rural health care providers, DaVita's ability to receive sustainable reimbursement is critical to ensuring that access to care is preserved. The economics of the dialysis industry are very fragile, particularly in facilities that serve rural areas. The average rural dialysis clinic operates at a loss. Nearly 90 percent of patients are Medicare or Medicaid beneficiaries, and these reimbursements are insufficient to cover the cost of the treatments. Given the insufficiency of Medicare reimbursement, the dialysis industry relies on a unique "social contract" in which other payors subsidize the Medicare rates to ensure adequate access to care for all patients.

Here in Virginia, we provide care to Veterans through VA-established negotiated contracts. During the last 10 months, VA has awarded negotiated contracts with a number of dialysis providers throughout the country, covering most areas in which Veterans are authorized to receive Purchased dialysis care treatments. These contracts, if maintained, will continue to provide mutually agreed-upon, sustainable reimbursement. The VA, and not providers, will ultimately decide if these contracts continue for the complete five-year duration. The VA has not assured providers that these contracted rates will remain in effect, which results in the industry concern about VA's commitment to maintain existing contracts.

DaVita recognizes and supports VA's goal to standardize reimbursement for the purchase of non-VA provided health care services and to reduce its costs in a way that would not threaten veterans' access to care. DaVita believes that there is a way to achieve cost savings and standardization of payments, while concurrently improving the health status of Veterans with ESRD who are authorized by VA to receive their dialysis and kidney-related care in the community. Since last fall we have proposed to VA that they implement a patient-centered, integrated care management dialysis program for these extremely sick Veterans. The result would be:

- avoidance of rural clinic closures,
- improvement in the health status of Veteran dialysis patients, and
- the creation of a patient-centered approach for managing the health of Veterans with kidney disease.

It is important to consider that dialysis is only about a third of the total cost of care for these extremely sick Veterans; the majority of costs come from avoidable ER visits and hospital stays, and other costs due to infections and missed treatments. An integrated care management program would focus on key interventions, such as the placement of fistulas for dialysis access, which have proven to reduce the instances of hospitalizations for patients. This not only results in improved health and quality of life for Veterans, but would also reduce VA's overall Purchased Care costs for these patients.

In its recently released Broad Agency Announcement, the VA included a request for industry to submit proposals related to the VA Innovation Initiative. VA is seeking solutions from the health care industry that would improve the provision of dialysis care in community clinics and in Veterans' homes. We are delighted that VA has reached out to the kidney care provider community and will submit our proposal for consideration before the end of the month. Because DaVita understands that investments in prevention and coordination of care leads to improved outcomes and lower total costs, our proposed coordinated care program promotes patient-centered care for veterans with ESRD who have been authorized to receive Purchased Care. This integrated care management program will combine lab, pharmacy and medication therapy management, vascular access care, vaccinations, case management and access to diet and nutrition counselors and nephrologists. The program will promote utilization of and coordination with VA services where possible, and will collect and provide clinical data to VA through Electronic Medical Record technology when possible or in another format if VA prefers. VA currently does not receive clinical data from providers in the Purchased Care Program.

In addition, DaVita has expertise in providing and remotely monitoring dialysis care and treatments in patients' homes that would be of particular benefit to patients in rural areas. For instance, in-home biometric monitoring will allow us to monitor a patient's key health data in a remote setting. If an abnormal value is recorded an alert will be sent to one of our nurses who can either call or video conference with the patient to determine what medical actions are needed. This allows us to get real-time data without sending a nurse to the house. This system will also allow us to provide educational materials and reminders—including medication reminders, appointment reminders, etc—to the patient and care givers.

We also have the ability to take advantage of mail order or in-center delivery of medications so patients do not have to make extra trips to the VA or local pharmacy.

An integrated approach would be beneficial in many ways. Patients in similar programs, such as ongoing Medicare pilots, have experienced increased quality of life, greater satisfaction with the care they receive, and higher levels of engagement in their own care. In addition, they have benefited from preventive care measures such as immunization, lower rates of infection, greater compliance with medication therapy regimens, and lower hospitalization rates. VA is known for its progressive approach to health care delivery, and the Department can maintain this same approach with dialysis care for Veterans in the Purchased Care Program by implementing an integrated care management initiative that benefits both patients and taxpayers. As you may know, VA is moving to a patient-centered medical home approach for all VA facilities. This would be the first step in the Purchased Care Program to mirror what VA intends to accomplish within VA facilities in the next two years.

On behalf of DaVita, I would like to thank you for your interest in the care that we provide to Veterans and for your commitment to ensuring that Veterans in rural areas continue to receive the quality of and access to the care they have earned. We are grateful to the Subcommittee for your leadership in seeking new ways to promote quality care for all Veterans and especially the unique population of Veterans with kidney disease whom we serve.

I would be happy to answer any questions you may have.

**Prepared Statement of Michael F. Mitirone,
Commander, Department of Virginia, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's views on this pressing issue concerning the quality of health care provided to veterans in rural areas and in particular those in rural Virginia.

The American Legion, a long time advocate for America's veterans and their families, has noted the change in demographics of veterans and also the recent trend of veterans moving to rural and extremely rural areas of this nation. Even with that conscious decision, these veterans have earned the right to receive access to "The Best Care Anywhere." The Veterans' Health Administration (VHA) has endeavored to provide the required patient services, particularly gender-specific services, regardless of location, but there is still much to be done. The American Legion has passed a national resolution supporting enhancements to VHA's Rural Health Care programs to ensure veterans receive the timely and quality health care they have earned, regardless of where the veteran chooses to live.

The American Legion's primary health care evaluation tool is a program called "A System Worth Saving." This Task Force, first established in 2003, annually conducts site visits at VA Medical Centers nationwide to assess the quality and timeliness of VA health care. In preparing for these visits, The American Legion team researches General Accountability Office (GAO) reports, VA's Office of Inspector General (VAOIG) reports, and news articles relating to potential breakdowns in a system that we consider, "The Best Care Anywhere." This task force, we believe, is valuable on a national level to identify trends and improvements made in the VA Health Care System, as well as identify local issues and areas for improvements.

During the 2010 "System Worth Saving" Task Force visits to 32 VA Medical Centers across the country, a commonly repeated theme regarding rural areas was the shortage and turnover of personnel, especially nurses and personnel with specialty training. One of the reasons reported during Task Force visits for turnover and shortage is a lack of competitive compensation.

Of the 23.4 million veterans in this country, nearly eight million veterans are enrolled in the VA Health care system, of which approximately three million are from rural areas. Rural veterans comprise about 40 percent of all enrolled veterans, or one out of every three enrolled veterans. For many of the three million veterans living in rural areas, access to health care remains problematic, as they simply live too far away from the nearest VA Medical Center or Community Based Outpatient Clinic (CBOC). VA defines urban, rural and highly rural veterans with the following definitions: urban: any enrollee located in a census area defined as urbanized; rural: enrollees not designated as urban; highly rural: those enrollees defined as rural and reside in counties with less than seven individuals per square mile. Only two-thirds of rural and highly rural veterans enrolled in the health care system received VA medical services in FY 2008. Unfortunately, for many this means that rural veterans cannot see a doctor or a health care worker to receive the care that they need

due to their geographical limitations. Given these barriers, it is no surprise that our rural veterans have poorer health outcomes compared to the general population.

In VHA's Office of Rural Health Strategic Plan for 2010–2014, VA's strategic goals are to: improve rural access and quality of care, enhance technologies, improve research studies and analyses, improve education and training, improve collaboration of service options and recruiting and retaining medical professionals. VA provides care to more than 5.5 million veterans each year at over 1,100 locations, including inpatient hospitals and CBOCs. Demographic shifts and changes in where veterans live call for continued realignment of the delivery system with the needs of all veterans enrolled in mind. One of the continued challenges for VA is determining the locations to build a major medical center or where it is more feasible to construction CBOCs, contract services, or telehealth programs.

Men and women from geographically rural and highly rural areas make up a disproportionate share of servicemembers and comprise about one-third (31.9) of the enrolled Veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF); many of these servicemembers are returning to their rural communities. This is due to the high number of Reserve Component servicemembers who deploy from and return to their hometowns. This trend of veterans returning to rural communities will continue and VA must ensure that it is prepared to meet the increased demand for rural health care services.

The VA relies heavily on the CBOCs to serve the rural veteran populations. For example, the Marion VA Medical Center in Illinois has seven CBOCs located in Illinois, Indiana, and Kentucky that provide services to veterans in 52 counties in three states. Currently there are 42,000 veterans enrolled in rural CBOCs. The challenge of rural health care is a national issue. According to the National Rural Health Association (NRHA), many of the issues are a result of population size, age structure, health risk factors, economic development, ethnic composition, technology, and mix of health care providers, all impacting the health care needs of rural veterans and how they access health care services.

The American Legion conducted a site visit at the Salem VA Medical Center in Salem, VA in FY 2004, and at that time patients traveled an average of 80 miles and waited 30 minutes for specialty care. In FY 2009, there were 23,169 unique users veterans in the Salem VA Medical Center catchment area with 33,094 enrolled. The rural area of Bedford is approximately 30 miles from the nearest CBOC and 80 miles away from the Salem VA Medical Center. Bedford, Virginia has 1,524 veterans enrolled with only 770 users. There is currently one veteran in Bedford, VA that is enrolled in the Home Based Primary Care program and eight veterans that reside in Bedford, VA enrolled in the Care Coordination Home Telehealth program. The most common fee basis service for veterans living in the rural areas of Virginia is physical therapy and neurosurgery. There is an assigned Rural Health Team that provides outreach and patient education to veterans.

Another example of the difficulty to service rural and highly rural veterans is the Sheridan VA Medical Center in Wyoming and whose closest CBOC is 9 hours away. Some of the issues at this and other VAMCs are that when the roads are affected by rain or snow, the VA Medical Center's Volunteer Transportation Network vans are unable to go pick up veterans for their appointments. In some cases, travel times are nearly 20 hours each way to pick up a veteran and the veteran and volunteer driver must sleep in a homeless shelter each way on the trip. Also, many veterans who live in rural areas of the United States do not wish to make the long and tedious drive to the VAMC, even if a volunteer driver is willing to take them. Some veterans have gone over 30 years without seeing their primary care provider, but decide to see a doctor when it is usually too late, such as when cancer or other serious medical conditions worsen.

At some VA facilities unique approaches are being developed for assisting veterans and their caregivers. At the Iron Mountain Veteran Affairs Medical Center in Michigan, management reported that they do not have an adult day center because of the rural density. The VA is developing a voucher program so family and friends are able to receive payment and training to take care of their veterans. This will allow the veteran to be able to stay out of the VAMC and get the best care possible.

The American Legion applauded Congress and the Administration's passage of the Caregivers and Veterans Omnibus Health Services Act this year. One of the provisions in the law is to increase housing and transportation assistance for veterans living in rural communities. In addition, under VA's current mental health strategic plan mental health services have been expanded to primary care settings in VAMCs and CBOCs, something The American Legion has called for. The American Legion continues to urge VA to improve access to quality primary and specialty health care services using all available means at their disposal for veterans living in rural and

highly rural areas. Veterans should not be penalized or forced to travel long distances to access quality health care because of where they choose to live.

Mr. Chairman, while VA is making continued improvements to the access and delivery of health care to rural veterans, more still needs to be done. We commend the committee for holding this field hearing in our community to witness firsthand some of the challenges we and other rural veterans continue to face across America today.

Mr. Chairman and Members of the Committee that concludes my testimony.

**Prepared Statement of Daniel Boyer, Post Commander,
Grayson Post 7726, VFW Past State Commander, Veterans
of Foreign Wars of the United States**

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

It is my honor to be here today to represent members of the Veterans of Foreign Wars of the United States here in Bedford and around our wonderful state of Virginia.

I come before you with profound gratitude for what the VA is striving to achieve on behalf of our veterans. No agency or department is perfect, and yet I know that with the support of the Congress and this committee, the VA is making strides forward and is working diligently to care for all generations of veterans.

With these thoughts in mind I would like to address the rural health care challenges we are facing here in southwest Virginia.

Access to VA services in rural areas is always a primary concern, and that is no different in our region. From my hometown of Galax, VA, we have the Salem VA hospital that is approximately 100 miles to the north. Also located in our region is the Johnson City, Tennessee, VA hospital that is approximately 125 miles to the West. Either of these can be quite a journey, particularly when a veteran has two non-contiguous appointments. It can be a frustrating process for a veteran to travel long distances for multiple appointments spread throughout the day. We are very thankful for our Community-Based Outpatient Clinic (CBOC) in Hillsville, and we believe that the addition of a second CBOC in Marion, although limited to three days a week, will provide even greater assistance. There is clearly a need for the VA to open more clinics in rural areas, and the onus is on VA to find solutions for our veterans whether it be through additional private contracting, private-public partnerships, collaboration at multiple levels of government, or other creative means to make sure veterans are getting the care they deserve.

Another area that will potentially improve access to care is Telehealth. The VFW believes this is a major opportunity to improve health care outcomes, particularly in rural communities. Though there are privacy issues and technological limitations that must be addressed, they should not delay any expansion of telehealth services. The House Veterans' Affairs Subcommittee on Health recently held a hearing that spent considerable time discussing rural broadband and wireless expansion, and we encourage the committee to continue expanding the body of evidence that clearly supports a robust telecommunications infrastructure in our rural communities.

We are also concerned that many cases of Traumatic Brain Injury (TBI) are not being properly diagnosed. We are obviously playing catch-up in our understanding of TBI, and access to medical professionals who can properly diagnose TBI is a problem nation-wide. As you might imagine, veterans living in rural communities are especially vulnerable to misdiagnoses and ill-suited treatment, and the VA needs to make sure a sufficient network of doctors is in place to take what we are learning and put it to use in these communities. Moreover, post-diagnosis treatment can be time-consuming and can hinder efforts to treat rural veterans suffering with TBI. This is a serious issue that the VA and this committee need to tackle head on.

Closely tied to TBI is our concern with proper diagnosis and treatment of mental health conditions. We applaud VA for raising awareness on mental health issues and for working to reduce the stigma attached to seeking mental health treatment. We urge the Congress provide continuous oversight of VA mental health programs to ensure the need for counseling and other types of treatment is being met here and in all the rural areas of the country. At the Salem, VA, facility alone nearly 2,500 veterans have received diagnoses that may be caused by PTSD. One concrete step that could be taken to ensure all veterans who struggle with mental health conditions receive timely and professional care is to staff our rural CBOCs to provide inpatient mental health counseling and other specialty services.

Specifically, strong outreach and education programs will be necessary to help eliminate the stigma of mental illness and other barriers that dissuade many from

seeking care. We also need meaningful post-deployment health assessments that will incentivize servicemen and women to provide honest responses so that can receive appropriate kinds of care and secure benefits they have earned. Routine examinations should include mental health assessments. VA staff should be fully competent to identify warning signs, should be aware of all available programs, and should fully utilize them.

Suicide among our veterans is a national priority and it is certainly a rural issue as well. Veterans who live in rural communities often have limited health care access. Having the resources needed to combat the isolation is critical. The VA's suicide hotline is an effective tool for those who call, but we should work to ensure every veteran who is at the end of their rope knows there is a helping hand. Again, it comes back to outreach. These programs must be visible in the everyday lives of veterans. We know this is especially challenging in highly rural areas and we hope the VA will redouble their efforts with regard to rural outreach—not only for the suicide prevention hotline, but for all their programs.

One way the VA is reaching out to address these and other issues is through the Mobile Vet Centers (MVCs) that are literally going to where our rural vets live and work, ensuring access to services are provided where it is needed. However, it is with some dismay that I tell you I have not seen one or heard of one being in our community. With that in mind, the VFW hopes that the VA is devoting proper time and attention to evaluating the success of the MVCs and considering adding additional resources if there is a demand for more Mobile Vet Centers.

In rural areas, simple word of mouth is still one of the primary ways information is distributed and the VA should not overlook hometown newspapers, local VSO chapters, and other means tailored to our older veterans. Though they should employ e-mail alerts, social media, and other electronic means to reach out, they should not expect this to reach every generation of veteran. We want to be a resource for the VA to reach rural veterans, and the potential to boost outreach by using VFW posts and those of other Veteran Service Organizations cannot be overstated. Another helpful opportunity for collaboration would be to use local VFW posts to conduct local screenings and wellness events. Just because a Mobile Vet Center is not available that shouldn't mean the VA can't send a doctor or other medical professionals to a rural area. Speaking on behalf of the VFW here in Virginia, if the VA sends us a doctor, we can supply the patients and the physical space needed to screen for mental illnesses and TBI along with other physical conditions such as glaucoma, hearing, diabetes, and other illnesses. Such opportunities would provide a platform for further collaboration and would be a positive contact with rural communities where there is no VA presence. Everyone benefits when mutually interested parties work together, and we hope that the VA would take seriously the many benefits of increased cooperation with the VSO community.

The Independent Budget said it best when it stated that 'health workforce shortages and recruitment and retention of health-care personnel are a key challenge to rural veterans' access to VA care and to the quality of that care'. The VA must aggressively train future clinicians to meet the unique challenges rural veterans face. The VA already has existing partnerships with over a hundred schools of medicine in the United States. To not apply them, and expand upon them if needed, would essentially squander this vast resource. We cannot allow that to happen.

The VFW is also concerned that the men and women who serve in our Guard and Reserve are not fully utilizing the VA benefits that they have earned. Demobilizing members of the Reserve Component are often so preoccupied with thoughts of family and home that they fail even to mention existing health conditions, not to mention ones that will certainly develop down the road as a result of their service. Local VFW Posts often fund and facilitate going away and coming home parties for Guard and Reserve units. We have successfully used these events to boost morale and to offer assistance with their VA paperwork through the Virginia Department of Veterans Service, and will continue to support our returning warriors through these events and other outreach efforts.

Finally, I would like to bring attention to the successes of our Virginia Wounded Warrior Program. Rural veterans are a primary target population of the Virginia Wounded Warrior Program. I hear and know very positive things about the program. We hope that the VA will continue to look at this hallmark state program and redouble their efforts to work with all layers of government—local, state, and other federal entities—to provide an integrated, total solution for not just our wounded warriors, but for all who have served, and their families.

Mr. Chairman, I again thank you for the honor to present our priorities to you. I would be happy to answer any questions that you or the members of the Committee may have.

**Prepared Statement of Clarence Woods, Commander,
Department of Virginia, Disabled American Veterans**

Mr. Chairman, Ranking Member Brown and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) Department of Virginia to testify at this oversight hearing of the Committee focused on the Department of Veterans Affairs (VA) and the health care needs of rural veterans in the Commonwealth of Virginia. As an organization of 1.2 million service-disabled veterans, rural health is an extremely important topic for DAV, and we value the opportunity to discuss our views. Also, as requested by Mr. Perriello, a Member of this Subcommittee, we are incorporating in this statement the particular concerns of our Department of Virginia (following on page 6 of this statement).

As a partner organization in the *Independent Budget* (IB) for Fiscal Year (FY) 2010, DAV believes that after serving their nation in uniform, veterans should not experience neglect of their health care needs by VA simply because they live in rural or remote areas far from major VA health care facilities. The delegates to our most recent National Convention, held in Denver, Colorado, August 22–25, 2009, again passed a longstanding resolution on improving health care for veterans living in rural or remote areas.

In the IB, we have detailed pertinent findings dealing with rural health care, disparities in health care, rural veterans in general, and the circumstances of newly returning rural servicemembers from Operations Enduring and Iraqi Freedom (OEF/OIF). Unfortunately those conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas, despite the fact that one-fourth of the U.S. population lives in these areas. State offices of rural health identify access to mental health care and concerns for stress, depression, suicide, and anxiety disorders as major rural health concerns.¹
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.² The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high quality health services.³
- Nearly 22 percent of our elderly live in rural areas; rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas, some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care.⁴

Given these general conditions of scarcity of resources, it is not surprising or unusual, with respect to those serving in the U.S. military and to veterans, that—

- There are disparities and differences in health status between rural and urban veterans. According to the VA's Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have the worse physical and mental health related to quality of life scores. Rural/Urban differences within some Veterans Integrated Service Networks (VISNs) and U.S. Census regions are substantial."
- More than 44 percent of military recruits, and those serving in Iraq and Afghanistan, come from rural areas.
- More than 44,000 servicemembers have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.
- Thirty-six percent of all rural veterans who turn to VA for their health care, have a service-connected disability for which they receive VA compensation.

¹L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010, vol. 2*, College Station, Texas: Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003. www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html

²President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003

³Institute of Medicine, NIH, Committee on the Future of Rural Health Care, *Quality through Collaboration: The Future of Rural Health*, The National Academies Press, 2005.

⁴L. Gamm, L. Hutchison, et al., eds., *Rural Healthy People 2010: A Companion Document to Healthy People 2010, vol. 3*, College Station, Texas: Texas A&M University System, Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003.

- Among all VA health care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from “highly rural” areas as defined by VA.

Veterans Rural Health Resource Centers are Key Proponents of Improvements

In August 2008, VA announced the establishment of three Veterans Rural Health Resource Centers (VRHRCs) for the purpose of improving understanding of rural veterans’ health issues; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and, developing special practices and products for implementation VA system-wide. According to VA, the Rural Health Resource Centers will serve as satellite offices of ORH. The centers are sited in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and, Salt Lake City, Utah.

The concept underlining their establishment was to support a strong ORH presence with field-based offices across the VA health care system. These offices are charged with engaging in local and regional rural health issues in order to develop potential solutions that could be applied nationally in the VA, including building partnerships and collaborative relationships—both of which are imperative in rural America. These satellite offices of ORH and their efforts, along with those of VISN rural health coordinators, can validate the importance of the work and extend the reach of ORH in Veterans Health Administration (VHA), to reinforce the idea that the ORH is moving VA forward using the direct input of the needs and capabilities of rural America, rather than trying to move forward alone from a Washington DC central office.

Currently, these Centers are under temporary charters, and recipient of centralized funding not exceeding five years. The nature of that arrangement has had unintended consequences on the Centers, including problematic recruitment and retention of permanent staff to conduct their work. We have been informed that all staff appointments to the VRHRCs are consequently temporary or term appointments, rather than permanent career positions, because of reluctance on the part of the host VA medical centers to be placed in the position of needing to absorb these personnel costs when Central Office funding ends. If the concept of field-based rural health satellite offices is to be successful and sustained, the Centers need permanency of funding and staff.

Further Beneficiary Travel Increases are Needed

In the FY 2009 Appropriations Act, Congress provided VA additional funding to increase the beneficiary travel mileage reimbursement allowance authorized under section 111 of title 38, United States Code, and intended to benefit certain service-connected and poor veterans as an access aid to VA health care. VA consequently announced payment of the higher rate, at 41.5 cents per mile. While we appreciate this development and applaud both Congress and the VA for raising the rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance, and provides only limited relief to those who have no choice but to travel long distances by automobile for VA health care. This challenge is particularly acute in frontier states, and in rural Virginia and other States, where private automobile travel is a major key to health care access.

Telehealth—A Major Opportunity

The DAV and our partners in the IB believe that the use of technology, including the World Wide Web, telecommunications, and telemetry, offer VA a great but still unfulfilled opportunity to improve rural veterans’ access to VA care and services. We note that this Subcommittee held a hearing on June 24, 2010, in Washington, on the topic of “overcoming rural health care barriers: use of innovative wireless health technology solutions.” While DAV was not asked to testify at that particular hearing, we have reviewed and appreciate the testimonies of other witnesses, and we subscribe to the broad-based use of telemetry, new monitoring technologies, and the internet to help relieve burdens in access to VA health care being borne by veterans in rural and remote areas. We trust the Subcommittee will be using its findings from the hearing to further its oversight of VA in the use of telehealth and related technologies in rural America.

The IB veterans service organizations (IBVSOs) understand that VA’s intended strategic direction in rural care is of necessity to enhance noninstitutional care solutions. VA provides home-based primary care as well as other home-based programs, and is using telemedicine and telemental health—but on a rudimentary basis in our judgment—to reach into veterans’ homes and community clinics, including Indian

Health Service facilities and Native American tribal clinics. Much greater benefit would accrue to veterans in highly rural, remote and frontier areas if VA were to install general telehealth capability directly into a veteran's home or into a local non-VA medical facility that a rural veteran might easily access, versus the need for rural veterans to drive to distant VA clinics for services that could be delivered in their homes or local communities. This enhanced cyber-access would be feasible into the home via a secured Web site and inexpensive computer-based video cameras, and into private or other public clinics via general telehealth equipment with a secured internet line or secure bridge.

Expansion of telehealth would allow VA to directly evaluate and follow veterans without their needing to personally travel great distances to VA medical centers. VA has reported it has begun to use internet resources to provide limited information to veterans in their own homes, including up-to-date research information, access to their personal health records, and online ability to refill prescription medications. These are positive steps, but we urge VA management to coordinate rural technology efforts among its offices responsible for telehealth, rural health, and Information Technology offices at the Department level, in order to continue and promote these advances, but also to overcome privacy, policy and security barriers that prevent telehealth from being more available in a highly rural veteran's home, or into already-established private rural clinics serving as VA's partners in rural areas.

The ORH: A Critical Mission

As described by VA, the mission of the ORH is to develop policies and identify and disseminate best practices and innovations to improve health care services to veterans who reside in rural areas. VA maintains that the office is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals, the DAV concurs that the VHA would be beginning to incorporate the unique needs of rural veterans as new VA health care programs are conceived and implemented; however, the ORH is a relatively new function within VA Central Office (VACO), and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals, we remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning rather than placing it closer to the operational arm of the VA health care system, and closer to the decision points in VHA executive management. Having to traverse the multiple layers of the VHA's bureaucratic structure could frustrate, delay, or even cancel initiatives established by this staff office. We also note that, executive direction within the office itself has been problematic, and that VA has experienced chronic difficulty in recruiting a permanent director of the office. We have been advised that a new director of ORH has been retained and assumed office on July 1, 2010.

We continue to believe that, rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VACO, perhaps at the Deputy Under Secretary level, with staff augmentation commensurate with these stated goals and plans. We understand that recently the grade level of the Director of ORH was elevated to the Senior Executive Service. We appreciate that change but grade levels of Washington-based executives, do not necessarily translate to enhanced outcomes and better health for rural veterans.

Rural Health Coordination at the Grassroots

The VHA has established VA rural care designees in all its VISNs to serve as points of contact and liaisons with the ORH. While DAV appreciates that the VHA designated the liaison positions within the VISNs, we remain concerned that they serve these purposes only on a part-time basis, along with other duties as assigned. We believe rural veterans' needs, particularly those of the newest generation of war veterans, are sufficiently crucial and challenging that they deserve full-time attention and tailored programs. Therefore, in consideration of other recommendations dealing with rural veterans' needs put forward in this statement as well as in the IB, we urge VA to establish at least one full-time rural liaison position in each VISN and more if appropriate, with the possible exception of VISN 3 (urban New York City).

Outreach Still Needs Improvement

We note Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, approved on September 30, 2008, included

\$250 million for VA to establish and implement a new rural health outreach and delivery initiative. Congress intended these funds to build upon the successes of the ORH by enabling VA to expand initiatives such as telemedicine and mobile clinics, and to open new clinics in underserved and rural areas.

Outreach Clinics are established to extend access to primary care and mental health services in rural and highly rural areas where there is not sufficient demand or it is otherwise not feasible to establish a full-time Community-Based Outpatient Clinic (CBOC) by establishing a part-time clinic. Ten Outreach Clinics were funded in fiscal year 2008, and 30 in fiscal year 2009. While the potential impact would affect over 997,000 rural and highly rural enrollees that reside within areas that VA serves, only 2,250 patients were seen by the end of fiscal year 2009.

Without question, section 213 of Public Law 109-461 could be a significant element in meeting the health care needs of veterans living in rural areas, especially those who have served in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. 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 local units of the National Guard to ensure that returning veterans and Guard/Reserve members, after completing their deployments, can have ready access to the VA health care and benefits they have earned by that service. Given this mandate is more than three years old, DAV urges VA's recently created National Outreach Office in the Office of Intergovernmental Affairs, Office of Public and Intergovernmental Affairs to move forward on this outreach effort—and that outreach under this authorization be closely coordinated with VA's ORH to avoid duplication and to maintain consonance with VA's overall policy on rural health care.

To be fully responsive to this mandate, VA should report to Congress the degree of its success in conducting effective outreach, and the result of its efforts in public-private and intergovernmental coordination to help rural veterans. We note VA is required to develop a biennial plan on outreach activities and DAV has had the opportunity to review the December 1, 2008, VA biennial outreach activities report to Congress. Clearly VA is conducting numerous outreach activities to veterans of all eras and has a special emphasis on veterans of OEF/OIF. However, we note the report lacks an overarching strategic plan as well as any parameters or statistical evidence to determine whether outreach efforts, individually or collectively, are achieving the desired results. Strategic planning is essential for successful business operations and a full understanding of the veteran population is an important element in providing education and outreach.

Virginia-Specific Concerns

As requested by Mr. Perriello's office, we wanted to provide the Subcommittee our local and regional perspectives and concerns on rural health care in the Commonwealth of Virginia.

Rural health initiatives are centrally funded by the VISN for only two years. Our DAV Department of Virginia is concerned that VA medical center directors will not support them once this protected, and "fenced" funding is stopped, or that they might be tempted to "rob Peter to pay Paul" within the medical centers by utilizing funds needed by other VA programs and applying them to the rural initiatives. We believe that rural initiatives should remain centrally funded and not be made to compete with other medical center programs.

Sick and disabled veterans in Virginia have been waiting patiently for years to see new VA CBOC being opened in our rural areas. We currently have two approved CBOC projects that are taking far too long. Each of these CBOCs is now more than a year overdue in opening. Efforts are not made to open new CBOCs expeditiously and projected opening dates are usually delayed by a bureaucratic system. Also, for those that are open (in Alexandria, Bristol, Charlottesville, Danville, Fredericksburg, Harrisonburg, Hillsville, Lynchburg, Norton, Tazewell, Virginia Beach, and Winchester), VA space planning needs improvement. In our experience, VA's planning configuration does not include making space available for the occasional visiting clinician but only for authorized permanent Full Time Employee Equivalence (FTEE.) When visiting clinicians come to these clinics to provide services (in mental health, podiatry, and other specialties), either they often have nowhere to see their patients, or space for them is very cramped. VA space planners need to do a better job of providing for itinerant providers within CBOC space configurations. Allowing more space than needed by permanent staff also provides us an opportunity to expand services sooner rather than having to wait additional years for clinic construction projects after the need is identified.

We believe CBOCs need to provide more services on site in order to obviate veterans' needing to travel long distances to major VA medical centers for services they cannot receive in CBOCs. The DAV Department of Virginia believes this problem can be solved by VA's building "super-CBOCs," or larger and more extensive outpatient facilities in rural areas.

We have noted that VHA is now working on "systems redesign" (reforming VHA as the new "Medical Home"). We believe this kind of logic could be applied to a VHA-VBA system redesign. We believe there are many opportunities between VHA and VBA to work together, but they are being missed.

While Popular, Privatization Is Not a Preferred Option

Section 216 of Public Law 110-329 requires the Secretary to allow veterans residing in Alaska and enrolled for VA health care to obtain needed care from medical facilities supported by the Indian Health Service or tribal organizations, if an existing VA facility or contracted service is unavailable. It also requires participating veterans and facilities to comply with all appropriate VA rules and regulations, and must be consistent with Capital Asset Realignment for Enhanced Services. In addition, Public Law 110-387, the Veterans' Mental Health and Other Care Improvements Act of 2008, directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of the VA, and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health care provider at VA expense. The act defines a "highly rural veteran" as one who (1) resides more than 60 miles from the nearest VA facility providing primary care services, more than 120 miles from a VA facility providing acute hospital care, or more than 240 miles from a VA facility providing tertiary care (depending on which services a veteran needs); or (2) otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of the veteran. During the three-year demonstration period, the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

DAV's concerns regarding the use of non-VA purchased care are the unintended consequences for VA, unless carefully administered. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the specialized needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably impacted by the loss of veterans from those programs. Also, the VA's medical and prosthetic research program, designed to study and, hopefully, cure the ills of injury and disease consequent to military service, could lose focus and purpose were service-connected and other enrolled veterans no longer physically present in VA health care programs. Additionally, title 38, United States Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when Public Law 104-262 was enacted in 1996. Unfortunately, some of that capacity has dwindled.

We believe, VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems such as blindness, amputations, spinal cord injury, or chronic mental health problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health care programs may only exacerbate the problems currently encountered.

In light of the escalating costs of health care in the private sector, to its credit, VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected veterans might seek care in the private sector as a matter of personal convenience, as a result of enactment of vouchers and privatization bills, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health record, and bar code medication administration. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, ones that are either generally not available in private sector systems or only partially so, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

In general, current law places limits on VA's ability to contract for private health care services in instances in 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 medical emergency prevents a veteran from receiving care in 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 to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general authority in the law (with the exception of the new demonstration project described above) to support broad-based contracting for the care of populations of veterans, whether rural or urban.

The DAV urges this Committee and the VA ORH to closely monitor and oversee the functions of the new rural pilot demonstration project from Public Law 110-387, especially to protect against any erosion or diminution of VA's specialized medical programs and to ensure participating rural and highly rural veterans receive health care quality that is comparable to that available within the VA health care system. Especially we ask VA in implementing this demonstration project to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state or other federal agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions' academic affiliates. We recommend the principles of our recommendations from the "Contract Care Coordination" section of the IB be used to guide VA's approaches in this demonstration and that it be closely monitored by VA's Rural Veterans Advisory Committee. Further, we believe the ORH should be designated the overall coordinator of this demonstration project, in collaboration with other pertinent VHA offices and local rural liaison staff in VHA's rural VISNs selected for this demonstration.

VA's Readjustment Counseling Vet Centers: Key Partners in Rural Care

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, DAV believes that these veterans, too, should have access to specialized services offered at VA'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 readjustment and psychological counseling related to their military experiences. Building on the strength of the Vet Centers program, VA should extend its current pilot program for mobile Vet Centers that could help reach veterans in rural and highly rural areas where there is no other VA presence.

VA Should Stimulate Rural Health Professions

Health workforce shortages and recruitment and retention of health care personnel (including clinicians) are a key challenge to rural veterans' access to VA care and to the quality of that care. The Future of Rural Health report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deeper involvement in education in the health professions for future rural clinical providers seems appropriate in improving these situations in rural 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 every year. In addition, more than 32,000 associated health sciences 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.

We believe these relationships of VA facilities to health professions schools should be put to work in aiding rural VA facilities with their health personnel needs. Also, evidence shows that providers who train in rural areas are more likely to remain practicing in rural areas. The VHA Office of Academic Affiliations, in conjunction with ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. The VHA office of Workforce Recruitment and Retention should execute initiatives targeted at rural

areas, in consultation with, and using available funds as appropriate from, the ORH. Different paths to these goals could be pursued, such as the leveraging of an existing model used by the Health Resources and Services Administration (HRSA) to distribute new generations of health care providers in rural areas. Alternatively, VHA could target entry level workers in rural health and facilitate their credentialing, allowing them to work for VA in their rural communities. Also, VA could offer a “virtual university” so future VA employees would not need to relocate from their current environments to more urban sources of education. While, as discussed above, VA has made some progress with telehealth in rural areas as a means to provide alternative VA care to veterans in rural America, it has not focused on training future clinicians on best practices in delivering care via telehealth. This initiative could be accomplished by use of the virtual university concept or through collaborations with established collegiate programs with rural health curricula. If properly staffed, the VRHRCs could serve as key “connectors” for VA in such efforts.

Consistent with our HRSA suggestion above, VA should examine and establish creative ways to collaborate with ongoing efforts by other agencies to address the needs of health care for rural veterans. VA has executed agreements with the Department of Health and Human Services (HHS), including the Indian Health Service and the HHS Office of Rural Health (ORH) Policy, to collaborate in the delivery of health care in rural communities, but we believe there are numerous other opportunities for collaboration with Native American and Alaska Native tribal organizations, state public health agencies and facilities, and some private practitioners as well, to enhance access to services for veterans. The ORH should pursue these collaborations and coordinate VA’s role in participating in them.

The IB for FY 2009, had expressed the concern that rural veterans, veterans service organizations, and other experts needed a seat at the table to help VA consider important program and policy decisions such as those described in this statement, ones that would have positive effects on veterans who live in rural areas. The IBVSOs were disappointed that Public Law 109–461 failed to include authorization of a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans service organizations, and other rural health experts to recommend policies to meet the challenges of veterans’ rural health care. Nevertheless, we applaud the Secretary of Veterans Affairs for having responded to the spirit of our recommendation to use VA’s existing authority to establish such an advisory committee. That new federal advisory committee has been appointed, has held formative meetings, and has begun to issue reports to the Secretary. We are pleased with the progress of the advisory committee and believe its voice is beginning to influence VA policy for rural veterans in a very positive direction.

Summary and Recommendations

DAV and our partner organizations in the IB believe VA is working in good faith to address its shortcomings in rural areas, but still faces major challenges. In the long term, its methods and plans offer rural and highly rural veterans potentially the best opportunities to obtain quality care to meet their specialized health care needs. However, we vigorously disagree with proposals to privatize, voucher, and contract out VA health care for rural veterans on a broad scale because such a development would be destructive to the integrity of the VA system, a system of immense value to sick and disabled veterans and to the organizations that represent them. Thus, we remain concerned about VA’s demonstration mandate to privatize services in selected rural VISNs, and will continue to closely monitor those developments.

With these views in mind, DAV makes the following recommendations to the Subcommittee and also to the VA, where applicable:

- 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 direct VA health care services.
- VA must fully support the right of rural veterans to health care and insist that funding for additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.
- The responsible offices in VHA and at the VA Departmental level, collaborating with the ORH, should seek and coordinate the implementation of novel methods and means of communication, including use of the World Wide Web and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health care facilities, providers, technologies, and therapies, in-

cluding greater access to their personal health records, prescription medications, and primary and specialty appointments.

- We recommend a further increase in travel reimbursement allowance commensurate with the actual cost of contemporary motor travel. The existing gap in reimbursement has a disproportionate impact on veterans in rural and frontier states.
- The ORH should be organizationally elevated in VA's Central Office and be provided staff augmentation commensurate with its responsibilities and goals.
- The VHA should establish at least one full-time rural staff position in each VISN, and more if needed.
- VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the ORH. VA should be required to report to Congress the degree of its success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans.
- Additional mobile Vet Centers should be established where needed to provide outreach and readjustment counseling for veterans in highly rural and frontier areas.
- Through its affiliations with schools of the health professions, VA should develop a policy to help supply health professions clinical personnel to rural VA facilities and practitioners to rural areas in general.
- Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities, the VA ORH and its satellite offices should sponsor and establish demonstration projects with available providers of mental health and other health care services for enrolled veterans, taking care to observe and protect VA's role as coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available by the ORH to conduct these demonstration and pilot projects, and VA should report the results of these projects to the Committees on Veterans' Affairs.
- Rural outreach workers in VA's rural CBOCs should receive funding and authority to enable them to purchase and provide transportation vouchers and other mechanisms to promote rural veterans' access to VA health care facilities that are distant from these veterans' rural residences. This transportation program should be inaugurated as a pilot program in a small number of facilities. If successful as an effective access tool for rural and highly rural veterans who need access to VA care and services, it should be expanded accordingly.
- At highly rural VA CBOCs, VA should establish a staff function of rural outreach worker to collaborate with rural and frontier non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available or VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

Mr. Chairman, this concludes DAV's statement. I would be pleased to address questions from you or other Members of the Committee.

Prepared Statement of Lynn Tucker, Museville, VA (Veteran Caregiver)

My name is Lynn Tucker. I am here to testify on behalf of my son Private First Class Benjamin Tucker, a lifelong resident of the rural community of Museville in the 5th Congressional District of Virginia. Ben enlisted in the United States Marine Corps in May 2004. Ben served for 22 months before tragedy struck in the form of a dirt bike accident leaving him with a traumatic brain injury. Ben is classified by the Veterans Administration as 100-percent disabled. I am here to testify on behalf of Ben's two brothers, Corporal Jonathan Tucker and Lance Corporal Clayton Tucker, who served two tours as Marines in Iraq. They suffer from the effects of repeated IED and RPG blasts and the deaths of many friends. I am also here to testify on behalf of all veterans needing care from the VA. My testimony today is based as a caregiver to Ben, who lives at home in Museville.

Ben's story reveals what should be our concerns for all veterans, particularly those representing rural areas; the concerns are: access to primary and specialty care, effective and efficient communication within the VA and approval and remittance of payments from the VA for medically related items and services. Problems in any of these areas affect rural veterans like Ben, Jonathan and Clay by limiting medical choices, causing travel hardships, and contributing to an overall breakdown in the quality of care and life. What we all need to remember here is that these individuals, and all veterans, made a commitment to serve and to protect our liberties without knowledge of the ultimate outcome.

Access to primary and specialty care is imperative for all veterans and especially difficult for rural veterans. For Ben who requires frequent specialized care, this is quite a challenge. Ben lives 45 minutes from the Danville CBOC, 1 hour and 15 minutes from the Salem VA, and 3 hours from the Richmond VA. Only the Richmond VA can provide all the different types of care Ben needs and is the least accessible.

In October 2006 Ben returned home after almost a year in hospitals and was totally dependent for all his care as he had no voluntary movement and was fed by a gastric tube. He was eligible for 15 hours weekly with the VA Home Health Aide Program. Due to his rural location, locating and retaining certified nursing assistants with the selected VA vendor was often impossible. Months would pass with no nursing help and no help from the VA in locating a vendor with nurses willing to drive the extra distance for a rural client. Just this last year we were able to retain a reliable and caring nurse through the VA when a new vendor was selected. With Ben's monthly VA disability payments another CNA was employed after a period of 4 months with no nursing help. Overall low payroll compensation with the added expense of additional driving discourages CNA's from accepting rural clients.

Ben has a Codman shunt in his brain to drain excess fluid and requires care from a neurosurgeon. The Salem VA does not have a neurosurgeon; therefore, Ben has continued to see a Roanoke neurosurgeon practicing with Carilion Hospitals. Getting approvals for appointments is so time consuming, we have stopped applying for approval of routine visits and use Ben's Medicare Insurance and pay the balance remaining. This practice is not an appropriate solution for veterans and conveys that the VA does not have an appropriate system in place to care for their own. Many veterans' families that our family is associated with express concerns about waiting for approval and appointments with primary care doctors and specialists. Per two VA clinic staffers in Salem, with the intake of more veterans from Iraq and Afghanistan, this situation is growing worse by the day. Do VA administrators understand this situation?

Effective communication is a barrier for veterans seeking care and necessary assistive equipment. Communication between VA staffers within the administration often results in long delays or unnecessary denials. During the summer of 2006 Ben applied for the grant to help pay for a custom wheelchair van. This request was submitted to the Roanoke Regional VA office. The form was passed along through the VA from person to person until somewhere a copy was made and the copy was passed along instead of the original. After several weeks, inquiries were made of the VA on Ben's behalf with no results. It was not until the family actually traced the path of the grant form, with the help of Kay Austin of the Paralyzed Veterans of America, that it was determined the form was in fact on the desk of a VA employee where it had laid for 2 months. The employee stated the original was needed, but had not tried to locate the original or call for a new original. Then Ms. Austin faxed a new form and a second completed copy was delivered personally to the VA employee.

Veterans often have to wait for needed medications to be refilled. Just this past month, Ben needed renewal on a medication that took over 12 days to resolve. The CBOC in Danville received my request by fax and the receipt was confirmed by a nurse. Three of the medications arrived in the mail, but the one in question was not on Ben's prescription list in My HealththeVet. I called the CBOC and left a message on the nurse line. No one called. Inquiries confirmed the message was retrieved off the voice mail, but no action was taken. Finally the nurse called to say we needed to contact Richmond for an approval. In all it took 12 days for the CBOC to tell me to call Richmond. Consider this: if you needed medication for your hypertension would you be willing to forgo that for 12 days? Is that not harmful to your health? Living in a rural area with the nearest pharmacy 30 minutes away and the nearest VA pharmacy an hour and 15 minutes away, this problem is compounded. Simple communication would have alleviated the wasted time, energy, and driving to fill this prescription.

In September 2008, a bath sling was requested for Ben by the Richmond VA physical therapy department to the Richmond VA prosthetics department. A picture and an Internet link were provided to the employee. After months, many calls, and e-mails with the link again, three improper slings were delivered. Calls were made to the Guldman vender in Texas for the sling attempting to provide Ben with the needed equipment. After calling the Guldman headquarters and being given information for Guldman MidAtlantic, on March 4, 2009 the correct bath sling was delivered overnight for free by Guldman MidAtlantic after hearing the difficulty of trying to procure the sling for Ben. A veteran in a rural location cannot easily travel to a VA center and resolve issues in person. VA employees must respond to e-mails

and calls and act appropriately to resolve the issue at hand. Veterans should not spend days, weeks, or months waiting by the phone.

During 2008 a recumbent stepper was requested to the Salem VA by a physical therapist for Ben. Ben was taken to the Salem VA and evaluated by a doctor who approved the request. After months, calls were made about the equipment and found the request had never reached the prosthetics department. Shortly the Salem VA called explaining Ben needed the evaluation he had already completed. The doctor never entered the evaluation into the computer and never forwarded the request to the prosthetics department. Once this issue was resolved and several months passed, calls were made checking the progress of the request again and discovered it was denied. The Danville CBOC was notified but no one notified us. Efforts were made to begin tracking the documentation to determine why the request was denied. The VA employee who denied the request was very exasperated and actually said, "Why am I in the middle of this?" The employee could not grasp why he had to defend his decision nor could he present procedural or policy issues relating to the denial. After a lengthy discussion debating the need for the equipment due to Ben's rural location and physical condition, the request was approved and the equipment delivered.

Payments from the VA for medical services or equipment outside the VA system are slow to nonexistent, and this situation traps the veteran between the VA and the outside vendor. After Ben's van was delivered November 13, 2006, the VA owed a payment to the dealer it had already approved. After several weeks the dealer contacted Ben's family asking for help in obtaining the payment from the VA. Phone calls were made seeking this payment to no avail. Several weeks later the dealer requested the payment from Ben. The payment for the van finally reached the dealer on February 20, 2007, 3 months after delivery of the van to Ben.

The van is not the only example of poor payment practices, Ben currently has collections against him for medical bills the VA agreed to pay. At first we paid some of the bills ourselves until realizing this wasn't an exception, but the norm. A great deal of time has been spent tracking many payments with the hospital and the VA not willing to communicate with each other. Currently all collection calls are referred to the VA.

Ben was referred for physical therapy at the Carilion Clinic in Rocky Mount. During one of his appointments I was called to the front desk because the center did not have the authorization number to pay for his therapy. It was necessary to contact the VA from the front desk of the facility in order that Ben could complete his appointment. Otherwise, Ben or his family would have had to agree to pay for the therapy.

Ben spent almost 5 months in 2006 at Craig Hospital in Colorado after we paid over \$14,000.00 to have him flown medically. On his return trip home, the VA agreed to pay for the flight because it was necessary for him to be evaluated by the Salem VA before returning home. On the day before the flight, the air ambulance company asked for a credit card number because the VA could not locate who approved payment for the flight. Once again, many phone calls were made adding to an already tense situation.

In May 2006, my husband and I sat in a meeting with the Richmond VA after Ben was discharged by the marines in April. Ben was an active duty marine for 22 months, 2 months short of eligibility for VA coverage, with no TRICARE insurance, and his VA claim not processed. The VA employee wanted to know how the bill of approximately \$40,000.00 per month was to be paid if Ben continued to stay in the polytrauma unit. With no help from the VA, we investigated and obtained cobra insurance with TRICARE for Ben and the VA was paid.

As a taxpayer and citizen of the United States of America it is striking how we take for granted the lives of those who voluntarily put theirs on the line. Ben, Jonathan, Clay, and all veterans enlisted without knowledge of the outcome. They made a commitment to their country. Where is their country now? Where will our country be when all the veterans return from Iraq and Afghanistan? Will they too be burdened with forms, phone calls, red tape, and delays? Will they too be turned away and not cared for? We cared to send them.

**Prepared Statement of Patricia Vandenberg, MHA, BS,
Assistant Deputy Under Secretary for Health for Policy and Planning,
Veterans Health Administration, U.S. Department of Veterans Affairs**

Good Morning, Mr. Chairman and Members of the Committee. Thank you for inviting us here today to discuss the progress the Department of Veterans Affairs (VA) has made in implementing section 403 of Public Law (PL) 110-387, as well as VA's

efforts to increase access to quality health care for veterans living in rural and highly rural counties in Virginia. I am accompanied today by Mr. Daniel Hoffmann, Network Director for the VA Mid-Atlantic Health Care Network (Veterans Integrated Service Network, or VISN 6), and Ms. Carol Bogedain, Interim Director for the Salem VA Medical Center. My testimony today will discuss VA's work in implementing the pilot program required by section 403 of PL 110-387 and our local efforts in the area.

Section 403 of Public Law 110-387

Public Law 110-387, Section 403 requires VA to conduct a pilot program to provide health care services to eligible veterans through contractual arrangements with non-VA providers. The statute directs that the pilot program be conducted in at least five VISNs. VA has determined that VISNs 1, 6, 15, 18 and 19 meet the statute's requirements. This program will explore opportunities for collaboration with non-VA providers to examine innovative ways to provide health care for veterans in remote areas.

Immediately after Public Law 110-387 was enacted, VA established a cross-functional workgroup with a wide range of representatives from various offices, as well as VISN representatives, to identify issues and develop an implementation plan. VA soon realized that the pilot program could not be responsibly commenced within 120 days of the law's enactment, as required. In March and June 2009, VA officials briefed Congressional staff on these implementation issues.

VA has made notable strides in implementing section 403 of PL 110-387, with the goal of having the pilot program operational in late 2010 or early 2011. Specifically, VA has:

- Developed an Implementation Plan, which contains recommendations made by the Workgroup on implementing the pilot program;
- Analyzed driving distances for each enrollee to identify eligible veterans and reconfigured its data systems;
- Provided eligible enrollee distribution maps to each participating VISN to aid in planning for potential pilot sites;
- Developed an internal Request for Proposals that was disseminated to the five VISNs asking for proposals on potential pilot sites;
- Developed an application form that will be used for veterans participating in the pilot program; and
- Taken action to leverage lessons learned from the Healthcare Effectiveness Through Resource Optimization pilot program (Project HERO) and adapt it for purposes of this pilot program.

VA has assembled an evaluation team of subject matter experts to review the proposals from the five VISNs regarding potential pilot sites. This team will then recommend specific locations for approval by the Under Secretary for Health. We anticipate this process will be complete this summer. After sites have been selected, VA will begin the acquisitions process. Since this process depends to some degree on the willingness of non-VA providers to participate, VA is unable to provide a definitive timeline for completion, but VA is making every effort to have these contracts in place by the fall. This would allow VA to begin the pilot program in late 2010 or early 2011.

VA is developing information materials for veterans participating in the pilot program, for non-VA providers, for VA employees, and for other affected populations so that, when the pilot is implemented, all parties will have the information they need to fully utilize these services. VA is committed to implementing the program directed by Congress and to maintaining the quality of care veterans receive. Other issues, such as securing the exchange of medical information, verifying veterans' eligibility for this pilot program, coordinating care, and evaluating the success of the pilot program, are also important priorities and VA is working to ensure their appropriate implementation in the pilot program.

VA notes that section 308 of Public Law 111-163, which was signed by the President on May 5, 2010, amends the requirements of Public Law 110-387 section 403 regarding the "hardship" eligibility exception and the mileage standard.

Local Initiatives

As noted previously, VISN 6 was selected as one of the Networks that will participate in the pilot program required by section 403 of PL 110-387. VISN 6 has identified potential locations for consideration for the pilot program.

Separately, in fiscal year (FY) 2009, VISN 6 received approval and funding from VA's Office of Rural Health for three programs to improve access for veterans in rural Virginia. These included a program to improve effective communication and improving health literacy; a rural women veterans health care program; and additional mental health substance abuse coordination. VISN 6 immediately began implementing these efforts in the summer of 2009, and all VA medical centers in VISN 6, including the Salem VA Medical Center, are benefiting from this continuing process. The programs are specifically targeted to assist veterans residing in rural and highly rural counties.

The first project is designed to help VA conduct outreach to veterans living in rural and highly rural areas and improve health literacy. We will accomplish this through several strategies. First, we are identifying veterans with common characteristics or conditions, such as chronic obstructive pulmonary disease, diabetes, or congestive heart failure, and we are providing personal or group education on their health care needs in areas easily accessible to our veterans. This may occur in a Veterans Service Organization facility, a Vet Center, or a community-based outpatient clinic (CBOC). Second, we are conducting patient prescription reviews with the aim of improving communication and coordination between each veteran and his or her clinical pharmacist and provider. When veterans better understand the health care decisions their providers are making, they can be a more effective partner in making those decisions. We are also expanding the use of VA's online personal health record, My HealthVet and enhancing self-care programs for chronic disease. To better support these initiatives, VISN 6 recently established rural health teams, which consist of rural health coordinators, clinical pharmacists, registered nurses, social workers, medical support assistants, program support assistants, and drivers. The hiring process for unfilled positions in the VISN 6 rural health teams is almost complete; all positions have been recruited and are pending final personnel actions. The teams are providing regular updates to VISN leadership and are implementing 90 day action plans they developed in May. Each VA medical center in the VISN has received funding to support these outreach and access efforts. In total, VISN 6 received \$4.89 million for this project.

The second project supported by VA's Office of Rural Health is a rural women veterans health program. This program is designed to help increase the number of providers in rural or highly rural areas who are proficient, skilled and knowledgeable in caring for women veterans. We have trained at least one provider in this program at each VISN 6 CBOC and medical center; as of the beginning of July 2010, 150 providers total have already been trained, and 150 more will be trained before the end of this fiscal year. The program will also focus on improving health literacy and the overall health education of women veterans. VISN 6 received \$1.92 million for this effort.

The final project supported by VA's Office of Rural Health is a new effort to support additional mental health substance abuse coordination. This program is designed to provide mental health services including substance abuse treatment for veterans in rural or highly rural areas through contracts with community partners to increase access to these services. Our contracting officials are finalizing this proposal and we expect to begin obligating funds by the end of the fiscal year. VISN 6 received approximately \$2 million for this program.

Last month, between June 15 and 17, 2010, VISN 6 held a Network-wide meeting that provided our rural health teams with goals, objectives and strategic direction. The meeting allowed the teams to learn more about tele-medicine, home-based primary care programs, women's health programs, the impact of post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) on veterans and their families, and the various partner programs offered by local governments in North Carolina and Virginia. This information sharing is critical to effective implementation of our outreach and access strategies for veterans in this area.

In summary, these efforts are part of a larger plan by VISN 6 to improve access to quality health care for veterans in rural and highly rural areas. The principles of this approach include engaging community providers and leaders; VA is here to complement their programs, not compete. Indeed, in fiscal year (FY) 2010 through June, the Salem VA Medical Center has disbursed more than \$15 million for fee-basis appointments, while the Richmond VAMC has disbursed just under \$15 million for fee-basis appointments; across all of VISN 6, more than \$178 million has been disbursed through fee-basis care.

We also need to educate and engage veterans and their families, and focus on common health issues among our veterans. Finally, quality health care and positive health outcomes are strongly associated with improved screening and health maintenance and compliance. These programs support the strategic goals of the Office of Rural Health. By improving health literacy and empowering our veterans to be-

come full partners in their health care decisions, we can deliver the quality care our veterans have earned.

Conclusion

Thank you again for the opportunity to discuss the status of the pilot program required by section 403 of PL 110-387 and the work VA is doing to improve access for veterans in rural Virginia. My staff and I look forward to answering your questions.

**Statement of Chris A. Lumsden, Chief Executive Officer,
Halifax Regional Health System, South Boston, VA**

Halifax Regional Health System (HRHS) is non-profit, community owned and locally governed organization located in South Boston, Virginia. We are a fully integrated health care provider serving over 100,000 residents over a five county area in southern Virginia. Beyond our 173-bed acute care hospital, we own and operate two nursing homes, and Alzheimer's facility, a home health care and hospice agency, and four primary care clinics in our service region. We have approximately 125 doctors on staff and employ about 1,200 people at HRHS.

The newest primary care clinic, Halifax Primary Care (HPC), was opened in South Boston in July of 2007. In June, 2009, HPC moved into a new 10,000 square foot state-of-the-art clinic here in town. The clinic is currently staffed by five physicians and one mid-level extender with a support staff of fifteen clinical and clerical employees. The facility was designed for easy expansion as additional doctors are recruited and more patients are served from this area.

HRHS and HPC fully support the efforts to provide convenient high quality medical care to all veterans residing in our service region. If we meet the criteria and can fulfill the standards required as a provider of medical services to the veteran population, HPC would consider it an honor and a privilege to help better serve such a distinguished constituency of patients. We have been working closely with the local Veteran's Clinic Steering Committee and hope that South Boston is approved as veterans primary care site. It will certainly help those veterans who now must now travel long distances for these type services.

