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VA HEALTH CARE IN RURAL AREAS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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JUNE 16, 2010

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VA HEALTH CARE IN RURAL AREAS

WEDNESDAY, JUNE 16, 2010

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:31 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Tester, Begich, and Johanns.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing will come to order. Aloha and welcome to everyone.

Today, we will discuss VA health care issues in rural areas. Rural settings are some of the most difficult for VA and other government agencies to deliver care, I believe, and I know many of my colleagues on this Committee share the view that we must utilize all the tools at our disposal in order to provide access to care and services for veterans in rural and remote locations. Expanding the use of telehealth technologies, rural outreach centers, mobile clinics, and other options will help us to make health care accessible to more veterans and reduce the burden on those living in rural areas.

VA also has the authority to partner with other government agencies or to contract with community medical professionals in order to provide care in local communities. Monitoring and evaluating the quality of this type of contracted care remains a challenge and I look forward to hearing more from VA on how to improve this.

We have worked to make immediate improvements for rural veterans. Recently, legislation from this Committee was enacted into law which now provides higher rates of mileage reimbursement and reimbursement for airfare for veterans who must travel to reach VA health care facilities. This law will now provide important incentives that the Department can use to recruit and retain high-quality health care providers in rural areas.

I remain concerned about how effectively we are reaching veterans in rural areas. This is significant and it is a concern in my home State, where a large rural population cannot drive to the VA facility on Oahu as they are separated by many miles of water. This poses a special challenge in helping these veterans access VA health care.

This Committee has held several hearings on health care in rural areas. For my part, I have worked to ensure that the neighbor islands in Hawaii have telemedicine capabilities, regular visits from medical personnel, and viable outpatient clinics. We have been largely successful in these efforts and I will continue to explore new ways to make further improvements.

Today, we will be focusing on States with exceptional challenges. Our first panel of witnesses will address care and services for veterans in Montana, which has large areas in which VA has little or no presence but has a significant veteran population to serve. Also on the first panel, we have a witness from Senator Burr's home State of North Carolina, who can discuss how they are reaching out in rural areas.

The second panel will address issues in Alaska, which is not just considered rural but actually remote. I do plan to review all the testimony and will be working with Members of this Committee and the full Senate to ensure that VA does its very best to meet the needs of veterans living in rural and remote areas.

Chairman AKAKA. Now, I would like to ask Senator Johanns for his opening statement. Senator Johanns?

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEBRASKA

Senator JOHANNS. Mr. Chairman, thank you, and let me say good morning and aloha. It is great to be here with you today.

Chairman AKAKA. Good morning and aloha.

Senator JOHANNS. I want to express, if I could, how much I appreciate the opportunity for the purpose of this hearing to act as Ranking Member. Senator Burr, as you know, asked me to pinch hit for him today. With the College World Series kicking off in Omaha this week, this seems especially appropriate.

I also want to indicate what an honor it is to be the Ranking Member next to the Chairman. Mr. Chairman, I have great respect for the work you are doing for our veterans.

Today's topic is one that every single Member of this Committee, I believe, understands in some form or capacity. Providing health care to rural veterans is critical, especially in States that are rural, like Montana, like Nebraska, Alaska, and I could go on and on.

I thought today it might be appropriate—sometimes we start with areas where we disagree. Today, I want to start with areas where we agree and build upon those areas in my comments.

First, I think we all agree that greater use of technology is essential. Technology provides the ability for medical professionals to perform remote consultation and even some medical procedures or examinations in the comfort of a veteran's own surroundings. That is part of the reason I introduced a bill last month with Senators Klobuchar and Murray to help veterans electronically access VA programs. Easier programs will likely be used more often.

Now, testimony from a similar hearing we held last year suggested that VA was increasing its use of telehealth and telemedicine, and I applaud that. I am very interested in hearing about the progress we have made in the past year and what we are anticipating in the year ahead.

The challenge of providing care for rural veterans also raises the opportunity for VA to work in coordination with providers in our rural communities. Their challenges are often identical to ours. That is one of the recommendations made by the Veterans Rural Health Advisory Committee, which is going to be mentioned, I think, in the testimony today.

In 2008, Congress passed legislation to test the concept of allowing VA to team up with community providers to care for veterans who live far away from a VA health care facility. Our goal here is to have VA deliver timely, quality health care services to our veterans. I also look forward to hearing where we are at with this effort of working with our community health care providers.

Finally, outreach is tremendously important for providing care to our rural veterans. One of the reasons why Senator Burr wanted Mr. Putnam, a Veteran Service Officer in North Carolina, to testify today is to emphasize the importance of working with folks at the local level to meet the needs of rural veterans.

On a final note, Mr. Chairman, I was pleased to see that the Office of Rural Health has released its strategic plan covering the next 5 years. I am a big believer in looking out 5 years and even longer to try to assess where we are at today and where we need to be going.

The plan outlines several goals and objectives to improve the delivery of health care to rural veterans. It will give the Committee a blueprint from which to ensure that VA is indeed reaching more rural veterans with a concerted strategy. It is my hope that in 5, 6, and 7 years we can look back and check off goals being obtained.

So, Mr. Chairman, thank you again for your service to veterans. Thank you again for this oversight hearing, and I look forward to our witnesses' testimony. Thank you.

Chairman AKAKA. Thank you very much, Senator Johanns. You have been a great Member of this Committee and have really been helpful.

Let me now ask Senator Murray to proceed with her statement.

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Well, thank you very much, Mr. Chairman, Senator Johanns, for holding today's hearing to talk about how VA is caring for our veterans in rural areas. I want to thank our witnesses, all of them who are here today, as well. I look forward to hearing your testimony.

As we all know, the fiscal year 2011 budget includes $250 million to improve access to care in rural areas. It is a good step forward and I am glad to see that that is in the VA's budget. But we continue to hear from a lot of our veterans in rural areas and underserved areas that they are still really struggling to access basic care today.

When I go home and talk to veterans in Washington State, I often hear about how they just can't travel several or more hours on snowy or icy roads, especially during our winter conditions, just to see a physician. Despite the efforts the VA has made to increase access to rural veterans through the establishment of new CBOCs,

Vet Centers, and mobile medical units, all great progress, there are a lot of gaps still with our rural veterans.

Throughout Eastern Washington State and out on the peninsula, the VA still doesn't have enough services there to treat a lot of our veterans. I have been pushing the VA very hard to open some contract clinics in Omak, Colville, and Republic and to expand care in Port Angeles. We have got to be creative with the resources we have and continue to aggressively find alternate options for care, whether it is through contract facilities or fee basis or other innovative programs, to get care to our rural and isolated communities.

This is a critical issue especially because the lack of access to care means a lot of these veterans put off preventive care and they don't get the necessary treatment they need. In fact, we know that the VA has found that rural veterans are in poorer health than those living in our urban areas. From recruiting and retaining health care providers in our rural areas to monitoring and managing the quality of care provided in non-VA facilities, we all know the challenges are very complex and there is no silver bullet to any of these issues. So, I really appreciate this hearing today and I look forward to hearing from our witnesses about progress that is being made and how we can do better.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Tester, will you proceed with your statement.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. I want to thank you, Mr. Chairman. I appreciate your leadership in this Committee over the last many years on this issue and others. We appreciate it very much.

I want to thank the witnesses today, in particular Jim Ahrens. Jim, it wasn't easy getting here, but I do appreciate you coming a long way to tell a very important story.

Most of the folks in this room know the numbers. Forty-four percent of the enlistees in the military come from a rural or highly rural area, even though only one-quarter of the population lives in those rural areas. What the folks in this room may not think about is how this fact should change our approach in allocating VA dollars and resources. If we put all our energy into where the general population lives, we will not live up to our country's promises for all veterans.

It was 3 years ago next month that I held a field hearing in Great Falls, MT, on the state of health care for rural veterans. At that point in time, the travel reimbursement for veterans was 11 cents a mile, not enough to pay for gas. There were only eight Community-Based Outpatient Clinics serving an area as big as the Eastern Seaboard. Mental health services were generally very tough to come by and many folks didn't understand how to respond to combat stresses, PTSD, and TBI. American Indian veterans, who have the highest rate of enlistment of any minority group in the country, were shuffled between the VA and Indian Health Service. And a lot of folks who had served this country so honorably were not getting the quality of health care that they had earned.

I am pleased to say that things have gotten better since then. We have raised the travel reimbursement rate. We have expanded the number of CBOCs. We have started to make some progress to improve mental health awareness and services. We have done these things by working together, Democrats and Republicans on this Committee, working with both a Democratic and a Republican VA Secretary. Veterans in Montana expect you to check your party politics at the door and focus on doing what is right and we owe them no less.

But make no mistake about it, there is always room for improvement, and that is what this hearing is all about. It is about seeing where to go from here. It is about making it easier for rural veterans to get to a VA facility for care or bringing the care closer to the veteran. It is about breaking down the bureaucracy so that Indian veterans get the care that they have earned. It is about making sure the VA has a steady supply of talented health care professionals in rural and frontier areas of this country.

I can promise folks from the VA that the Chairman and Senator Burr will be having another hearing on this issue in the next Congress, too. It is critically important that we do not let our rural and frontier veterans lose out on the health care and benefits that they have earned. I will do everything I can to continue to advocate for them on this Committee and in the U.S. Senate.

I know that many of the witnesses on the first panel feel the same way and we will hear from them shortly. I appreciate, once again, you all being here.

Chairman AKAKA. Thank you very much, Senator Tester.

Senator Begich, do you have a statement?

STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA

Senator BEGICH. Mr. Chairman, I will hold my statement until introducing panel two. But first, I want to thank you for your willingness to hold this meeting on rural health care. It is very important, obviously, to many of our States here, but very much so to Alaska, which is very, very rural in a lot of ways and access issues are a huge problem.

So, I will hold my comments and look forward to the testimony of both this panel, and—obviously I am biased, no offense—to the second panel because there are lots of Alaskans on the second panel.

Chairman AKAKA. Thank you very much, Senator Begich.

I must address one further issue before we continue the hearing. Dr. Jesse, I know that this is not your fault, but unfortunately, as the Department's representative today, you must be the one to take this message back to VA.

I would like to note that the Department's testimony was submitted over 29 hours late. This is upsetting for me and, I am sure, for other Members, as well, as it does not allow us and our staff sufficient time to review the testimony in order to have a productive hearing. The deadline for submitting testimony, which is clearly listed in the Committee's rules, is there to avoid wasting everyone's time.

Frankly, I am very surprised that the Department could not meet the deadline for this hearing. This is a standard oversight hearing being held on an issue on which VA has been proactive and which has been the subject of recent attention, including hearings and briefings. This should not have been difficult testimony to develop, which suggests there is a serious flaw in the Department's processes. In the past, the Department has been able to meet this deadline without difficulty and I do not know what has changed to cause this habitual noncompliance, but I recommend the Department address this problem immediately so as to avoid any issues during the next hearing. So please take this message back to the Department.

Dr. JESSE. Yes, sir, I will.

Chairman AKAKA. I thank you.

Before we welcome our first panel and hear their statements, I recognize Senator Tester and Senator Begich. Both have been vocal advocates for the concerns of rural veterans. As our panels today are comprised largely of witnesses from their home States, I will be passing the gavel to them as they can each preside over the panel dealing with their home State. In the meantime, I have a hearing on the Armed Services Committee, so I need to step out.

I want to thank all of our witnesses for being here today and I will review all of your testimony in depth.

Senator Tester?

Senator TESTER [presiding]. Once again, I want to thank the Chairman for his leadership and important attention to this issue.

I want to welcome the witnesses once again. I introduce Adrian Atizado, the Assistant National Legislative Director for Disabled American Veterans. Next we have Jim Ahrens, the Chairman of the Veterans Rural Health Advisory Committee for the VA and Ronald Putnam, a Veteran Service Officer from Haywood County in North Carolina. Finally, we have Dr. Robert Jesse, the Acting Principal Deputy Under Secretary for Health in the Department of Veterans Affairs. He is accompanied by Glen Grippen, the Network Director for VISN 19, which does include the State of Montana.

I want to point out that when we had the field hearing back in July 2007, which I spoke of in my opening statement, I think the only person newer on the job than me that day was Glen Grippen. Glen had been on the job at VISN 19 for 2 weeks at that point in time, as I recall. I am glad we are both still around.

Mr. GRIPPEN. One week.

Senator TESTER. One week. All right. I am glad we both are still around, Glen, and I want to thank you all for being here this morning.

We will start out with the testimony from Adrian.

STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ATIZADO. Senator Tester, Members of the Committee, I would like to thank all of you for inviting DAV to testify at this hearing on rural veterans health care. As you all know, DAV is an organization of 1.2 million service-disabled veterans, and as such, rural health is an extremely important topic for our membership.

Veterans residing in rural to frontier areas face similar health care challenges as other citizens in these communities. Human and financial resources needed to provide quality health care and access to such care are the central shortcomings. Access to core services, such as emergency medical care, mental health and substance abuse services, hospital and long-term care is severely limited due to historical shortages of qualified health professionals.

Indeed, this deficit as well as the low-density patient population means establishing and supporting the types of specialized care veterans need is a great challenge. Such lack of resources result in what studies have shown as significant disparities and differences in health status between rural and urban veterans.

As a partner organization for the *Independent Budget*, the DAV believes that after serving their Nation, veterans should not experience neglect of health care needs by VA simply because of where they live. In fact, the delegates to our most recent national convention again passed a longstanding resolution to improve health care services for veterans living in rural and highly rural areas.

DAV believes Congress and VA are creating a potentially effective infrastructure to improve access and quality of care for enrolled highly rural veterans. However, we believe that there are some weaknesses that must be addressed in order to fully embrace the goal.

The Office of Rural Health, or ORH, is a relatively new function within VA's central office and it is only at the threshold of tangible effectiveness with many challenges remaining. Given its charge, we are mainly concerned about the staffing and organizational placement of this office. We believe that rural veterans' interests would be better served if ORH were elevated to a more appropriate management level with staff that is augmented commensurate with the office's responsibilities.

DAV believes that the three Veterans Health Care Resource Centers are key components of improving health care and health status of veterans residing in rural to frontier areas. The concept underlying their establishment was to support a strong VA Office of Rural Health presence within the enormous VA Health Care System. Currently, the centers are under temporary charters with temporary staffs and receive centralized funding, but only for a 5-year period. The nature of this arrangement has had unintended consequences, such as in the recruitment and retention of permanent staff to conduct their work.

If the concept of field-based Rural Health Satellite Offices is to be successful and sustained, we believe these centers need permanency of funding and, obviously, staff.

The VHA has also established VA Rural Health Care designees in all its VISNs to serve as points of contact and liaisons with the Offices of Rural Health. These VISN rural consultants, as outlined in the ORHS strategic plan, is crucial and we remain concerned over the part-time designation of 13 positions, which means only eight are full-time, and these 13 positions have collateral duties. We believe rural veterans' needs, especially those of the newest generation of war veterans, are so crucial and challenging that they deserve full-time attention and tailored programs.

Now, as a final matter, I would like to discuss a need to foster enhanced telehealth services functionality and availability that cannot only improve health care access, but quality of care and health status, as well. VA's pioneering work in telemedicine has proven to reduce hospital admission, shorten hospital stays, and lower health care costs, and according to VA, the agency provides care to over 96,000 rural veterans through telehealth. But as you consider there are 3.1 million enrolled rural and highly rural veterans, the VA believes greater expansion of VA telehealth offers a great, but still unfulfilled, opportunity. Moreover, with the expected growth in VA's telehealth budget—I believe it is almost over a doubling of that budget—we urge VA management to coordinate rural technology efforts among all of its offices responsible for telehealth to promote advances, but also and more importantly to overcome privacy, policy, and security barriers that currently encumber expansion of this program.

DAV hopes VA and Congress will work together to address these and many other issues that will be laid out before the Committee today. This concludes my statement and I would be happy to address any questions that this Committee may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: Thank you for inviting the Disabled American Veterans (DAV) 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. 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 Senator Tester, a Member of this Committee, we are incorporating in this statement the particular concerns of our DAV Department of Montana.

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, 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]

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[1] L. 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

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

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

• 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 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.
• 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 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

[4] L. 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.

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 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. 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 tele-mental 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 Veterans Health Administration (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 is experiencing difficulty in recruiting a permanent director of the office.

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.

MONTANA-SPECIFIC CONCERNS

Our DAV Montana past Department Commander furnished information responsive to Senator Tester's request. With respect to VA, the report indicates a local challenge in DAV's Transportation Network. VA's local processing time to qualify a DAV volunteer to drive for the Volunteer Transportation Network in Montana requires up to 50 days. As a result DAV Montana has lost potential volunteers, either because of their own extended travel requirements to facilities to try to qualify, or because of the lengthy time of processing their requests to volunteer. The report also indicated inconsistency within VA facilities between states; for example, the Ft. Harrison VA Medical Center (VAMC) requires a tuberculin test every year for all its volunteer drivers; in other states VAMCs do not impose this requirement. Our Montana DAV believes these kinds of rules should be standardized for DAV volunteer drivers. The DAV National Organization concurs.

DAV Montana is advocating a renovation project for the Ft. Harrison facility to convert inpatient ward space to private rooms. Montana DAV believes this would be a benefit to all enrolled Montana veterans, and would allow modernization of the

rooms at the same time. Currently challenges in multi-bed ward rooms relate to HIPAA privacy issues, privacy issues related particularly to women veterans, cross contamination and infection issues, and lavatory use issues, among others. Also, privacy for a veteran who has only days or even hours to live is disrupted by the current Ft. Harrison space configuration and, for the sake of their families, DAV Montana asks that this project be approved. The DAV National Organization takes no position on this recommendation, but we sympathize with the needs of VA facilities to make infrastructure improvements, many of which are long overdue and backlogged. Ft. Harrison's situation is but one example of many reflecting these kinds of unmet needs.

We understand from our Montana correspondent that a "Consolidated Patients Account Center (Central Plains Office)" is being considered by VA for possible placement in VISN 19. Were this new center located at Ft. Harrison, it would create almost 400 new VA positions in Montana. Our Montana DAV reported that VA Ft. Harrison is already performing consolidated accounts receivable invoicing for several other VISNs, and asserted that the facility is capable of taking on this related task. DAV Montana proposes that VA co-locate the new Consolidated Patients Account Center at Ft. Harrison because closely similar accounting processes are already being completed at that site. The DAV National Organization takes no position on this local matter but commends it to Senator Tester for further consideration.

Our DAV past Department commander also reported a challenge with regard to veterans who are in need of air travel while under oxygen therapy. He asks that the Committee inquire of the Federal Aviation Administration (FAA) to examine current on-board oxygen restrictions imposed by the Canadian regional carrier that services many small Montana communities. He asks that special accommodations be made for disabled veterans and other persons to travel when oxygen therapy is a medical requirement. While the DAV National Organization has no national resolution from our membership on this particular matter, we are sympathetic to this need and would not object to such an inquiry.

Montana DAV also reported on the extreme shortage of qualified Disabled Veterans Outreach Program (DVOP) specialists, as well as Local Veterans Employment Representatives (LVERs) in Montana "One Stop" locations and other states of limited population but significant geography.

These DVOPs and LVERs were especially trained to aid veterans who were disabled or veterans who face a variety of barriers to employment, or have special needs preventing them from returning to the workforce. Through the Federal authorization, Montana reported it once had sufficient available funds in these programs to work with the individuals and local employers to make sure these veterans received the help they needed either through local services or additional education to assist these individuals to return to the workforce. What they were also able to accomplish was to identify any of those possible barriers to employment such as depression, TBI, PTSD and other special needs. These individuals had already networked throughout the community, county, state or other Federal agencies to help these veterans with special needs.

According to the Montana DAV report, since the early 1990s, the U.S. Department of Labor (DOL) used a formula for authorizations for DVOPs and LVERs in each state based on veteran population. One Stop locations in the state of Montana initially had a DVOP or LVER at almost all of its sites. The number of these key veterans outreach and employment specialists originally was in the high twenties; today, DAV Montana reports six individuals are on duty.

To date currently in Montana, our correspondent reported many One Stop locations do not have a representative trained in any of these barriers that many veterans need to overcome. He also reported the concern of a funding shortage for special programs in the state to support the needs of veterans and disabled veterans to return to the workforce. DAV Montana recommends that the Federal formula on authorizations for frontier states be changed, or that frontier states be exempt so that these rural states can gain authorization and funding for a sufficient number of trained DVOPs and LVERs at each of their One Stop locations. The DAV National Organization takes no position on this individual state's shortage; nevertheless, our comments above on outreach challenges within VA are certainly consistent with this report from Montana about the DOL veterans outreach programs.

Our Montana Department also reported that the Department of Transportation (DOT) offers no grant programs for veterans service organizations to support veterans' transportation to VA medical appointments. Similar to most of our Departments and many DAV Chapters, the Department of Montana DAV Volunteer Transportation Network depends on local fundraising, available grants, and DAV national funds to support this large program. In Montana during the most recent year, 31,184 volunteer hours were logged over 685,982 miles, with 16,880 individual vet-

erans being transported to VA appointments, involving nearly 300 volunteers in VA clinics, and local area coordinators in the medical center in Ft. Harrison, but with only two paid VA employees (Hospital Services Coordinators). Given the over 5,000 members of the DAV residing in Montana, the transportation network is reduced from 44 active vans to 36, and currently Montana DAV has four inactive vans that are being retired due to high mileage and maintenance issues. Currently, Montana DAV deploys vans from 20 different locations throughout the state, and has identified four new locations in expansion planning, of which two vans will be based on Indian reservations.

The DAV Department of Montana continually seeks grants to support expanding the transportation program from its early days with only two privately own vehicles in 1988. Montana DAV approached the local transportation services coordinators for the state civilian transportation network, but found that no such grants were available to a program such as DAV's that was dedicated to the mission of transporting veterans to VA health care.

Montana DAV raises this issue in hopes that Congress would require DOT to change its regulations for the acceptance of grant requests from veterans service organizations to apply for grants that are designed to help veterans obtain VA services and gain access to VA medical appointments. The DAV National Organization takes no position on this request but passes it to the Committee as a matter of information. As this Committee is aware, the DAV National Organization does not accept Federal grants, nor do we encourage subordinate entities to accept Federal grants. In fact, we try to dissuade our Departments and chapters from applying for any federally appropriated dollars.

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 special-

ized 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 vouchering 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 facili-

ties 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 Committee 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, including 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.

Senator TESTER. Thank you, Mr. Atizado. I appreciate your testimony. There will be questions when we are done with the panel. Jim Ahrens?

STATEMENT OF JAMES F. AHRENS, CHAIRMAN, VETERANS RURAL HEALTH ADVISORY COMMITTEE, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. AHRENS. Thank you, Senator Tester and Members of the Committee. I am from Craig, MT, on the Missouri River. It is a

beautiful place, somewhat like Alaska—somewhat. It is my distinct honor to serve as the Chairman of the Veterans Rural Health Advisory Committee, and that is a committee of 16 people across the country who work specifically on rural issues. The committee recently finished a report and sent it to the Secretary. He is reviewing it and hopefully we will get it published fairly soon after the review through the Department.

Let me outline for you just four of the issues from the 13 recommendations we made. I would like to talk a little bit about those four issues and then give you some observations of what I think should be carried out by this Senate Committee and by the VA.

One of our recommendations is to—and you are going to hear a lot of this—pursue partnerships with State and Federal agencies and local health service providers to increase the enrollment of rural and highly-rural veterans and to broaden their understanding of VA benefits and their programs. It is interesting to me that all the veterans aren't enrolled. You can't run a program, or market a program, anyway, unless you know your customers, and we don't know where our customers are.

We need to ensure that access and continuity of care is facilitated as close to home as possible. I think this resonates well with the committee. This is something we really believe in.

The committee also recommended an implementation of an enterprise-wide system that facilitates the organization and scheduling of VA telehealth services. Veterans need to be able to get into the system easily and use the services. We need to deliver training programs at the local level to veterans and their families so that they understand what is going on and what services are available to them. I have a neighbor who was in the Korean War, never used the system at all, probably doesn't even know what is going on in the VA system. We need to let that person know what is happening.

Now I would like to share with you some of my own observations. I would be disingenuous if I said they are all my own. I have talked to a lot of people and they share these. These are not the recommendations of the Veterans Rural Health Advisory Committee or the VA, but these are things that people in the field are thinking about.

Obviously, there have got to be more services in places where veterans really live. You know, veterans—most of our disabled veterans, from our data, live in the South and the West. In the West, anyway, there are not a lot of services in some of the big areas. Senator Tester can tell you all about that from Montana.

We need to utilize more interactive telemedicine. They should focus on rural areas. In other words, recent legislation to create a tele-mental health program collaborative between the VA and critical access hospitals, well, that ought to be expanded. Private hospitals in Montana—every hospital in Montana has a telemedicine service, but the VA doesn't utilize that. Whether they can or can't, I don't know, but you could use it if you wanted to.

Van transportation networks need to be enhanced. Senator Tester and this Committee did a wonderful thing in increasing the mileage reimbursement. We ought to raise that to what the IRS al-

lows. And it should be, I think, given to all enrolled veterans, including those with other than service-connected disabilities.

Enhance and promote the Internet utilization of My HealtheVet for all enrollees.

Offer a secure VISTA, veterans health record, that providers in the community can use. I don't know how many times I have talked to local doctors who have somebody in their office who can't find out what is going on with that patient. Now, this is fraught with problems—HIPAA, confidentiality, and all that—but it can be done if we work at it.

Make the VA medical record available immediately to providers who see veterans in emergencies. You get somebody in an emergency room and can't even get their record. Perhaps these records could become available to hospitals and doctors by adding the staffing function to the 24-hour emergency suicide hotline which the VA runs. You could put somebody there and somehow or another some of that information could be given to the provider or to the hospital just to help the man or woman who is in an emergency situation.

I think we need to increase the availability of flexible scheduling at Community-Based Outpatient Clinics. Make it easier for the people to get into the system.

There should be a closer working relationship with the VA and Indian Health Service. It is starting, and we have got to do that. Well, you know the issues. There should also be more working relationships between the VA and other federally-funded health care organizations like Community Health Centers, Rural Health Clinics, Critical Access Hospitals, and smaller facilities.

Mental health services should be readily available to all veterans, especially those living in rural areas. TBI—in the West, there are no facilities, I don't think in Washington, either, or certainly not in our area to take care of these people. There are major areas, and this is a growing concern.

All veterans in the 7s and 8s should get enrolled in the VA medical system, and maybe they could take advantage of the drug program.

We need resources in local areas to educate people in the private sector and the VA so that they can work together and help solve these problems, because we have to be able to bring this collaborative effort together.

Mr. Chairman, I am out of time. I thank you for the opportunity to testify and I would be happy to answer questions at the right time.

[The prepared statement of Mr. Ahrens follows:]

PREPARED STATEMENT OF JAMES F. AHRENS, CHAIRMAN, VETERANS RURAL HEALTH ADVISORY COMMITTEE, CASCADE, MONTANA

Chairman Akaka and Members of the Senate Committee on Veteran's Affairs, It is my pleasure to testify before you today on behalf of veterans living in rural America.

I currently serve as Chairman of the Veterans Rural Health Advisory Committee. (VRHAC) The 16 members of the VRHAC are appointed by the Secretary of the VA. The mission of the Committee is to advise the Secretary on healthcare issues affecting enrolled veterans residing in rural areas.

I have been involved in the issues of improving health care to those residing in rural America for many years. While I was president of the Montana Hospital Association we developed and implemented the innovative Medical Assistance Facility

(MAF) health care delivery model. After ten years of demonstrating its effectiveness, the MAF then became the model for the Critical Access Hospital program. Today there are over 1300 Critical Access Hospitals (CAH's) in the United States. This innovative model of delivering health care has saved and maintained rural America's access to health care.

Access to VA health care services is a critical and growing issue for rural veterans. There is an increasing need for physical and mental health services to be delivered at local access points for the rural veteran. The VA needs to continue to explore and develop innovative ways to deliver these services.

This Committee is very familiar with issues that face Veterans nationwide and in particular veteran's health care access issues in rural areas. Because of your expertise I will not dwell on the problems, but will attempt to provide you with ideas and programs that will enhance the health care of veterans and improve the health care delivery systems in rural America.

Let me begin by enumerating the recommendations of the Veterans Rural Health Committee. These recommendations were recently provided to Secretary Shinseki. as part of the VRHAC's Annual Report to the Secretary. They are as follows:

1. Appoint a robust rural health executive and management team that demonstrates the requisite expertise, experience, leadership, vision, and dedication to addressing the needs of rural Veterans. Utilize contract staff to augment government personnel to ensure access to the broadest range of expertise possible.
2. Engage the VRHAC as a resource in refining the Rural Health Strategic Plan.
3. Initiate an internal outreach initiative to further institutionalize rural health concepts and programs within the VA.
4. Facilitate a formal dialog between the VRHAC and other VA advisory committees, as well as other significant Federal collaborating entities (e.g., Department of Defense and Department of Health and Human Services, Office of Rural Health Policy, et al.).
5. Pursue partnerships with state and Federal agencies and local health service providers to increase enrollment of rural and highly rural Veterans and to broaden their understanding of VA benefits and programs.
6. Ensure that access and continuity of care is facilitated as close to home as possible for rural Veterans through delivery of services at VA facilities or through contracted partnerships for primary care and ancillary health services.
7. Reconsider existing VA cost metrics that may act as disincentives for expansion of care into rural and highly rural communities.
8. Leverage the National Health Information Network (NHIN) platform to demonstrate practical, legal, and sustainable health information exchanges in partnerships with non-VA physician practices, community health centers, and other relevant providers in rural areas.
9. Implement an enterprise-wide system that facilities the organization and scheduling of VA Telehealth services.
10. Develop services that leverage mobile phones and the cell phone infrastructure to enhance patient-provider health communications, address health care priorities, and improve efficiency across the VA health system.
11. Conduct studies of rural and highly rural enrolled and non-enrolled Veterans to determine their number, demographics, locations, and unmet health need with a focus on the efficacy of primary care, mental health, and physical rehabilitation services organized through small regional rural facilities.
12. Consistently and proactively deliver training to rural providers serving Veterans and their families with the specific focus on post-deployment health and mental health needs of rural Veterans.
13. In all recruitment and retention efforts for health professionals to serve Veterans in rural and highly rural areas, engage in models of collaboration that add to and to not reduce overall access, comprehensiveness, and sustainability of health services in rural communities.

These recommendations were provided to the Secretary after careful consideration and hours of discussion.

I would now like to share with you some personal recommendations for improving VA rural health care. Let me point that the term "personal" should be taken lightly.

These suggestions are an amalgam of the thoughts of many. Some of these recommendations are similar to the VRHAC recommendations.

1. There should be more health care services in places where Veterans actually live in rural America. 2008 VA enrollment data indicates that most of our rural and highly rural Veterans are in VISNs in the Midwest. Most of our disabled Veterans and many rural Veterans live in the South and the West. This information is included the VRHAC report to the VA Secretary.

2. The VA should utilize more interactive Telemedicine. These expanded Telemedicine activities should focus on rural areas. The recent legislation creating the pilot rural tele-mental health program collaborative between the VA and rural Critical Access Hospitals (CAH's) is a great start. More effort is needed to build upon the existing Telehealth systems located in either civilian rural health facilities or VA facilities.

3. Van transportation networks should be enhanced.

4. The mileage reimbursement rate should be equal to the IRS payment which currently is fifty cents per mile. Consideration should be given to expanding this reimbursement to all enrolled Veterans, including others than those with service-connected disabilities. This would be especially helpful in recruiting friends as drivers for VA patients who can't drive or who can't return home immediately after treatment because of medical issues, e.g. sedation.

5. Enhance and promote the internet utilization of "My HealtheVet" by all possible enrollees.

6. Offer a secure version of VISTA (The Veterans Health Information Systems and Technology Architecture) medical records package to rural practitioners who see Veterans.

7. Make this VA medical record available immediately to providers, who see veterans in Emergencies. Perhaps these records could become available to hospitals and doctors by adding a staffing function to the twenty four hour emergency suicide hotline. The Committee might consider an amendment to Federal HIPPA Privacy regulations in order to make this happen

8. Increase the availability of flexible scheduling at Community Based Outpatient Clinics (CBOCS). The VA should make provisions allowing local health care practitioners to provide care one or two days a month at the those CBOC's. Rural Veterans appreciate the expansion of CBOC's in rural areas; however care should be taken not to recruit critically needed physicians, mental health providers and other allied health personnel away from existing providers in order to staff these clinics. If a Veteran gains close access to a primary care provider but his family loses access to their primary care provider, the Veteran's burden may increase.

9. There should a closer working relationship between the VA and the Indian Health Service. This relationship is working well in some limited areas, but needs to be expanded. Working relationships should be nurtured between the VA and other federally funded rural health care organizations such as Community Health Centers, CAH's, and Rural Health Clinics etc. The standards of care for Federal programs should be operational and respected across all Federal programs designed to improve the health care for Veterans and others served by such programs.

10. Mental health services should be readily available to all veterans especially those living in rural communities.

11. All Veterans, including 7's and 8's, should be enrolled in the VA medical system.

12. A new and sustained effort is needed to bridge the services of the VA and private rural health care systems. Resources are needed to educate rural health care providers on how to work within each other's systems and cultures. Rural providers need help in learning how to navigate through the VA and the VA needs more information on the quality of care delivered by rural providers. The VA should continue to utilize physicians and other providers through contracts and fee for service arrangements, however this arrangement should be expanded to include ancillary services. There is no reason for a Veteran to be seen in a CBOC for routine care and then be required to drive 1 to 2 hours to another VA facility for an MRI when the MRI service is available in a community facility in the same town where the initial services were rendered.

Mr. Chairman and Members of the Committee, I want to thank you for the opportunity to make these points. I hope that by working together we can assist in providing quality health care services to our Veterans living in rural areas. I would be happy to address any questions that you might have at the appropriate time.

Senator TESTER. I appreciate your comments and recommendations.

Mr. Putnam?

STATEMENT OF RONALD PUTNAM, VETERAN SERVICE OFFICER, HAYWOOD COUNTY, NORTH CAROLINA

Mr. PUTNAM. Good morning, Senator Tester and Members of the Committee. I appreciate the opportunity to come here and testify.

I would first like to let everyone know I am a County Service Officer. I see veterans every day and assist them in filing for their benefits, both health and other benefits, from the Veterans Administration.

Haywood County is a remote county in the western part of North Carolina, 200 square miles. It doesn't compete with Alaska and Montana, but we are still rural. My county has 57,000 citizens and 7,000 of those citizens are veterans.

I would like to report today on my colleagues that work in North Carolina, the other County Service Officers. I want to report to this Committee that the VA medical centers in North Carolina are all out in the community and starting to work with these rural teams. Not all the teams are fully staffed. The team out of the Charles George VA medical center in Asheville that I am working closely with still lacks a social worker. However, I want to applaud the VA on actually coming out and collaborating with the County Service Officers, the State Service Officers, and the other veterans associations to see where it is they need to go to find these veterans that are not receiving VA health care and have not applied.

Second, I would like to bring up that in rural America, all over rural America, I speak—I am also on the National Service Officers Committee and a chairman of one of their committees—across America, we face a generation that is quickly passing: our World War II and Korean War veterans. Just to shed a little in-light on the people that the VA is trying to reach with 21st century technology, just this past year, I handled a claim for a veteran in Haywood County and the gentleman had a second grade education. North Carolina provides an opportunity for veterans to apply for a high school diploma from the Governor if they had joined the service during wartime and served. So, in the past 2 years I have made application for eight individuals and the highest education level of those eight individuals was a seventh grade education.

These men live in remote, small, mountainous, rural communities. They don't go anywhere except to church and to the local feed store. These men find out about things from the newspaper and if their preacher tells them on Sunday morning. They also find out from other individuals. I feel that this social disconnect and the time that these individuals were brought up in history makes it very difficult for the Veterans Administration to reach without personal intervention.

Once again, I do applaud the VA for working closely with county, State, and other Service Officers across the Nation because we are the front line of the VA. We are funded by local Governments and this Committee.

I would like to bring up one bill that is in this Committee, H.R. 3949, an outreach bill. I would like this Committee to consider it strongly because that bill and those funds would enable the Service Officers across the Nation to help the VA to reach these individuals.

I would like to let you know that the team working out of the Charles George VA medical center in my area have already been in the field. They came out this past weekend to two National Guard units and set up shop there. I can't say enough about how it started. It is getting results on the ground. It is beginning to

work. It is kind of scaring me because it is actually making sense and they are actually talking to the people they need to be talking to.

I would just hope that this Committee and this Congress and this Administration continues to fund that. As my colleagues here have already mentioned, there are quite a few veterans that are going to be around a long time—Vietnam-era veterans, Gulf War veterans—that are going to be with us for some time; they are not going away and they are not going to move to town. So we are going to have to go out there and find them.

I appreciate this opportunity again, and I will be willing to take any questions that you have. Thank you very much.

[The prepared statement of Mr. Putnam follows:]

PREPARED STATEMENT OF RONALD PUTNAM, VETERAN SERVICE OFFICER, HAYWOOD COUNTY, NORTH CAROLINA

INTRODUCTION

This is the testimony of Ronald L. Putnam for the Senate Committee on Veterans Affairs on Rural Outreach for Veterans, June 16, 2010. I would like to thank the Chairman and ranking member and Members of this Committee for the opportunity to speak on Rural Outreach and to introduce myself.

My name is Ronald L. Putnam; I am the Haywood County Veteran Service Officer and the Director of Veterans Services in Haywood County, North Carolina. I served in the United States Marine Corps, the North Carolina Army National Guard, Army Reserve, and the North Carolina Air National Guard, and I retired from the North Carolina Air National Guard with a total of twenty four years of service. During my eleven years of active service with the Marine Corps, I served in combat in Beirut, Lebanon. I served during the first Gulf War as a Marine Corps Recruiter in Hickory, North Carolina. I was also called to Active Duty twice in support of Operation Noble Eagle while a member of the North Carolina Air National Guard. I am a member of the North Carolina Association of County Veteran's Officers; I am on The Executive Board, The Education Committee and The Legislative Committee of that association. I am also a member of The National Association of County Veterans Service Officers and I am the Chairman of the Washington Liaison Committee of that association. I am also a member of several national veteran organizations. I would like the Chairman and the Members of this Committee to know that I am honored to testify today and that I also think that it is my duty to do so, to the best of my ability.

BACKGROUND

As the United States developed into a viable country in our distant past, most of the country remained rural in nature with a few population centers. This is particularly true in a large part of the United States, but applies equally throughout our great Nation. The population centers developed into cities which, through their very nature, provide many services to their citizens. This is not unlike the Veterans Administration and their benefits delivery mission. Those who live in the population centers or cities are available to receive their benefits due to their close proximity to the service centers.

Realistically, it is not acceptable to require all of our Nation's veterans to live in population centers if they wish to utilize the earned services and benefits that their military service has afforded them. The Department of Veterans Affairs recognized this issue early on and began developing Regional Offices and Medical Centers throughout the Nation. Again, these were developed primarily in the population centers and those residing in rural America did not have the same benefit as those living nearer to the services being offered.

As our Nation entered into one conflict and war after another, the population of veterans surged to historic levels and veteran benefits grew at the same time. After the end of World War II, many local governments took it upon themselves to develop veteran services at the State and County level. This was a good solution in some respects, but many local governments do not have funding mechanisms in place that can assist in paying for local services to veterans.

In the late 1970's, many local governments throughout the country went through tax revolts which severely limited available funding for discretionary spending.

Rural America suffers more in poor budget years due to the lack of overall funding for services. Sadly, many local agencies view veteran services as a discretionary budget item. This resulted in many offices being consolidated into other governmental offices or eliminated completely; a sad commentary indeed.

Many veterans, particularly combat veterans, choose to live in rural, even remote areas. The experiences they lived through during their military service have left many of them with a sense of anger and inability to deal with other people. The rural areas of our country have become a sanctuary for many veterans who suffer from Post Traumatic Stress Disorder and other service-connected disabilities which adversely affect the veterans. Outreach has been frequently referred to as a solution to the problem.

Regardless of budget shortfalls and consolidation of services, many viable local veteran services operations have survived over the years. They remain in place and stand ready to assist the Federal Government in benefits delivery and claims management.

SOLUTIONS

The National Association of County Veterans Service Officers is an organization made up of local government employees. Our members work for the local government offices and are tasked with assisting veterans in developing and processing their claims. County Veterans Service Offices exist to serve veterans and partner with State Veterans Service Offices, the National Service Organizations and the Department of Veterans Affairs to serve veterans. The National Association of County Veterans Service Officers views the local County Veterans Service Officer as an extension or arm of government, not unlike the VA itself.

If outreach has been referred to as a possible solution to the problem of bringing the veterans into the VA system of care, then NACVSO is a realistic solution to this problem. We live and work with the veterans of our Nation every day. We are there in the communities.

Our member County Veteran Service Officers are present in 37 of our 50 states and located in over 700 local communities. This readily available workforce represents approximately 2,400 full-time employees who are available to partner with Department of Veterans Affairs, Department of Defense and the Department of Labor to help speed the process of claims development and transition of our military personnel to civilian life.

Unfortunately, many of the County Offices in the rural areas have had severe financial problems in maintaining their offices. If the Veterans Administration is looking to develop outreach into the local communities, it only makes sense to look toward developing a closer relationship with local government at the state and county level. This could help solve the financial problems of the county offices and at the same time use the states to ensure compliance with proper use of funding and oversight for fund disbursement.

RECOMMENDATIONS

There have been efforts in play to assist the rural veterans improve their access to Veterans Administration benefits. Some have involved legislation. Many bills have been introduced both in the Senate and the House of Representative to establish outreach programs in most areas of the country. With the passing of public law 109–461 and 111–163 and your support for H.R. 3949 which is in this Senate committee would provide for funding to Rural County Veterans Service Offices to enhance outreach efforts throughout the Nation that would greatly enhance the efforts of local county and state veteran officials throughout the country.

The National Association of County Veterans Service Officers strongly encourages you to support this and other veteran outreach bills. The veterans who live out in our communities and their dependents well being, depends on your support.

ACCOMPLISHMENTS

I would like to report on the VA Rural Health Initiative in my county. The Public Affairs Officer for VA Rural Health Initiative at Charles George VAMC in Asheville N.C. Scott Pittillo has visited me on several occasions to talk about the objective of his departments' goal of reaching rural Veterans with education about VA Health Care services. We have talked about ideas to work together with other Veterans service officers and Veterans organizations to help reach the rural veterans in Western North Carolina. Although his team is just getting started it is very encouraging to me to see this kind of cooperation between the VA and local Veterans representatives.

SUMMARY

Although, the objective of the rural health incentive is to reach rural veterans about their VA Health Care Benefits that they are eligible for and greatly deserve is a common goal for the VA and all State, County and National Service Organizations veteran service officer to work together in achieving this goal we invite this administration and Congress to join with us in support of our efforts to reach these unique Veterans. Although a lot of the VA's current efforts to communicate more closely with veterans by utilizing, modern media, and technology, I want to remind both this Committee and the Veterans Administration that their still a number of WWII, Korea, and Vietnam veterans that have unique education deficiencies and social disconnects, that make it extremely hard to receive the information that is being presented on these twenty-first century medians. I will remind this Committee, the Veterans Administration, and all my colleagues, that the best communication with these veterans is face to face interaction with someone who is knowledgeable, well trained, and willing to assist these men and women that we owe such indebtedness to. Thank you for your attention to these matters. God bless this Committee and the United States of American.

Senator TESTER. Thank you, Mr. Putnam. I appreciate your comments.

Dr. Jesse?

STATEMENT OF ROBERT JESSE, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GLEN W. GRIPPEN, NETWORK DIRECTOR, VETERANS INTEGRATED NETWORK 19

Dr. JESSE. Yes. Good morning, Senator Tester, Members of the Committee, and our apologies for the lateness of our testimony. I am happy to have the opportunity to present to you today.

I would like to thank you for inviting us here today to discuss the current state of VA's care and service for our veterans in rural areas and specifically in VISNs 19 and 20. I am accompanied today on this panel by Mr. Glen Grippen, the Network Director for the Rocky Mountain Network, which is VISN 19, and on the next panel by Mr. William Schoenhard, who is the Deputy Under Secretary for Operations and Management.

Increasing access for veterans is one of Secretary Shinseki's top priorities. This means bringing care closer to home, increasing the quality of care that we deliver, and providing veteran-centered care in a time and manner that is convenient to our veterans.

My written testimony covers in great detail VA's national efforts to improve access, quality, and coordination of care for our rural veterans, as well as specific initiatives in VISN 19 and 20 that directly relate to our rural veterans.

In the time I have now, I would just like to highlight the broader work VA is doing for the veterans in rural America. VA offers a number of important programs designed specifically to increase access to veterans living in rural areas. VA has planned and funded more than 350 projects, actually getting close to 400 at this point, projects and initiatives to help improve access for rural veterans. Our efforts have supported many successful projects, including new facilities, home-based primary care mobile health resources, telehealth, and many other local initiatives.

Telehealth is one of the major mechanisms by which VA is increasing access to health care for veterans in rural areas. All together, there are between 30 and 50 percent of telehealth activity in VA supports veterans in rural areas, and data from fiscal year

2009 show ongoing growth in all these areas of telehealth, and as was mentioned, there is a robust increase in the budget to cover that activity.

Another key element of VA's strategy for improving services for veterans in rural areas is a new model of care. VA is undertaking probably the most significant change in its model of care delivery since the rapid expansion in the CBOCs beginning back in the 1990s, and in many ways, this new approach is a continuation of the same strategy VA has always pursued, bringing care closer to veterans and making care more accessible.

We are redesigning our systems around the needs of our patients, improving care coordination and virtual access through secure messaging, social networking, telehelp, and telephone access. An essential component of this approach is transforming our primary care programs to increase the focus on health promotion, disease prevention, and chronic disease management through multidisciplinary teams.

Concerning Montana, VA's Rocky Mountain Network, VISN 19, actively works to enhance the delivery of health care to veterans in rural areas in the Rocky Mountain Region. VA understands that veterans and others who reside in VISN 19's rural and frontier areas face a number of challenges associated with obtaining health care, including geography, but also weather and terrain. For example, VISN 19 is supporting four projects made possible by the Office of Rural Health that harness technology and improve access and quality. VISN 19 received $7.3 million from the ORH to develop ten primary care telehealth outreach clinics that will serve more than 7,000 veterans, and the VA Rocky Mountain Network received four grants totaling $1.4 million to support non-institutional care for veterans in that area.

Turning to Alaska, much is happening in VISN 20 to support veterans in rural areas. The Alaska VA Health Care System has recently opened or will soon open three clinics, Mat-Su CBOC in Wasilla, the Homer Outreach Clinic, and the Juneau Outreach Clinic, which is currently operating part-time in temporary space and will be moved to a permanent space later this fall.

Alaska VA has also been conducting a project focusing on collaborations with existing Alaska Native Tribal Health Corporation facilities and federally-supported Community Health Centers to provide primary care and mental health services to Alaska's veterans. VA continues to work to improve the quality and access of services for this important population.

I would like to thank you all again for the opportunity to discuss VA's programs for veterans in rural areas. Again, this is a priority for the Secretary and VA is bringing to bear all of its resources to ensure that every veteran can access the care he or she has earned through their service in uniform.

This concludes my prepared statement and my staff and I look forward to answering your questions. Thank you.

[The prepared statement of Dr. Jesse follows:]

PREPARED STATEMENT OF ROBERT JESSE, M.D., PH.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good Morning, Mr. Chairman and Members of the Committee. Thank you for inviting me here today to discuss the current state of the Department of Veterans Affairs (VA) care and services for our Veterans in rural areas, specifically in Veterans Integrated Service Networks (VISN) 19 and 20. I am accompanied today by Mr. William Schoenhard, Deputy Under Secretary for Operations and Management; and Mr. Glen Grippen, Network Director for the Rocky Mountain Network (VISN 19).

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 of the care we deliver; and it means providing Veteran-centered care in a time and manner that is convenient to our Veterans. This is the obligation we have, inspired by the service and sacrifice our Veterans have made on behalf of this Nation.

My testimony will discuss VA's national efforts to improve the access, quality, and coordination of care for our rural Veterans, then detail specific initiatives in VISN 19 and VISN 20 that directly relate to our rural Veterans.

NATIONAL PROGRAMS

VA offers a number of important programs designed specifically to increase access for our Veterans living in rural and highly rural areas. While the Office of Rural Health (ORH) oversees and administers many of these critical efforts, VA also uses telehealth as one method of improving accessibility for these Veterans. VA is also developing and instituting a revolutionary new model of care that will assist all Veterans, not just rural Veterans, by providing an even more Veteran-centric approach to health care. Moreover, the pilot required by Public Law 110–387 section 403 is specially designed to improve the quality and availability of contracted care in rural areas when a VA medical facility is just too far away.

OFFICE OF RURAL HEALTH INITIATIVES

Since it was established in 2008, the Office of Rural Health (ORH) has worked to address the significant challenge of serving our Veterans in rural areas. VA has planned and funded more than 350 projects and initiatives to address these concerns. Our efforts have supported many successful projects including: institutional physical expansion in the form of new community-based outpatient clinics (CBOC) and outreach clinics; home-based primary care; mobile health care resources; and many other local initiatives.

CBOCs offer Veterans a full array of exceptional VA services, including primary care, mental health care, and in some instances, VA will arrange specialty care services in communities where Veterans live and work. In FY 2008, ORH established 10 outreach clinics in rural areas for our Veterans, followed by an additional 30 outreach clinics in FY 2009. These are part-time clinics that extend access to VA's primary care and mental health services where there is less patient demand, or for other reasons it is otherwise not feasible to establish a full-time CBOC. These outreach clinics are required to collaborate with the local community to support the continuum of care and can be either VA-staffed or contracted to a local provider.

ORH has continued to support the expansion of the innovative program of home-based primary care teams, funding 38 Teams, 14 of which involve collaboration with the Indian Health Service or Tribal Organizations. Overall, 30 teams are operational and 8 are still hiring staff to deliver these benefits to our Veterans. These highly-skilled medical teams provide comprehensive health care right in the home of our Veterans with multiple chronic conditions, conditions that would normally preclude a Veteran from being able to visit a VA clinic. Rural Mobile Health Care Clinics are now operational in VISNs 1, 4, 19 and 20. These Clinics extend access to primary care and mental health services in rural areas where it is not feasible to establish a permanent clinic or hospital. They also offer for our Veterans ongoing coordination of overall medical care, wellness promotion and immunizations, health screening, referrals to specialty clinics, individual counseling, and other important services. Through the end of the first quarter of FY 2010, these clinics had seen 236 (VISN 1), 104 (VISN 4), 143 (VISN 19), and 123 (VISN 20) unique Veterans, respectively. The VISN 19 Mobile Clinic is based out of the Cheyenne VA Medical Center (VAMC) and it conducted its first visit on August 25, 2009, in Sterling, CO. It regularly visits Laramie, Wheatland and Torrington, WY. The Mobile Telehealth Clinic is staffed with VA health technicians and nurses providing onsite care to our Vet-

erans and has a secure tele-video connection with the Cheyenne VAMC. This ensures Veterans receive the care they have earned through their service in their community; in essence, we're bringing VA to Veterans.

Rural Health Resource Centers (RHRC) provide an essential resource that helps VA study what is important for rural Veterans, test new programs, and educate rural Veterans with the latest information. There are three RHRCs across the country, with the Western Rural Health Resource Center located in VISN 19's VA Salt Lake City Health Care System in Salt Lake City, UT. These Centers perform policy analyses, design pilot projects, develop collaborations with a range of partners (such as the Indian Health Service, Tribal Organizations, and academic affiliates, to name a few), and provide education and updates to health care providers and Veterans on how VA can better deliver high quality, accessible health care to rural Veterans. Some focus on specific populations of Veterans; for example, the Western Region RHRC is focusing on Geriatric and Native Veteran populations.

VA has also established a dedicated Rural Consultant for each VISN who enhances the delivery of health care to Veterans in rural areas and leads activities to build an ORH Community of Practice, promoting information exchanges and learning within and across VISNs and supporting a stronger link between ORH and the VISNs.

The mission of the Veterans Rural Health Advisory Committee is to examine outstanding issues and recommend ways VA and its team can improve medical services for enrolled Veterans who live in rural areas. The Committee developed a set of guiding principles which they have recommended to the Secretary for consideration in developing rural health policy. The Committee represents a broad cross section of Veterans and rural health care providers and advocates.

TELEHEALTH

Telehealth is another mechanism by which VA is increasing access to health care for Veterans in rural areas. All together, between 30 and 50 percent of telehealth activity in VA supports Veterans in rural and highly rural areas, depending upon the area of telehealth. Data from FY 2009 show ongoing growth in all areas of telehealth.

Telehealth involves the use of information and telecommunication technologies as a tool in providing health care services when the patient and practitioner are separated by geographic distance. VA has three robust national telehealth platforms in place to support expanded health care access for Veterans through telehealth at the VISN, facility and CBOC level. These platforms are: real-time video conferencing, store-and-forward telehealth, and home telehealth, which are discussed in greater detail below. Because of the support of telehealth by VA and Congressional leadership, more Veterans are able to realize their benefits. Telehealth provides health care to underserved rural areas and involves 35 clinical specialties in VA.

Over the past 6 years, telehealth in VA has transitioned from use in a range of discrete local projects and programs toward a unified, enterprise level approach that provides routine telehealth services that are mission critical to the delivery of care to Veterans. VA has long been acknowledged as a national leader in developing effective and sustainable telehealth programs that increase access to care. VA's senior leadership, at both the national and VISN level, are committed to the expansion of telehealth to enhance access to care for Veteran patients, especially in rural and remote locations.

The importance of the systems approach VA is taking to its ongoing telehealth development is that the health care assets that are needed to provide care in rural areas exist in urban areas, and VA can leverage its clinical assets through a large interoperable telehealth network to support care locally. It is important to emphasize that although telehealth increases access to care, there remains an obligate need for face-to-face delivery of care. An appropriate balance of both "physical" and "virtual" clinical services is needed to provide comprehensive health care to meet the needs of Veterans, including Veterans in rural areas.

The successful implementation of robust and sustainable telehealth services that VA entrusts to provide care to Veteran patients must satisfy stringent clinical, technological and business requirements that ensure they are appropriate, responsive to the needs of Veterans, and cost-effective. These requirements include acceptance by patients and practitioners as well as staff training and quality management systems. To make sure we deliver safe and effective care, VA has introduced quality management programs for CCHT, Clinical Video Telehealth (CVT) and care coordination store-and-forward (CCSF). In FY 2009, these quality management programs were combined for all three areas of telehealth to create a single assessment process in which the policies and procedures of telehealth programs are assessed biannually

in each VISN. In addition, VA collects routine outcomes data for program management purposes. These systems allow us to quantify, validate and monitor the clinical benefits of these approaches.

VA provided real-time video-conferencing, also known as CVT, to more than 37,000 Veterans in rural and highly rural areas in FY 2008. Of these, 2,030 Veterans from rural areas served in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) and 112 OEF/OIF Veterans lived in highly rural areas.

The majority of CVT services were for mental health conditions, but Veterans also receive rehabilitation, speech pathology, polytrauma and spinal cord injury care. Ensuring VA is responsive to the needs of our Veterans and making mental health care accessible is a top priority for VA. In FY 2009, 21,603 Veterans received tele-mental health services in rural areas and 1,600 in highly rural areas. CVT services were available to Veterans at 250 sites in rural or highly rural areas. Moreover, VA is establishing a National Tele-Mental Health Center. This Center will coordinate tele-mental health services nationally with an emphasis on making specialist mental health services, such as those for Post Traumatic Stress Disorder (PTSD) and bipolar disorder, available in rural areas.

Store-and-forward telehealth, known as CCSF, involves the acquisition and interpretation of clinical images for screening, assessment, diagnosis and management. These images can include photographs, x-rays, MRI results, and retinal scans, for example. These services were provided to 61,776 Veterans in rural areas and 2,911 in highly rural areas during FY 2008. In FY 2009, this workload increased by 86 percent. CCSF services were predominantly delivered to screen diabetic eye disease (tele-retinal imaging) and prevent avoidable blindness in Veterans. Last fiscal year, VA offered tele-retinal screening services at 283 sites, 78 of which were in rural or highly rural areas, and today, VA has 310 participating sites, 84 in rural or highly rural areas. The remainder of CCSF activity primarily covered tele-dermatology. VA set a goal of a 20 percent increase in use in FY 2010, and just as with CVT, VA is on pace to meet that objective. VA also has a pilot program underway to expand nationally for tele-dermatology in five VISNs in 35 sites, 20 of which are in rural areas.

Every Veteran wants to live as independently as possible, but sometimes health conditions mean this cannot be done safely. To help Veterans continue living in their own homes and local communities, VA provides home telehealth services, known as CCHT. CCHT covers a range of chronic conditions including diabetes, chronic heart failure, hypertension and depression. Currently, 41,000 Veterans receive CCHT for non-institutional care, chronic care management, acute care management and health promotion or disease prevention. Thirty-eight (38) percent of these patients are in rural areas and two percent are in highly rural areas.

Concerning specialty care, VA has home telehealth programs in 140 VA medical centers that enable 41,000 Veteran patients to remain living independently in their own homes. These programs are particularly applicable for the management of chronic disease and non-institutional care. Forty (40) percent of home telehealth patients are in rural and remote locations. Using funding in FY 2009, VA increased the delivery of care via home telehealth to Veteran patients in rural and remote locations by 19 percent and is seeking to achieve a further increase of 20 percent in FY 2010.

VA continues to optimize its Polytrauma Telehealth Network to facilitate provider-to-provider and provider-to-family coordination, as well as consultation from Polytrauma Rehabilitation Centers and Network Sites to other providers and facilities. Currently, about 30 to 40 videoconference calls are made monthly across the Network Sites to VA and DOD facilities. New Polytrauma Telehealth Network initiatives in development include home buddy systems to maintain contact with patients with mild Traumatic Brain Injury (TBI) or amputation, and remote delivery of speech therapy services to Veterans in rural areas.

VA is undertaking a range of initiatives to expand access to telehealth services in rural and highly rural areas. These initiatives focus on the clinical, technological and business processes that are the foundation for the safe, effective and cost-effective implementation of telehealth in VA to support Veteran care. For example, VA is working to formalize the clinical processes necessary to use telehealth to support the 41,096 Veterans with amputations receiving care from VA. Telehealth enhances access to care in rural areas as close to Veterans' homes and local communities as possible, if the Veteran wishes to use the services. We are also working to implement CVT services to make specialist care more widely available, including in rural areas. VA recently completed the necessary work to implement its Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) program within CCHT programs. This development will expand the reach of this successful and groundbreaking program for weight management to Veterans in rural and highly

rural areas. We have also completed a program for supporting Veterans with substance abuse issues via home telehealth available during FY 2009.

NEW MODEL OF CARE—MOVING FORWARD

One key element of VA's strategy for improving services for Veterans in rural and highly rural areas is a new model of care. VA is undertaking the most significant change in its model of care delivery since the rapid expansion of CBOCs began in the 1990s. In many ways, this new approach is a continuation of the same strategy VA has always pursued: bringing care closer to Veterans and making care more accessible.

To support this effort, VA has joined the Patient-Centered Primary Care Collaborative, a national coalition of other public and private sector members to improve primary care. We are redesigning our systems around the needs of our patients, improving care coordination and virtual access through enhanced secure messaging, social networking, telehealth, and telephone access. An essential component of this approach is transforming our primary care programs to increase our focus on health promotion, disease prevention, and chronic disease management through multidisciplinary teams. These changes will focus on improving the experience patients and their families have when seeking care from VA. We will benchmark with private sector organizations such as Kaiser-Permanente. We intend to seek patient input to help guide this transformation.

The President's FY 2011 budget submission describes this model in greater detail. The VA Tele-health and Home Care Model initiative will use technology to remove barriers to Veterans and increase access to VA services. This initiative will enable VA to become a national leader in transforming primary care services to a medical home model of health care delivery that improves patient satisfaction, clinical quality, safety and efficiencies. VA Tele-health and Home Care Model will develop a new generation of communication tools (i.e. social networking, micro-blogging, text messaging, and self management groups) that can be used to disseminate and collect information related to health, benefits and other VA services.

The Veteran-Centered Care Model will improve health outcomes and the care experience for Veterans and their families. The model will standardize health care policies, practices and infrastructure to consistently prioritize Veterans' health care over any other factor without increasing cost or adversely affecting the quality of care. VA looks forward to working with Congress to ensure these plans become a reality for Veterans of all eras across the country.

PUBLIC LAW 110–387, SECTION 403 PILOT PROGRAM

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 Pub. L. 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 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 exception" and the mileage standard.

VISN 19 INITIATIVES

VA's Rocky Mountain Network (VISN 19) actively works to enhance the delivery of health care to Veterans in rural and highly rural areas in the Rocky Mountain region. VA understands that Veterans and others who reside in VISN 19's rural and frontier areas face a number of challenges associated with obtaining health care, such as geography, weather, and terrain. VISN 19 is pursuing a range of initiatives to share the expertise and experience of the entire VA system with these Veterans.

For example, VISN 19 is supporting four projects made possible by VA's Office of Rural Health (ORH) that harness technology to improve access and quality. VISN 19 received $7.3 million from ORH to develop 10 Primary Care Telehealth Outreach Clinics that will serve more than 7,000 Veterans in Glenwood Springs and Salida, Colorado; Hamilton and Plentywood, Montana; Idaho Falls, Idaho; Moab and Price, Utah; and Evanston, Rawlins and Worland, Wyoming. All of these clinics will be established by the end of 2010. VISN 19 also received $2.8 million to develop an innovative virtual Intensive Care Unit (ICU) and Rapid Response Team monitoring system with video conferencing; the virtual ICU is operational and successfully maintaining access to critical care services in Fort Harrison, MT, Grand Junction, CO, and Cheyenne, WY. VISN 19 received another $3.8 million to establish a VISN Telehealth Care Shared Resource System to provide expanded specialty care conferencing and consultation for care providers and Veterans in rural areas. Some of the disciplines or conditions included are endocrinology, Traumatic Brain Injury (TBI), cognitive impairment services, pain management, dementia, Post Traumatic Stress Disorder (PTSD), dermatology, rehabilitation and wound care, cardiology, and pre- and post-surgery care. This project is also exploring the feasibility of expanding services to non-VA telehealth networks. Finally, VISN 19 received $1.7 million to provide innovative education and wellness strategies to Veterans in rural areas using primarily telehealth modalities. The program will deliver intensive case management and education to Veterans with high-risk conditions, such as TBI, PTSD, depression, obesity, heart failure, diabetes, pulmonary disease, and substance use disorders.

VISN 19 also utilizes rural outreach clinics to offer services on a part-time basis, usually a few days a week, in rural and highly rural areas where there is not sufficient demand for full-time services or it is otherwise not feasible to establish a full-time CBOC. There are currently six designated outreach clinics in VISN 19: Havre, MT; Burlington, CO; Craig, CO; Elko, NV; Afton, WY; and Logan, UT which were recently approved and funded.

With regard to specialty care for our Veterans, the VA Rocky Mountain Network received four grants totaling $1.4 million to support non-institutional care for Veterans. These resources have helped us expand the home-based primary care and medical foster home programs to more Veterans in the region, preserving their independence while providing them the safe and effective care they need. VISN 19 is also home to the Mental Health Care Intensive Care Management-Rural Access Network for Growth Enhancement (MHICM-RANGE) Initiative, which has added mental health staff to CBOCs and increased the use of tele-mental health services. Similarly, VISN 19 has conducted outreach and developed relationships with the Indian Health Service, as well as other agencies and academic institutions committed to serving rural areas.

Other efforts specific to Montana include:

• A $6.7 million contract for construction of a 24 bed inpatient mental health facility at the VA Montana Healthcare System. This expansion will provide Veterans residential rehabilitation in substance abuse and PTSD in Montana. Currently, Montana Veterans needing these longer stay programs are required to travel to VA facilities in North Dakota, Wyoming, or Idaho.

• A pair of grants totaling $707,172 to partner with a private company, Billings Clinic, to pilot Programs of All-Inclusive Care for the Elderly (PACE) services for

Montana Veterans in Yellowstone County and Livingston, Montana. PACE provides community-based care and services to frail, elderly individuals as an alternative to institutional nursing home placement, and provides all health care and related services to participants over time and across all delivery settings. VA Montana plans to serve 15 Veterans through the PACE program.

• A part of the grant previously mentioned for a Home-Based Primary Care Team to provide the maximum of in-home care to rural and frontier Montana Veterans with complex medical conditions. The Team provides assistance to caregivers supporting concerns with housing and financial issues, and helps improve home safety and fall prevention, which maximizes the independence of the Veterans. VA Montana plans to serve 25–30 patients in the HBPC program.

• An $818,506 rural health eye care project in the Missoula and Bozeman Montana CBOCs. Each site will utilize Tele-retinal Equipment to connect providers at the site with locations throughout the VA Montana HCS. In addition, VA Montana proposes to rent surgical space as needed, along with support staff for a VA ophthalmologist to perform eye surgeries (cataract removal) in Bozeman, MT at a local contract surgical site. This site will provide support to VA locations in Eastern Montana including Billings, Miles City, Glasgow, Glendive, Lewistown, Havre, as well as Western Montana in Missoula, Kalispell, Cut Bank and Hamilton. We expect services will be available at the Missoula and Bozeman CBOCs by the end of August 2010.

VISN 20 INITIATIVES

Much is happening in VISN 20 to support Veterans in rural areas, particularly in Alaska. The Alaska VA Healthcare System (Alaska VA) has recently opened, or will soon open, three clinics: the Mat-Su CBOC in Wasilla opened in April 2009; the Homer Outreach Clinic, opened in December 2009; and the Juneau Outreach clinic, which is currently operating part-time in temporary space in the U.S. Coast Guard Clinic, Juneau Federal Building, and will be moved to a permanent space later this fall after renovations on the first floor of the Federal building are complete.

In the area of telehealth, VISN 20 has implemented a tele-dermatology consultation system using store-and-forward technology and a consistent, defined curriculum of basic training and continuing education for primary care providers. This program has been implemented in Anchorage and has expanded to the clinics in Fairbanks and Kenai during FY 2010. The Kenai CBOC recently received funding to obtain tele-retinal imaging equipment and has begun offering this service, which particularly benefits Veterans with diabetes. VISN 20 also has adopted care coordination home telehealth (CCHT) programs; in Alaska, 220 Veterans have enrolled. Twenty-seven (27) percent of the enrollees live in highly rural areas, 20 percent live in rural areas, and 53 percent live in urban areas. The Alaska VA has been a leader in the rollout of this technology, and CCHT has been adopted by the Alaska Federal Health Care Partnership. It is being offered to other Federal beneficiaries, to include clinics of the Alaska Native Tribal Health Consortium, as a result of VA collaboration.

During FY 2009, the Alaska VA successfully recruited a psychiatric nurse practitioner to support a tele-mental health clinic in Kenai, operating 3 to 5 days per month. As of May 31, 2010, 62 unique patients are being seen through this clinic, with an increase of 4 to 6 Veterans per month. In addition, a Social Work Mental Health Clinic for intake and ongoing therapy will begin at the Kenai CBOC during June, and a pain management group will begin at the Kenai CBOC in July 2010. At the end of March 2010, the Alaska VA neuro-psychologist started a TBI screening clinic via videoconference with the Fairbanks VA CBOC. Tele-mental health services are also offered to the Yukon-Kuskokwim Health Corporation (YKHC) in Bethel, AK, as they identify a need or forward a request. The Alaska VA has visited both YKHC and Maniilaq Health Corporation in Kotzebue to educate local health care providers about its tele-mental health resources. A January 2010 presentation to the Alaska Federal Health Care Partnership Telehealth and Technology Committee resulted in positive contacts with staff from the Alaska Native Tribal Health Consortium, Bristol Bay Area Health Corporation, and Maniilaq Health Care Corporation. This venue holds promise for spreading the message about tele-mental health resources at the Alaska VA. VA staff will continue to attend these quarterly meetings.

The Alaska VA is conducting a project focusing on collaborations with existing Alaska Native Tribal Health Corporation (ANTHC) facilities and federally-supported Community Health Centers (CHC) to provide primary care and mental health services to Alaska's Veterans. This project began in August 2009, with its goal to maximize existing VA authorities to enhance access to primary and mental health care for rural Veterans through purchased care provided by ANTHC and the CHCs. The

project includes the Bethel census area; Bristol Bay Borough, Dillingham Census Area, Nome Census Area, Northwest Arctic Borough, Wade Hampton Census Area, and the city of Cordova. Under the project, Veterans may be authorized three primary care visits and two mental health visits within a 6 month period. If the Veteran requires additional visits, the Veteran or health care provider may contact VA to request additional care as needed. VA sent letters to 548 enrolled Veterans in the pilot areas inviting them to participate, and through May 2010, approximately 20 percent (N=110) have enrolled and 17 have requested and been granted authorizations for care (14 for primary care and 3 for mental health care).

Another initiative underway in Alaska involved VA hiring a full-time employee, a Rural Veteran Liaison, to be a local community-based contact for VA questions on health care and benefits. In June 2009, the Alaska VA hired a Bethel-based liaison to perform outreach to the Yukon-Kuskokwim area. There are two other outreach programs the Alaska VA is supporting: the Tribal Veteran Representative (TVR) Program, which uses local community volunteers to assist VA in reaching out to Alaska Native Veterans; and an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) program focused on the newest generation of Veterans. The TVR Program identifies Alaska Native Veterans recognized or appointed by an Alaska Native health organization, tribal government, tribal council, or other tribal entity to act as a liaison with local VA staff. The representative is a volunteer, unless paid by the Alaska Native entity. VA provides collaborative training for the TVRs on VA health care and benefits programs. Four training sessions have been completed, two in Anchorage, one in Juneau, and one in Ketchikan. As of April 2010, 16 people have completed TVR training.

The Alaska VA has made special efforts to reach out to Alaska Native Tribal Health Consortium organizations upon the first major deployment of the Alaska National Guard in support of OEF/OIF. A multi-disciplinary group of VA staff traveled to rural areas to educate Veterans and the community about PTSD, TBI, and suicide awareness and prevention. In addition to the educational aspect of these sessions, VA staff and Alaska Native Tribal Health System staff focused on providing a pathway of care for each system to work together to ensure returning Servicemembers and other Veterans living in rural areas could seamlessly access their Alaska Native health benefits as well as access their benefits through the VA health care system. The presentations on the pathway of care focused on the VA enrollment, eligibility, and fee authorization process to assist Veterans in accessing VA health care and how to bill for reimbursement from VA should their health corporation seek authorization to provide services to Veterans. Packets of information with contact names and phone numbers were given to each participant, and information tables were staffed in community settings such as post offices, grocery stores, and other areas to raise awareness in the general community.

Finally, the Alaska VA has a signed a memorandum of understanding with the State of Alaska Department of Military and Veterans Affairs that outlines a partnership to work together to meet the needs of returning soldiers. OEF/OIF staff members regularly attend Post-Deployment Health Re-Assessment (PDHRA) events. In addition, the Alaska VA actively participates in pre- and post-deployment events for active duty Servicemembers. The National Guard's "Yellow Ribbon" events deliver information about VA benefits to Servicemembers and their families. The Rural Veteran Liaison and OEF/OIF staff members have accompanied these liaisons on a number of trips to rural Alaska to provide information about various VA programs and benefits.

CONCLUSION

VA continues to work to improve the quality and access of services for this important population. Thank you again for the opportunity to discuss VA's programs for Veterans in rural and highly rural areas. Again, this is a priority for the Secretary, and VA is bringing to bear all of its resources to ensure that every Veteran can access the care he or she earned through their service in uniform. This concludes my prepared statement. My staff and I look forward to answering your questions.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Jesse, I have been working with the VA to open new contract clinics in three underserved communities in my home state, Omak, Republic and Colville, so that local veterans can have easier access to VA-provided care. I have also been working with the VA to open a virtual clinic in Port Angeles. It is critical

for veterans in these communities that we get these up and running as soon as possible.

• Where are we with efforts to expand care in Omak, Republic and Colville as well as with the virtual clinic in Port Angeles?

Response. Status of Contract Clinics—Republic, Colville and Omak, Washington: Contracts for each site have been awarded and T1 lines have been ordered (which require a minimum of 30 days for implementation). Background investigation, fingerprinting and credentialing information has been sent to each site to complete and return to Spokane for verification (which should require 4–6 weeks for processing). It is projected that the three sites will start seeing patients mid-to-late August 2010 The contracts are with local providers to improve access to Primary Care (including preventive medical services) for rural Veterans. We are projecting the patient volume yearly for Republic will be between 78–130 Veterans, for Colville between 388–646 Veterans and for Tonasket between 139–232 Veterans. (Although Omak was the anticipated location within Okanogan County, the contract was awarded to a provider in Tonasket). The contractors will provide continuous delivery and management of primary and preventive care only. Mental health examinations are included in the contracts, although consultation and treatment services will be provided by VA. Referrals for specialty care, extensive diagnostic work-ups and non-emergency hospitalization will be made to the nearest VA medical centers.

Status of Port Angeles: VA Puget Sound Health Care System (VAPSHCS) staff is utilizing facilities at the virtual clinic in Olympic Medical Center in Port Angeles and at the Lower Elwha Tribal Health Clinic, part of the Lower Elwha Klallam Nation, to help meet the health care needs of Veterans living in the region. This partnership brings VA health care closer to Veterans in Jefferson, Clallam and Grays Harbor Counties in Washington State. As of May 31, 2010, there are 1,134 patients enrolled in the Port Angeles Clinic. In FY 2009, the clinic had 6,937 patient appointments. Veterans are assigned to one of three health care providers (1.0 MD, 1.6 Nurse Practitioners). The clinic has a full complement of support staff consisting of three health technicians, one medical support assistant and two registered nurses. In addition, the clinic staff includes one home based health nurse, one social worker and one mental health nurse practitioner. The clinic provides laboratory drawing services and can arrange for radiology services, if needed, through purchased care in the local community. The lease with Olympic Medical Center expires September 30, 2011. With the opening this month of the South Sound Community Based Outpatient Clinic (CBOC) in Chehalis, Washington, the priority focus is now on developing a formal CBOC request for the Olympic Peninsula. This will include updating the Veteran demographics in that region and recommending the optimal location.

• How is the VA addressing needs for veterans in highly rural areas where care is needed and there is limited access to services?

Response. Department of Veterans Affairs (VA) recognizes the importance of providing effective, high quality and accessible care to all eligible Veterans in rural and highly rural areas and is accomplishing this goal through mobile medical units (MMUs), telehealth services, Community Based Outpatient Clinics (CBOCs), outreach clinics, and community collaborations. An MMU has been operational out of the Spokane Washington VAMC since 1992. In addition, at the beginning of FY 2009, 4 MMUs became operational including one in Washington State located at the Puget Sound Healthcare System.

The Veterans Health Administration (VHA) has three national telehealth programs—Care Coordination Home Telehealth (CCHT), Clinical Video Telehealth (CVT), and Care Coordination Store and Forward Telehealth (CCSF). In FY 2009, VA's telehealth programs provided care to over 100,000 Veterans in rural and highly rural areas and increased the delivery of telehealth services to rural Veterans by 41 percent from FY 2008. With the additional funding provided by VHA's ORH telehealth initiatives, the number of telehealth services provided to Veterans in rural and highly rural areas is projected to increase by more than 20 percent in FY 2010 (FY 2010 actual data will be available in November 2010). Veterans Integrated Service Network (VISN) 20 network-wide (Washington State) initiatives include Teledermatology.

CBOCs and Outreach Clinics also play an important role in providing accessible care to highly rural Veterans. In FY 2010, ORH funded fifty-one CBOCs in counties identified as being 100 percent rural. This includes the Chehalis, Washington CBOC that became operational in May 2010. Thirty-nine Home Based Primary Care Teams have also been activated, including one at the Walla Walla, Washington VA Medical Center.

VA also recognizes the importance of partnering with local provider organizations as a means of extending VA's reach and improving access to care for highly rural

Veterans. Referred to locally as community partnership contracts, three were recently awarded to providers in Tonasket, Republic and Colville for primary care.

• I have heard stories of veterans traveling a couple of hours for routine care including dental appointments. How does the VA determine when to provide care on a fee-basis instead of forcing the veteran to drive long distances for basic care?

Response. Enrolled Veterans are eligible to receive the full range of health care services included in the medical benefits package codified at 38 CFR § 17.38. When VA facilities determine that they cannot furnish economical hospital care or medical services because of geographic inaccessibility or they are not capable of furnishing care or services required, VA may utilize the authority in U.S.C. 1703 (often described as "fee basis" care) to purchase these services from a community provider. Other authority, such as the authority to enter into sharing agreements pursuant to 38 U.S.C. 8153, is utilized for Veterans who do not meet the statutory eligibility requirement of 38 U.S.C. 1703. Clinical status of the patient and availability of the services both factor into the decision. Local VA Medical Center providers determine the most appropriate care and location of services. It is important to note that VA provides a Beneficiary Travel benefit for those qualifying Veterans who are required to travel to their appointments. This benefit currently provides mileage reimbursement of 41.5 cents per mile to eligible Veterans. VA also works with Veteran Service Organizations and other transportation resources to assist Veterans traveling to appointments at VA facilities.

Question 2. Dr. Jesse, recently the VA proposed to adopt the Medicare payment method for all non-VA inpatient and outpatient health care services in the absence of contracts between these providers and the VA. I am concerned about the impact this potential change might have on certain services like laboratory services and dialysis providers. While I agree with the VA that we need to be fiscally prudent, I feel that a change this large should be phased in to ensure a smooth transition process. I am also concerned the first areas to be impacted would be rural and underserved areas where alternate care options are not available.

• What is the status of the pending rule to reduce reimbursement of providers to the Medicare rate?

Response. The Department of Veterans Affairs (VA) published 2900-AN37, Payment for Inpatient and Outpatient Health Care Professional Services at Non-Departmental Facilities and Other Medical Charges Associated with Non-VA Outpatient Care, as a proposed rule on February 18, 2010 (75 FR 7218). VA received numerous public comments and has prepared a final rule, currently under legal review. Once the Secretary approves the final rule, it will be sent to the Office of Management and Budget (OMB) for their review under Executive Order 12866 (Regulatory Planning and Review). After OMB's review, which can take up to 90 days, VA will publish the final rule in the *Federal Register*.

• One of the services impacted by this proposed rule is dialysis. For veterans with End Stage Renal Disease who live in rural or under-served areas, what preparations are being made to mitigate the closure of clinics in some of the most rural areas in VISN 20 and other rural areas in the country?

Response. VA is carefully reviewing all of the comments we received on this proposed rule. Several comments indicated the proposed regulation would have a significant impact on small dialysis providers. We anticipate addressing this concern in the final rule, and we will work closely with Veterans requiring dialysis treatment to ensure they receive services as close to home as possible.

Question 3. Dr. Jesse, Recently the VA announced the Surgical Complexity Initiative, which organized VA hospitals, based on their capabilities, to provide three levels of surgeries: complex, intermediate and standard. As part of this reorganization, the Spokane VA Medical Center was found to be performing some "intermediate" level surgeries although it is a "standard" surgery facility. Under the new initiative, it may only perform surgeries of "standard" complexity. Now the Spokane VA provides services to rural veterans across Northeastern Washington, who would struggle to access services provided by the VA in Seattle or Portland. I am concerned that this surgery downgrade may lead to veterans postponing elective procedures because they are unable to travel long distances for care. I would also like to know how the VA determines whether to refer patients to local providers on a fee basis or to send them to VA facilities.

Response. VA is the first hospital system to conduct a comprehensive review to determine what level of inpatient surgeries may be performed in each of its 112 surgery programs. After an expert work group's review of surgical standards, VA conducted on-site studies of each of its hospitals between June 2009 and March 2010. As a result, VA has assigned each of its medical centers an inpatient "surgical complexity" level—complex, intermediate or standard. While aimed at ensuring patient

safety and high-quality care for all Veterans, the initiative affected only a very small number of surgical procedures. Each of VA's 21 hospital networks developed a surgical strategic plan to ensure that Veterans receive needed care while facilities strengthen quality, safety and service.

• How does the VA plan to address this at facilities like Spokane that work with a largely rural population and where alternate medical care options may not be available?

Response. Each of the 21 Veterans Integrated Service Networks (VISN) has a policy in place for the transfer of appropriate care and delivery of medical services when not available at any given facility. Furthermore, each VA medical center has a policy for the transfer of care either into the community or to the most closely located VA facility depending on circumstances at the time of presentation, including the severity and complexity of the Veteran's disease and the requirement for urgent or emergent care.

• During the interim period of the Surgery Complexity Initiative , how are VA doctors preserving their expertise if they are no longer able to practice certain procedures at their facilities?

Response. In 2009, the surgeons at the 13 VHA Surgical Programs designated to be Standard performed 25,111 surgical procedures of which 347 have been determined to be "intermediate" and no longer able to be scheduled per VHA Directive 2010–018, Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures. Therefore, the Operative Complexity Initiative will have little overall impact on the ongoing practice of the individual surgeons currently on staff at these facilities.

• What limitations is the VA taking into consideration along with health concerns when determining whether to provide care in the local community on a fee-basis or sending the veteran on to another facility?

Response. Each VA medical center has a policy for the transfer of care either into the community or to the most closely located VA facility depending on circumstances at the time of presentation, including the severity and complexity of the Veteran's disease and the requirement for urgent or emergent care.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. As for Behavioral Health, do you think the staffing is adequate to provide the proper level of care for our rural veterans, explain how you are providing Behavioral Health care for rural veterans.

Response. The parameters of required mental health care for Veterans, including rural Veterans, are specified in the Office of Mental Health Services (OMHS) "Uniform Mental Health Services in VA medical centers and Clinics", Handbook 1160.01. In rural areas, mental health services are primarily delivered through VHA's community based outpatient clinics (CBOCs) and, as required or needed, through VHA medical centers, via fee and contracts with community providers, and tele-mental health services.

Basic principles of care for Veterans in rural areas include the following:

(1) *Ambulatory Mental Health Care:* Facilities must offer options for needed mental health services to Veterans living in rural areas even when medical centers or clinics offering relevant services are geographically inaccessible. When necessary, this can include the provision of tele-mental health services with secure access near the Veteran's home, or sharing arrangements, contracts, or non-VA fee basis care to the extent that the Veteran is eligible from appropriate community-based providers, as available.

(2) *Residential Care:* Each Veteran receiving VA health care services must have timely access to Mental Health Residential and Rehabilitation Treatment Programs (MH RRTPs) as medically necessary to meet the Veteran's mental health needs.

MH RRTPs provide specialized, intensive treatment and rehabilitation services to Veterans who require them in a therapeutic environment. Veterans living in rural areas need to be referred to these programs when they are medically necessary to treat the Veteran's mental health condition.

(3) *Veterans with Serious Mental Illness:* VISNs and facilities have been provided guidance to implement Mental Health Intensive Case Management—Rural Access Network Growth Enhancement (MHICM-RANGE) programs for Veterans who need them in smaller facilities, especially in more rural areas. MHICM is a program of intensive services for Veterans with serious mental illness with teams that have col-

laborative linkages with other VA mental health professionals and with experienced full-time staff.

Ongoing initiatives that further enhance access to mental health services include the following:

(1) *Vet Center/Readjustment Counseling.* An effort that is complementary to rural mental health services are Vet Centers/Readjustment Counseling Services (RCS). RCS's Mobile Vet Center program is a major initiative for extending the geographic reach of outreach and counseling services to Veterans particularly Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans and their families.

(2) *Rural Pilots.* Public Law (PL) 110–387, § 107 directed VA to conduct a pilot program to evaluate the utility of providing OEF/OIF Veterans with peer outreach, peer support, readjustment counseling services, and mental health services in collaboration with contracted community mental health providers. We anticipate that the pilot projects will begin provision of services in three VISNs by October 1, 2010.

(3) *MHICM-RANGE expansion.* An expansion of the MHICM-RANGE program has been supported by the VA's Office of Rural Health. This initiative adds mental health staff to CBOCs, enhances tele-mental health services and uses referral to community mental health services and other providers to increase access to mental health care in rural areas.

(4) *My HealtheVet Program.* OMHS has partnered with the My HealtheVet Program office and Office of Information and Technology to develop online resources designed to complement traditional mental health services and to expand access to these services to Veterans in rural areas.

VA is committed to adequate staffing to provide the proper level of care to Veterans residing in rural areas. There are many challenges to recruitment and retention of staff, most notably: (1) availability of qualified mental health care professionals in small rural communities is often limited; and (2) at times, in rural areas as in other places, VA salaries are not competitive to attract mental health personnel. VA has addressed these challenges by continuing to expand access to telemental health services, use of fee-basis contract arrangements with community providers, and education and training of community providers in rural areas about Veterans issues.

Question 2. Telehealth and Telemedicine, including home telehealth systems are becoming more acceptable to administer care to veterans. What are your plans to expand telehealth, and have you surveyed Veterans on how they are utilizing it and if they feel it is working for them? What are the major challenges with telehealth in rural Alaska?

Response. VA plans to expand both the numbers of patients receiving care via telehealth and the scope of these services. Examples of telehealth services that VA is developing include teleaudiology, telepathology, dementia care, spinal cord injury, post-amputation care and pain management.

The Veteran patient experience with telehealth is a critical component of developing these services and for ongoing refinement and improvement. Veteran patients show satisfaction levels between 86 percent and 90 percent with telehealth services routinely provided by VA.

The challenges encountered with developing telehealth services in Alaska are comparable to those that exist elsewhere, but they are magnified by geographic, distance, climatic and economic circumstances that are unique to Alaska and its Veteran population. These challenges include the buy-in of clinicians and resolving the clinical, technology and management challenges necessary to implement and then sustain services.

Question 3. Recently a White Paper on the Alaska VA Health Administration's use of Special Authority for Fee-Basis Care was provided to this Committee dated June 7, 2010, which discusses U.S.C. 1703 (a)(5), tell me how this is working for Alaska?

Response. This authority expands access to both outpatient and inpatient care from non-VA providers for Alaska Veterans where such care will "obviate the need for hospital admission". Its use in Alaska allows Veterans to be pre-authorized for outpatient care if the care is not available at an Alaska VA facility.

Question 4. How many veterans utilized this authority and where did you send them for treatment?

Response. The Alaska VA Healthcare System (AVAHS) provided care to 15,170 Veterans in fiscal year 2009. Of these, 8,959 Veterans received a combination of VA and non-VA care. Approximately 58 percent of care was delivered within the Municipality of Anchorage. The rest was distributed across the remainder of the State: 19.7 percent of non-VA care was delivered in Fairbanks; 8.6 percent in the Kenai/Soldotna area; 3.1 percent in Juneau; 3.6 percent in the Palmer/Wasilla area; 2.4

percent in Homer; and 1 percent in Kodiak. The remaining 3.6 percent was delivered in communities across the state with concentrations of less than one percent of the State's population.

Question 5. What was the total number of patient care visits in 2009 that were sent for care to places other than the VA facilities in Alaska? Of that number, how many were sent to "Non-VA Preferred Providers" within Alaska?

Response. During fiscal year 2009, 596 unique Veteran patients (3.9 percent of all users) generated 719 outpatient visits and 217 inpatient admissions in VA facilities in the contiguous 48 states. A total of 1,471 inpatient periods of care were authorized across the State of Alaska in fiscal year 2009. During fiscal year 2010 to date, 1,140 inpatient periods of care have been authorized. Approximately 26,580 authorizations of non-VA care were provided in fiscal year 2009. Considering each authorization averaged three visits, there were approximately 79,000 visits for non-VA care in Alaska. Unlike a Health Maintenance Organization (HMO) or other private insurance plans, VA does not have "preferred providers."

Question 6. With respect to Pre-Approval and emergency care, could you explain ramifications of "prudent layman's criteria for clinical review" as described in the White Paper?

Response. The "prudent layperson standard" is used by Alaska as a clinical assessment of the urgent nature of the episode of care (a prudent layperson would have reasonably expected a delay in seeking care would have been hazardous to life or health). Application of this standard for assessing an episode of care assists in assuring that consistent clinical standards are utilized across all programs. Assessing the emergent nature of the care is required for VA to approve these cases. By using an industry standard criteria, such as prudent layperson, the Alaska facility assures standardization in their decisionmaking process and consistency with emergency care determinations across all VA authorities for emergency non-VA care (38 U.S.C. 1725 and 1728). This standard also assures the decision is based on what a "prudent layperson" would determine to be an emergency, affording Veterans the most expansive of standards in making decisions on payment for non-VA health care.

Question 7. Again with respect to Pre-Approval as discussed in the White Paper of June 7, 2010 and referring to U.S.C. 1703 (a)(5), is it reasonable to assume that a fully qualified eligible veteran that is transported to a Non-VA facility for care under emergency conditions should expect that the charges incurred from such treatment would be covered by the VA?

Response. For enrolled Veterans, it is reasonable for a Veteran to expect that each episode of emergent care will be paid for by VA if these clinical standards are met. This does not apply to the costs of travel, which are governed by other authorities and eligibility is not limited to the prudent layperson standard.

Question 8. Many folks that we talk to that are sent outside are confused and irritated that it would appear that the exact same care is available in Alaska. I know that the overriding issue may be resources and the VA can mitigate the costs better by treating the veterans in government facilities but when do we take the veteran into consideration and start doing what is best for them. Sending them outside to Washington or Oregon for their treatment they could receive in Alaska is stressful for the Vet and their families. Explain why they get sent out and if this Special Authority could be utilized more in state.

Response. The Alaska VA has maximized its Special Authority within the intent of Federal regulations. The AVAHS follows regulatory guidance for providing care to Veterans in Alaska as directed in 38 CFR § 17.93 (Eligibility for Outpatient Services) and 38 CFR § 17.53 (Limitations on Use of Public or Private Hospitals). Following this guidance, AVAHS maximizes the use of internal resources for care when available. Accordingly, when required services can be provided within a clinically appropriate timeframe by a VA facility in the Lower 48, Veterans are referred to that facility since 38 CFR 17.52 directs that non-VA "* * * care within Alaska be consistent with the incidence of the provision of medical services for Veterans treated within the 48 contiguous States". When services are not available internally, local Federal partners are utilized. If local Federal partners are not available, contract facilities are a third choice. Non-VA care is provided when Federal or contract services are not available based on demand or urgency of request.

Senator TESTER. Thank you, Dr. Jesse. I appreciate your testimony.

Correct me if I am wrong, Glen. You are going to be here, available for questions, is that correct?

Mr. GRIPPEN. Yes, sir.

Senator TESTER. OK. And I will make sure to at least have one or two for you.

We will have 5-minute rounds. The order of questioning will be Senator Murray, followed by Senator Johanns, Senator Begich, and I will go last. Senator Murray?

Senator MURRAY. Thank you very much, Mr. Chairman, and to all of you for your testimony today.

Dr. Jesse, I have been working with the VA, as you know, to open new contract clinics in three of our underserved communities in my State, Omak, Republic, and Colville, so that those local veterans can get easier access. I have also been working with the VA to open a virtual clinic in Port Angeles that is really critical for that community, as well, and I wanted to ask you this morning, where are we with those efforts to expand care in Omak, Republic, and Colville, as well as the virtual clinic in Port Angeles?

Dr. JESSE. I can't give you the exact details, but I do know that all of those are moving forward, but we can get back to you on the record for their exact status.

Senator MURRAY. If you could do that for me, those veterans are waiting to hear——

Dr. JESSE. Absolutely——

Senator MURRAY [continued]. And we certainly are, as well. Do you have a timeframe when you can get back to me on that?

Dr. JESSE. As soon as possible. We can get that in the next couple of weeks, I am certain.

Senator MURRAY. In the next couple of weeks. OK. I would appreciate that a lot. Thank you.

Dr. JESSE. Sure.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO ROBERT JESSE, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Context of Inquiry: During the June 16, 2010 Senate Veterans' Affairs Committee hearing on rural health, Senator Murray requested an update on the status of the Port Angeles, WA, virtual clinic.

Response. VA Puget Sound Health Care System staff are utilizing facilities at the Olympic Medical Center in Port Angeles and at the Lower Elwha Tribal Health Clinic, part of the Lower Elwha Klallam Nation, to help meet the health care needs of Veterans living in the region. This partnership brings VA health care closer to Veterans in Jefferson, Clallam and Grays Harbor Counties in Washington State. As of May 31, 2010, there were 1,134 patients enrolled in the Port Angeles Clinic. In FY 2009, the clinic had 6937 patient appointments. The Veterans are assigned to one of three health care providers (1.0 MD, 1.6 Nurse Practitioners). The clinic has a full complement of support staff consisting of three Health Technicians, one Medical Support Assistant and two Registered Nurses. In addition, the clinic staff includes one Home Based Health Nurse, one Social Worker and one Mental Health Nurse Practitioner. The clinic provides laboratory drawing services and can arrange for radiology services, if needed, through purchased care in the local community. The lease with Olympic Medical Center expires September 30, 2011. With the opening this month of the South Sound Community Based Outpatient Clinic (CBOC) in Chehalis, Washington, the priority focus is now on developing a formal CBOC request for the Olympic Peninsula. This will include updating the Veteran demographics in that region and recommending the optimal location for a clinic site.

Senator MURRAY. I have heard stories of veterans, as I said in my opening remarks, traveling for hours for routine care, and I hear a lot about dental appointments, as well, for folks. Can you

tell us how the VA determines when to provide care on a fee basis instead of forcing the veteran to drive long distances?

Dr. JESSE. There are, I think, a couple issues that need to be discussed in the context of that. First of all, the most important thing for us is that the veteran can get the best care in a way that is most convenient for them. That being said, that generally means as close to home as possible. Sometimes, that care, when it is complex, is not available in the local areas.

A good example would be—and we have had some of this discussion, I think, from the last meeting in regards to cancer care—that patients might need to be sent down to Seattle to get that care when, in fact, some of that care might be available in Anchorage; and we are actually now looking to build the kind of contracts we can to get that care in Anchorage so they would have to travel less far, when appropriate. We do know that some of the veterans would prefer to travel down to Seattle, and if that is the case, we would accommodate that. And in certain cases——

Senator MURRAY. So is this on a case-by-case basis or are there guidelines? Are there rules, or just——

Dr. JESSE. Well, it is—it has been, I think, case by case. We are in the process of establishing contracts so that we can have those services available so that they don't have to travel.

Senator MURRAY. So there aren't any——

Dr. JESSE. But we don't have all the——

Senator MURRAY [continuing]. Specific guidelines when you go to fee basis versus making somebody travel?

Dr. JESSE. Not that I am aware of.

Senator MURRAY. It is case by case determined. Should there be guidelines?

Dr. JESSE. Well, I think where the guidelines would come into play would be having the availability of those services through contracts or through other mechanisms locally. We have historically not been as good about that as we should have been. We relied on the patients having to come to our centers, traveling many miles, like Montanan's going down to Denver, which would be a good 400 miles, just like to travel down to the lower 48. And I think one of the real initiatives——

Senator MURRAY. It takes that long in some places from my State to get——

Dr. JESSE. Yes. And so I think one of the major important initiatives of the Office of Rural Health is to really determine—to move that away from being case by case and to develop the policy and the opportunity to deliver that care as close to the home as possible.

Senator MURRAY. All right. I wanted to ask you, as well, the VA recently proposed to adopt the Medicare payment method for all non-VA inpatient and outpatient health care services in the absence of contracts between providers and the VA. I am really concerned about the impact of that potential change on services like laboratory or dialysis providers, especially dialysis providers. We have heard a lot of concern about that.

We all know we have got to be fiscally prudent, but a change this large I think ought to be phased in so we can have a smooth transition process. I am also very concerned about the impact on rural

and undeserved areas. So can you share with this Committee the status of that pending rule?

Dr. JESSE. Certainly. I think there are actually two issues here: one being fiscally responsible; but more important than that is access, and we need to ensure not only access today, but access 5 years from now to the needed services so that we weigh both concerns.

Specifically related to dialysis, this has been a huge financial burden on the VA. It is not that we have been paying a little bit more than Medicare. We have been paying sometimes 400 percent of Medicare and it has had a huge financial impact, which, as you know, takes away from the ability to provide other services. So the VA, in moving toward that Medicare, our proposal is to phase it in over 4 years——

Senator MURRAY. Four years?

Dr. JESSE [continuing]. Which is historically what, I think, the Department of Defense did when they have made changes along these lines in TRICARE, but also what Medicare has done when they have made major changes like this.

Senator MURRAY. OK.

Dr. JESSE. Four years, I think, should be sufficient time to——

Senator MURRAY. Well, I would like my staff to follow up with you——

Dr. JESSE. Sure.

Senator MURRAY [continuing]. Because we are very concerned, especially about the dialysis and how we can mitigate some of the closure of the clinics in some of our rural areas.

Dr. JESSE. And the VA also is, as I mentioned—access is important and there is a lot of effort going on to improve the VA's ability to deliver dialysis services.

Senator MURRAY. OK. I appreciate it. Thank you very much. Thank you, Mr. Chairman.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO ROBERT JESSE, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Context of Inquiry: During the June 16, 2010 Senate Veterans' Affairs Committee hearing on rural health, Senator Murray requested an update on the status of VA's proposed adoption of the Medicare Prospective Payment Systems (PPS) and fee schedules for dialysis care. She would like a timeline for the proposed regulation's implementation and the phased transition to the Medicare PPS.

Response. VA published proposed rule, 2900-AN37, in the *Federal Register* on February 18, 2010, with the public comment period ending April 19, 2010. This proposed rule would amend current payment regulation, 38 CFR § 17.56, to allow for the use of Medicare Prospective Payment Systems (PPSs) and Fee Schedules in the reimbursement of inpatient and outpatient health care professional services at non-VA facilities and other medical charges associated with non-VA outpatient care. VA received 18 public comments related to the proposed rule. VA has addressed the public comments and is in the process of circulating the Final Rule for internal VA concurrence. Once internal VA concurrence is complete the Final Rule will be subject OMB review. The publication date for the Final Rule is expected to be fall of 2010.

Senator TESTER. Senator Johanns?

Senator JOHANNS. Thank you, Mr. Chairman.

Dr. Jesse, let me continue, if I could, with questions for you.

Dr. JESSE. Sure.

Senator JOHANNS. I haven't been to a hearing on these issues yet where the promise of telehealth/telemedicine wasn't emphasized, and I, as a former Governor, certainly promoted it, also recognizing this as a way of trying to get medical services into rural areas. I think we would all agree it would be great to have a cardiologist and a psychiatrist and an oncologist in every area of our States. It is just not going to be possible. We know that. They are hard to recruit, even to larger cities, much less a very rural area.

One of the things that you say in your testimony is that you believe that telehealth has reduced hospital admissions. That conjures up the notion that maybe it saves some money. Do you have any measurement at all at your fingertips that can demonstrate to us that our investment in telehealth is, in fact, paying off by whatever measure you might use? Talk about that and walk me through how I can be convinced that, in fact, our continued emphasis on this effort is working, resulting in better care or fewer hospital admissions or whatever.

Dr. JESSE. Certainly. As a cardiologist, I appreciate your recognition of——

[Laughter.]

Dr. JESSE [continuing]. Of how difficult it is to get the services, and particularly in the area I practice, which is acute cardiac care, where things are very time dependent. There are very real challenges that occur in getting very urgent and timely care to these patients.

There are three forms of telehealth that we are looking at. First, tele-consultation, which would get cardiology expertise, say, to a primary care provider in a remote area, hence, the connection of medical services.

The second is storing forward, which is what we do with the teleretinal imaging, for instance. So rather than people having to travel distance just to get an eye exam, the diabetics where we do this annually, and a good 25 percent of our patients are diabetics, we can do that. We can put that technology into primary care offices. It goes into the medical record. It is then read remotely by experts and we can codify this and follow it over years.

And then the other is the home telehealth. Again, I will use my background as a cardiologist and point out we have been actually doing this since the mid-1980s with the home monitoring of pacemakers and implanted devices. So it is not new; and, in fact, in that example, 2 years ago or 3 years ago, there was a large number of recalls of pacemakers and implantable devices. By having the home monitoring process in place, we estimated we saved 25,000 clinic visits across this country.

So just to see the travel costs, the staff time, the patients' time, especially where they have to travel and be seen in clinics, it is a tremendous savings that adds up in that case.

In the broader sense, yes, we can easily quantitate that we reduce admissions because we can intervene on things early, and that is the rough block of money. I think the heart of this question, though, is as we move from a health care model that is inherently episodic—people come to us when there is a problem—to one that is driven by wellness, prevention, and risk mitigation in the long sense; it is having that connectiveness between the patient and the

health care system in order to manage that, which I think will be the real payoff in the long run.

We don't have those numbers right now, but if you look at the cost of managing just hospitalizations alone and managing patients with chronic diseases, if that can be better managed through telehealth to prevent those admissions, and more so avoid the secondary or bad outcomes from those diseases, that is where the true cost savings comes in.

So the simple answer is we can give you hard numbers about prevented admissions. The 20-year plan is at this point, I think, a good model, but is not hard and proven.

Senator JOHANNS. This is something that the VA is really going to have to help us with, because we are putting money out there. I think we are testing a lot of different approaches here. We hear testimony, though, that, gosh, maybe this isn't doing all it needs to be doing or we need to do more. Somehow, some way, we have got to figure out how to measure this. We have got to be able to figure out that this strategy works very, very well with telehealth, maybe another one doesn't, and be honest about that so we can focus our spending in an appropriate way, because, again, I would love to say that we are going to have specialists throughout every rural area in America. There aren't that many. And so we have got to somehow figure out what is working and what is not working.

Mr. Ahrens, I think you offered a thought here about whether telehealth was getting the job done. I am out of time now, but if you could take just a minute and offer your thoughts in reaction to what Dr. Jesse has said. Are you as excited about telehealth maybe as you once were, or are there—are we making the progress you want to see?

Mr. AHRENS. Senator, let me answer it this way. I think we are making progress, but we ought to measure it. And some of the money that you put out could be used for measurement studies. Does it save money? I am convinced it does, but you have got to have the metrics out there which show that it does. You need outcome measurements, and I think it would be well worthwhile for the Office of Rural Health to do one of those studies to show you. And we need to expand it; there is no question about it. You can't deliver health care to everybody in rural America without using it.

Senator JOHANNS. Yes. Adrian, you mentioned this in your testimony. Is there anything you want to offer as I wrap up here?

Mr. ATIZADO. Yes, Senator. I think that there is sufficient study that shows telemedicine does save money, primarily on the preventive medicine side. The other anecdotal evidence shows the use of specialized consultants does help, as well. You have to understand that when you go to especially the frontier areas of our Nation, there is no safety net. I mean, you have got one primary care doctor doing everything.

Senator JOHANNS. Yes.

Mr. ATIZADO. They are on call 24/7. They can't take a vacation. So when they have these technologies, in fact—there is, I think, an article in the *AARP Bulletin* magazine about this where the physician actually had a telemedicine hook-up videoconference with a cardiologist who could listen to the vital signs and breathing sounds of a patient who had a chronic condition. That saved that

patient having to drive 7–8 hours with a chronic condition to the nearest town or city that has the services that they need.

So, I mean, the evidence seems logical that it would save money. It is just a matter of proving it. The whole idea of saving admissions and lowering the cost of health care is, VA parlance, they are a business. I mean, they are a health care provider, so they have to talk in this sense. But as far as users of VA health care, it seems apparent to us that it is something that VA should do.

I must note, if I could have a few more seconds, the FDA, FCC, and HRSA have set aside funding not only to build broadband infrastructure to the rural communities, but certain initiatives are devoted to telemedicine in rural areas. I think with the advent of new technology, which is moving rapidly as we speak, for telemedicine, a lot of policymakers and a lot of industry experts are actually looking at VA and their research into whether or not they are going to invest in telehealth and telemedicine.

So I think it is crucial, as Mr. Ahrens said, that VA, in fact, document not only health outcomes, not only cost savings, but health status and the ability for telemedicine to deal with the workforce shortage that everybody is facing now.

Senator JOHANNS. Thank you, everybody.

Senator TESTER. Senator Begich?

Senator BEGICH. Thank you very much, Mr. Chairman.

If I can, Dr. Jesse, let me add follow-up questions in regards to telemedicine, but also on utilization by other facilities that are non-VA regarding the contracts that you are trying to work out.

You had made the comment you were trying to expand these contracts, and you used Anchorage as an example. You are working through it. Can you elaborate a little bit more? What does that mean? Why I ask this is because, to be very frank with you, I have heard that on a regular basis. This is one thing that we have: for a huge opportunity for medical facilities, and Indian Health Care Service is a great example, because of the way we manage them up there, but huge facilities both in Anchorage and Fairbanks that, I think, are underutilized.

So, help me understand. When you say you are working out a process or you are working through contracts, tell me what that means and what kind of time table.

Dr. JESSE. OK. So I think Mr. Schoenhard could probably speak to that better, since he is involved in the details of that, but——

Senator BEGICH. OK. He is behind you and smiling, so that is——

Dr. JESSE. Is it the Providence Health——

Mr. SCHOENHARD. Yes.

Dr. JESSE. So it is the Providence Health System——

Senator BEGICH. If you want to reserve some of your answer, you can, and——

Dr. JESSE. Since you have asked for it, it is the Providence Health System in Anchorage that they are in the process of developing or negotiating to cover at least the cancer care.

Senator BEGICH. Let me ask you, if I can, and I will hold more detail until the next panel, but let me ask you, can you or do you keep data on, in any State, utilization of non-VA facilities by VA recipients, or do you have data points? If I said to you, what is the

percentage in Montana or Nebraska or Alaska that take advantage of them based on proximity and other reasons, do you have such answers—what kind of services they receive?

Dr. JESSE. Yes. So this is complex, because there are a couple terminologies that we need to be clear about. One is, what is called fee care? Fee care by the strict definition means we don't provide the service and we authorize the veteran to go and get it.

Senator BEGICH. Right.

Dr. JESSE. And we pay that bill. That is a small component of what is in broadly more encompassing non-VA care, which would include both fee care but also care that is through contract, through community providers, care that is delivered through contract or other agreements, if you will, through our academic affiliates.

And the other is what we don't have a handle on, because we don't really pay for it, which is care that the veteran themselves——

Senator BEGICH. Right, get on their own.

Dr. JESSE [continuing]. Chooses to get on the outside, because many of them also do have secondary insurance and/or in addition to Medicare. That dual care is a particular challenge to us, not from the financial side, but from the managing care side.

So we have the ability to track fee care, obviously. We have a lot of contract care that is—the ability to roll it up is a little less robust because some of it is—it rolls in rather than being just a flat rate that we are paying out on an annual basis. But we can tell you what that is with at least some level of precision, I am sure.

Senator BEGICH. Is that something that you can provide to us——

Dr. JESSE. I believe so, yet without making a promise, I will go back and tell you what granular we can provide to you.

Senator BEGICH. Excellent. And again, as you say, there is fee and there is contract and——

Dr. JESSE. Right. There is a host of vehicles by which we——

Senator BEGICH. The more defined data you can provide, the better off——

Dr. JESSE. Sure.

Senator BEGICH. I would be very interested in that.

Dr. JESSE. OK.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MARK BEGICH TO ROBERT JESSE, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Context of Inquiry: During the June 16, 2010 Senate Veterans' Affairs Committee hearing on rural health, Senator Begich requested that VHA provide his office with information on the utilization of fee-basis care for all 50 states. The Senator would like this information broken down by the percentage of overall VHA care (by state) that is delivered through fee-basis and the amount spent (by state) on fee-basis care.

Response. Non-VA purchased care data (fee-basis) is collected nationally for processing payments through the Financial Management System (FMS). This data can be associated or grouped with a state through two different methods (both attached).

Method 1: The data is grouped by the Provider State. This is the state identified by the Provider for billing purposes and is not always the actual, physical location where care was received. For example, larger providers will use centralized billing centers which may be located in a different state from where care was provided. We estimate that 80% of the addresses in the Provider file are the same physical loca-

tion where the care took place. The other 20% of addresses in the Provider file include centralized or offsite billing centers.

Method 2: The data is grouped by the Veteran's Home of Record State. This state is identified by matching the Social Security Number (SSN) in the payment files to the SSN record in the VHA enrollment file. The VHA enrollment file contains the primary mailing address for all enrolled Veterans. When the payment data is associated with this state grouping, it is directly associated with the state where the Veteran primarily resides. With this grouping, there will also be some instances where Veterans receive care in states other than their state of primary residence (e.g. where major cities are located near state borders).

Disbursed Amt (Provider State by Year)

*Provider State is based on Providers Billing Address State as identified in the Central Fee Vendor File
*Includes only NonVA Fee Disbursements PAID through Central Fee

Totals =>	$3,820,700,161.76	100.00%	$3,029,213,855.87	$2,227,643,666.15
Provider Billing State	FY09	FY09 Percent of overall VHA fee-basis care	FY08	FY07
AK	$30,678,303.26	0.80%	$29,055,956.15	$25,214,349.71
AL	$55,796,028.67	1.46%	$47,107,724.34	$35,224,904.66
AR	$45,173,867.12	1.18%	$36,845,033.92	$29,726,112.06
AS (American Samoa)		0.00%	$4,829.01	$4,864.00
AZ	$91,171,214.28	2.39%	$74,776,333.79	$61,364,049.25
CA	$300,798,078.68	7.87%	$250,631,020.74	$195,094,670.75
CO	$61,488,086.34	1.61%	$52,482,229.19	$40,446,858.69
CT	$36,328,467.31	0.95%	$27,054,689.91	$20,775,451.57
DC	$1,665,754.64	0.04%	$1,332,361.62	$1,654,988.21
DE	$6,433,503.31	0.17%	$3,241,726.45	$2,438,860.90
FL	$214,905,588.36	5.62%	$211,279,216.95	$159,469,518.36
GA	$319,300,687.33	8.36%	$258,132,891.58	$158,888,795.26
GU (Guam)	$2,292,542.66	0.06%	$2,015,853.74	$1,144,834.51
HI	$28,971,943.63	0.76%	$24,854,729.31	$20,197,331.30
IA	$42,592,355.58	1.11%	$27,709,938.07	$22,231,585.64
ID	$18,912,014.71	0.49%	$12,665,985.79	$11,122,558.39
IL	$120,453,971.40	3.15%	$81,870,684.93	$54,433,039.98
IN	$58,688,935.34	1.54%	$42,569,461.71	$26,601,357.01
KS	$41,727,493.83	1.09%	$37,876,908.01	$30,891,207.26
KY	$98,081,749.69	2.57%	$47,636,871.43	$35,980,058.06
LA	$61,029,881.03	1.60%	$54,708,162.16	$41,208,941.21
MA	$70,353,180.04	1.84%	$58,031,145.92	$47,515,514.19
MD	$72,907,015.52	1.91%	$56,688,538.22	$44,423,892.29
ME	$31,936,384.33	0.84%	$26,537,071.35	$23,460,321.42
MI	$73,593,632.36	1.93%	$49,857,526.47	$30,941,261.16
MN	$94,236,085.74	2.47%	$68,279,931.46	$45,799,893.18
MO	$104,305,763.36	2.73%	$74,372,807.10	$51,723,332.02
MP (Mariana Islands)	$19,905.33	0.00%	$8,523.59	$287.25
MS	$28,204,105.71	0.74%	$19,481,055.73	$15,313,928.82
MT	$28,067,580.29	0.73%	$21,247,197.64	$15,776,686.61
NC	$147,714,705.73	3.87%	$107,566,148.37	$90,191,586.15
ND	$25,899,380.39	0.68%	$16,647,185.19	$9,966,366.89
NE	$26,042,152.00	0.68%	$21,290,315.70	$23,545,690.27
NH	$21,057,101.18	0.55%	$17,627,270.32	$14,522,517.82
NJ	$43,411,191.41	1.14%	$37,696,594.09	$28,817,886.33
NM	$23,330,855.00	0.61%	$19,096,810.21	$21,531,616.24
NV	$54,524,148.59	1.43%	$44,915,946.95	$36,420,968.80
NY	$99,100,737.23	2.59%	$76,599,459.28	$54,033,507.94
OH	$173,861,720.87	4.55%	$126,689,912.93	$80,045,014.88
OK	$37,147,238.20	0.97%	$35,225,126.21	$22,747,951.21
OR	$61,261,617.48	1.60%	$63,787,073.57	$46,677,742.74
PA	$179,197,580.45	4.69%	$137,291,846.77	$88,209,357.54
PR	$16,285,215.42	0.43%	$12,421,104.34	$9,302,527.02
RI	$8,882,545.58	0.23%	$8,466,801.05	$6,770,492.29
SC	$51,086,403.68	1.34%	$39,902,642.79	$25,206,436.75
SD	$37,289,753.41	0.98%	$26,425,130.43	$18,420,436.16
TN	$110,698,721.80	2.90%	$92,403,693.01	$65,107,624.57
TX	$277,234,308.75	7.26%	$202,930,434.36	$153,948,227.04
UT	$28,555,226.61	0.75%	$23,773,148.01	$15,957,840.17
VA	$40,850,440.59	1.07%	$32,312,444.77	$23,128,035.56
VI	$1,492,707.65	0.04%	$1,031,346.11	$1,014,045.53
VT	$5,241,073.81	0.14%	$4,837,233.82	$4,990,744.38
WA	$89,040,745.12	2.33%	$82,212,114.61	$62,131,208.07
WI	$58,837,686.28	1.54%	$48,440,414.45	$34,002,926.13
WV	$38,637,084.88	1.01%	$30,620,735.94	$26,974,195.46
WY	$10,045,462.69	0.26%	$8,784,582.42	$5,753,009.26
ZZ (Unknown)	$13,860,237.11	0.36%	$11,861,933.89	$9,156,257.23

Disbursed Amt (County State by Year)

*Veteran State is based on Veteran Home of Record Address State as identified in the VHA Enrollment File
*Includes only NonVA Fee Disbursements PAID through Central Fee

Totals =>	$3,820,700,161.76	100.00%	$3,029,213,855.87	$2,227,643,666.15
Veteran Home of Record State	**FY09**	**FY09 Percent of overall VHA fee-basis care**	**FY08**	**FY07**
AK	$47,120,086.87	1.23%	$41,415,507.54	$36,526,528.46
AL	$61,927,550.39	1.62%	$50,161,849.92	$35,888,814.34
AR	$50,577,302.51	1.32%	$39,522,812.29	$31,670,061.17
AS (American Samoa)	$414,021.41	0.01%	$272,412.19	$294,166.37
AZ	$113,526,450.46	2.97%	$96,331,674.35	$73,992,006.10
CA	$273,108,212.82	7.15%	$244,789,864.89	$185,437,231.52
CO	$63,734,498.90	1.67%	$54,491,012.03	$41,219,338.91
CT	$40,425,715.63	1.06%	$28,355,060.70	$21,822,915.66
DC	$3,070,526.61	0.08%	$2,796,990.39	$1,331,305.99
DE	$8,593,731.79	0.22%	$4,948,132.36	$4,183,014.72
FL	$288,862,984.37	7.56%	$262,368,790.16	$200,238,063.51
GA	$100,721,814.80	2.64%	$86,501,818.74	$52,758,624.59
HI	$31,356,564.90	0.82%	$26,224,909.99	$22,054,307.46
IA	$43,910,586.39	1.15%	$30,794,358.31	$23,946,446.51
ID	$25,000,086.89	0.65%	$17,599,966.98	$14,578,089.70
IL	$108,725,410.32	2.85%	$76,229,757.14	$50,438,663.43
IN	$70,611,054.97	1.85%	$54,366,952.90	$35,951,577.88
KS	$37,784,495.47	0.99%	$33,223,833.63	$26,194,982.78
KY	$72,691,855.13	1.90%	$54,153,413.40	$45,213,586.05
LA	$97,257,396.78	2.55%	$76,927,267.77	$42,725,289.32
MA	$52,700,170.76	1.38%	$47,111,812.73	$39,497,551.06
MD	$54,047,848.69	1.41%	$37,413,405.75	$28,075,070.45
ME	$35,988,518.37	0.94%	$30,080,445.94	$26,826,292.35
MI	$90,201,650.89	2.36%	$64,006,751.17	$39,408,488.36
MN	$108,860,280.72	2.85%	$73,199,909.86	$49,566,382.10
MO	$111,098,857.17	2.91%	$91,278,530.95	$55,824,951.25
MP (Mariana Islands)		0.00%		
MS	$37,303,632.72	0.98%	$24,781,715.59	$19,092,123.89
MT	$29,870,196.77	0.78%	$22,242,853.54	$16,877,130.90
NC	$161,631,202.79	4.23%	$117,406,012.99	$97,553,829.50
ND	$19,452,613.11	0.51%	$12,288,659.16	$7,783,619.21
NE	$31,094,888.11	0.81%	$24,170,098.31	$24,602,493.86
NH	$23,846,762.40	0.62%	$19,253,534.66	$14,669,307.37
NJ	$34,565,924.46	0.90%	$28,601,688.44	$19,573,511.65
NM	$37,362,043.71	0.98%	$29,359,322.39	$30,482,871.83
NV	$97,376,471.90	2.55%	$70,701,189.65	$59,283,706.71
NY	$101,468,675.16	2.66%	$79,331,835.94	$57,487,226.93
OH	$175,495,345.54	4.59%	$128,030,798.79	$82,401,908.56
OK	$55,313,753.05	1.45%	$44,112,735.60	$28,749,053.05
OR	$67,118,737.17	1.76%	$65,102,600.89	$47,866,813.13
PA	$152,938,651.82	4.00%	$119,971,361.83	$78,134,979.23
PR	$16,967,117.11	0.44%	$13,187,047.45	$10,098,836.02
RI	$9,859,664.63	0.26%	$9,010,615.17	$6,792,920.43
SC	$76,916,361.97	2.01%	$55,125,429.82	$36,884,669.62
SD	$33,730,559.61	0.88%	$23,636,806.56	$16,612,019.31
TN	$99,877,188.51	2.61%	$80,251,468.36	$57,284,178.99
TX	$248,068,827.77	6.49%	$176,656,753.31	$139,462,300.12
UT	$25,835,460.03	0.68%	$20,256,361.36	$14,559,103.81
VA	$67,620,078.76	1.77%	$55,061,237.55	$38,965,948.00
VI	$1,669,456.23	0.04%	$1,224,056.49	$1,074,783.64
VT	$6,930,190.65	0.18%	$6,967,976.20	$7,599,109.43
WA	$84,946,376.62	2.22%	$75,848,143.11	$54,914,371.90
WI	$61,594,417.55	1.61%	$47,209,775.70	$29,166,844.98
WV	$50,180,674.02	1.31%	$39,070,046.97	$32,176,273.74
WY	$13,855,697.33	0.36%	$11,506,223.06	$8,052,661.49
ZZ (Unknown)	$5,491,518.25	0.14%	$4,280,264.90	$3,777,318.81

Senator BEGICH. There has been some good testimony on telehealth. In Alaska, we use it a great deal, not only from a VA perspective, but our travel consortium, which is our Indian Health Services, which is a huge piece of the puzzle. How we move through delivering health care in areas where even a van—I know, Mr. Ahrens, you talked about increasing the vans—but, we can't even get a van there, let alone a plane, depending on weather.

There was a comment earlier about where the Office of Rural Health Care is located. Do you think elevating that to a higher level will get some more recognition of the data that needs to be collected, the need to understand it better and deliver it better, or is the location—you were concerned about where it was located and kind of the system where the office is. Mr. Ahrens, I didn't hear you make a comment on that. Do you have any comment in regards to that?

Mr. AHRENS. The Office of Rural Health in the VA?

Senator BEGICH. Yes.

Mr. AHRENS. I think the higher the elevation you can give it, the better off we are. We are slowly getting it staffed. There have been a lot of staff changes. I think it has got the attention of the Secretary and we ought to keep it right at the highest level we can, because it is very important.

Senator BEGICH. Do you think where it is located now, that the telehealth issues—I mean, I agree with you, if you don't have the data, it is irrelevant. I mean, you can spend a lot of time talking about how important it is. We see it in real life in Alaska. But do you think that has any relationship to doing some of that hard data collection that is necessary, or is it just two separate issues that need to be addressed? In other words, data collection is its own issue, and then moving this office up higher.

Mr. AHRENS. Well, again, keep the office as high as you can. This data collection is very important. We don't even know where veterans are, and we need to know their utilization of services, if that is what you are asking me. We have to have certain data in order to proceed. If you are running a business, how are you going to pursue that if you don't know where your customers are?

Senator BEGICH. Right.

Mr. AHRENS. So we have to continue to get that. We can't even make some decisions with our committee because we don't know where they are, what disease entity they might have, and what services should be placed in those areas. If we knew a little more of that, we would be better off. So the Office of Rural Health ought to get on that and get it done.

Senator BEGICH. My time has expired. The report you sent up to the Secretary, do you anticipate that to be available to us? At what point do you think?

Mr. ATIZADO. As I said, it is under the Secretary's scrutiny. If I could release it to you today, I would, but I can't. It is a public document. It should be available to you.

Senator BEGICH. Great. Thank you very much, Mr. Chairman.

Senator TESTER. Thank you, Senator Begich.

Jim, Senator Murray had asked Dr. Jesse about fee basis and who goes where and about the fact that there were no guidelines for that. Has the Veterans Rural Health Advisory Committee taken

that up at all? Is that something that is within your purview? Has it been part of the conversation?

Mr. AHRENS. There has been a lot of discussion about fee-based, and I think it is the consensus of the committee that, especially in rural areas, there ought to be more of it. Now, what is coming up in this discussion is, can you provide the same quality of care in the private sector that the VA thinks they provide. So I think you can do that, but then we have got to overcome that barrier.

So it makes a lot of sense to me to use fee-based in areas where they are very remote, like Scobey, MT, or someplace like that.

Senator TESTER. I get you. It seems a bit odd, as far as if we take individual by individual and not have guidelines. I mean, I appreciate your honesty, Dr. Jesse. Jim, does that seem odd to you? You have been in the business for a long time.

Mr. AHRENS. Well, I think I would establish protocols so they can be part of the business, and if they can't be met, they shouldn't be.

Senator TESTER. All right. Dr. Jesse, a quick question. It does deal with rural veterans' health care along the area of dialysis. Has the VA looked at home dialysis?

Dr. JESSE. Yes. Actually, we had a long discussion about this the other day. I think, if I remember the number correctly, it is about 7 percent of our veterans now get home dialysis. There are two ways to do this. One is through a conventional hemodialysis type of machine. The other, which is where most of the home dialysis is done, is through peritoneal dialysis. It is doable. It doesn't even require sending somebody into the home; patients and their families can be trained to do it——

Senator TESTER. Is it cost effective?

Dr. JESSE [continuing]. And it is one of the options that we are looking at to improve it's distribution. It is an area that even outside of the VA has struggled to really catch on.

Senator TESTER. Is it cost effective?

Dr. JESSE. Well, we think it is at least cost neutral.

Senator TESTER. OK, that is good. I think you have to take into account everybody——

Dr. JESSE. So those are exactly the two questions the Secretary asked me the other day when we were meeting about this. We think that this is an opportunity, but it has struggled to catch on and we are not sure why.

Senator TESTER. Well, I think it is an incredible opportunity. It might be lack of knowledge. Let us move on.

Mr. Ahrens, I know for a fact, and you talked about it in your testimony as one of the recommendations, that we need to work more with IHS and VA; then you even took it a step further, VA and other health care facilities. Every time we have approached this, it has become somewhat of a turf issue. So could you talk a little bit more about what we could do to encourage IHS and VA to work together, because it is an incredible opportunity for saving some money and offering better health care.

Mr. AHRENS. I would be happy to. I think it has to start at the top. You have to have the head of the Indian Health Service and the head of the VA make it a priority. In my opinion, over the years, even working in the private sector, it hasn't been that high a priority. Once you do that, everything falls into place. But you

have got to do that and you also have to have each State collaborate at the local level, where you can get the various Indian Health Service organizations and tribes together to sit down and start talking. It is a long, long process, but you have got to start it because we are wasting money by having these two systems.

Senator TESTER. Any ideas on what we can do as far as recruiting and retaining health care folks in rural areas, what the VA could do better?

Mr. AHRENS. Well, I think most of the VA training facilities are located in major metropolitan areas, and somehow you have got to get practitioners to have some type of a residency or training program in rural areas. You know, we do this in Montana on the private side, where people stay in Montana. If they can serve their residency in Montana, you have got a pretty good retention rate. That is not happening to the full extent that it should, in my opinion. So you have got to do that.

Senator TESTER. OK. That is our priority with me, to try to get them back in the system. It is something I hear more about than any other single issue as I have town hall meetings.

We have spoken in the past about opportunities with prescription drugs for Priority 8s. Could you just talk to me a little bit about how it might work?

Mr. AHRENS. Well, I am not sure exactly how it will work mechanically, but I think if you are enrolled and you are a veteran, you ought to be able to avail yourself of the services. So get these people enrolled in some fashion and let them use the drug benefit. I think it would be a wonderful opportunity.

Senator TESTER. OK.

Mr. AHRENS. Mechanically, I don't know how to do it. I leave it up to my friend, Dr. Jesse, to put it together.

Senator TESTER. All right. Do you have any ideas on that, Dr. Jesse? Is that something you would support, or is there something else that you think the VA could do for Priority 8 veterans?

Dr. JESSE. The Secretary has begun with, I think, authorization through Congress to actually open things back up to Priority 8s. It is being done in a fashion that would meter them in, because if we opened it up all at once, it would be overwhelming——

Senator TESTER. How about just with respect to prescription drugs?

Dr. JESSE. In respect to prescription drugs, there are a couple of challenges there.

Senator TESTER. OK.

Dr. JESSE. One is that we don't have the authority right now—I hope I am saying this correctly—to accept prescriptions from outside providers, so that, in fact, VA has to process that prescription. For many pharmaceuticals, the basics for hypertension and diabetic care and things, that is really not an issue. But there are some cardiac drugs that require monitoring and the like, where there is a lot of responsibility on the provider when we can't ensure that it raises some other issues. From a purely technical perspective, whether we could just open up, we will have to get back to you on that. I don't have the——

Senator TESTER. Could you, please? That would be good, if you could get back to us. If you need Congressional authorization, that

would be something. I think it really could be a win for Priority 8 folks.

Dr. JESSE. I will take that back to the Secretary.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER TO ROBERT JESSE, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Context of Inquiry: During the June 16, 2010 Senate Veterans' Affairs Committee hearing on rural health, Senator Tester asked VHA to evaluate the feasibility of providing pharmacy benefits to Priority 8 Veterans prior to their enrollment/eligibility for other VA care. In his recent travels through Montana, the Senator noted that his constituents seem most concerned about having access to safe, affordable, prescription drugs. Although full VA health care access for all Priority 8 Veterans is not feasible in the near term, the Senator asked if a prescription-only benefit for these Priority 8 Veterans would be a "bridge" to fill the gap until full Priority 8 enrollment can resume.

Response. It is true that providing access for all Priority 8 Veterans is not feasible in the near term. VA would like to acknowledge that while a stand-alone prescription benefit may seem attractive as an interim measure, there have been lessons learned by VA regarding the management of a drug formulary, the overall cost of providing a prescription benefit, infrastructure requirements, and potential patient risks from fragmented care. VA is committed to offering enrollment to greater numbers of beneficiaries based on available resources without sacrificing timely access or quality medical care for those Veterans already enrolled in VA's health care system.

Several years ago, VA gained experience through offering a stand-alone prescription benefit, the Transitional Pharmacy Benefit (TPB). This program was designed to ease the out-of-pocket costs for prescription drugs. Under this program, VA filled prescriptions from non-VA (private) physicians for patients waiting more than 30 days for their initial VA medical appointment.

For a limited time in 2004 and 2005, VA was authorized to fill prescriptions from non-VA (private) physicians until a VHA physician could examine the Veteran and determine a course of treatment. This program was made available in VA prior to the enactment of the Medicare prescription drug benefit which now offers a variety of choices to Medicare eligible Veterans that wish to select a stand-alone prescription benefit. The TPB program was offered to 44,322 eligible Veterans and 17,931 (40%) participated.

The TPB program demonstrated that its administrative costs were extremely high and the current infrastructure (i.e., software and business processes) is not designed to support this type of benefit. Through TPB, it was more costly to provide prescription coverage as a stand-alone benefit than to provide prescriptions through VA's comprehensive healthcare benefit. VA lacked software support to appropriately manage a stand-alone prescription benefit and lacked access to each patient's non-VA medical record, where important clinical information is maintained to properly evaluate the appropriateness of a medication.

Unique to VA's TPB experience was the comparison of formulary and non-formulary drug use. Forty-two percent of all TPB prescriptions received were for drugs not listed on the TPB Formulary. VA was able to reduce the percentage of non-formulary drugs dispensed to 27%, but this modest reduction was very labor intensive and costly. This stands in sharp contrast to VA's overall non-formulary dispensing rate of approximately 6%.

VA is concerned that a stand-alone drug benefit would induce demand by attracting a significant proportion of the non-enrolled population, thereby increasing costs for Veterans' healthcare. Depending on the eligibility criteria for a stand-alone drug benefit, it could also induce demand for enrollment.

VA believes that coordination of care by one provider is the cornerstone of high-quality health care. Without up-to-date information such as a detailed medical history, a complete medication use summary, and other pertinent clinical information that can only be provided by a single, primary care provider, there is risk that a course of treatment for an individual patient, based on incomplete or inaccurate information could lead to significant negative outcomes. Specifically from a quality of care perspective, practicing pharmacy in a fragmented, non-integrated manner, as is the norm in most of the U.S. health care system, is conducive to greater medication misadventures. VA has much experience to demonstrate that providing phar-

maceuticals as an integrated part of VA's healthcare benefit is effective and efficient from both a qualitative and quantitative perspective.

From an economic perspective, dispensing prescriptions prescribed by non-VA doctors would dramatically increase VA's outlays. Indeed, VA's current outlays for pharmaceuticals are below those of most managed care organizations in the US. VA has the infrastructure in place to develop and promulgate drug treatment guidelines and an effective National Formulary process. We strongly believe that the quality of care provided by a comprehensive Primary Care approach, integrated with a well-managed National Formulary process, is vastly superior to the fragmented, pharmaceutical delivery model that many Americans access today.

VA does not support plans to offer a stand-alone prescription benefit and is committed to working with Congress toward developing policy and a healthcare delivery system which builds on the strength of an integrated approach as opposed to the fragmented delivery of healthcare so common in United States.

Senator TESTER. Glen, I promised you a question. I am going to give it to you, and then we have got to go to a vote at 10:45, so we will recess and come back with Senator Begich's panel.

We have got more female veterans coming into the VA system every year. One of the services that is lacking in Montana—this is a Montana-specific question—is mammography screening, particularly in Helena. Is that something that we could really take a look at? Is it something that we could do? We need more than just equipment. We need more than space. Is it something that is on the radar screen as the female veteran population grows?

Mr. GRIPPEN. Senator Tester, first of all, thank you for all your support, working together closely with us. Certainly, women veterans are one of our highest priorities. We are taking a close look at our programs in women's health and we will make sure mammography and cervical prevention care are two key pieces of that, and we will take a closer look and provide information to you about where we are planning to go in that direction.

Senator TESTER. I would appreciate that a lot, Glen; and once again, thank you for your service.

I am sorry I didn't get a question for you, Mr. Putnam or Mr. Atizado. I really appreciate everybody's testimony today. I appreciate your commitment to veterans across this country.

With that, we will recess until Senator Begich gets back to reconvene.

[Recess.]

Senator BEGICH [presiding]. The meeting will come back to order. Thank you all very much; I appreciate your patience. We had a little issue on the floor and some of us were having to have some negotiations while we were trying to vote and leave to get back here. So thank you very much for your time.

I am going to make my comments very brief and just go right into the testimony, but I do want to say, as I said in my earlier comments, there is no more rural State than Alaska in the sense of delivery of services and how you can get from one point to the next. As I was just describing to Mr. Ahrens, who has a friend in Kodiak. I had to explain to him that I was just in Kodiak and could not leave for almost a full day because the weather conditions would not let me out of there, and I can only imagine the struggle when people need medical services.

As folks know from Alaska, with almost 76,000–77,000 folks that are veterans or registered veterans, we have one of the highest percent per capita, so we have a huge demand for veterans' services

in Alaska. At the same time, as I mentioned, it is very difficult to move around and get access to the services they need.

Today, this is the second panel that we have in front of us and I thank you all for being patient while we move through the process of voting on the floor and attempting to run Committee meetings at the same time.

We are joined today, and I appreciate the Alaskans that are here, Brigadier General Deborah McManus is the Assistant Adjunct General for Alaska, Commander of the Alaska Air and National Guard, and Alaska State Women Veterans Coordinator. She is accompanied by Verdie Bowen, who has traveled with us many places around the State. I thank you, Verdie, for being here. He is Director of the Office of Veterans Affairs for Alaska Department of Military and Veterans Affairs.

Dan Winkelman is the Vice President and General Counsel for the Yukon-Kuskokwim Health Corporation. Dan, thank you for being here.

Finally, Robert Jesse, M.D., gets a round two. You have survived round one, which is a good sign, so welcome again to this panel.

And also, Bill Schoenhard, Deputy Under Secretary for Health for Operations and Management at VA. Thank you for your visit to Alaska and getting a sense of what Alaska is about. You lucked out because the weather was pretty good. It was very good. So you will be our representative to explain to all the folks in D.C., when we say it is warm and not humid, you actually know what we are talking about now. Again, thank you for being here.

What I would like to do, General McManus, is start with you and have you to give your testimony. You each have about 5 minutes. The clock in front of you will signal. If you exceed that, the floor will release below you. Just kidding. [Laughter.]

So, General?

STATEMENT OF BRIGADIER GENERAL DEBORAH McMANUS, ASSISTANT ADJUTANT GENERAL—AIR, JOINT FORCES HEADQUARTERS—ALASKA, AND COMMANDER, ALASKA NATIONAL GUARD; ACCOMPANIED BY VERDIE BOWEN, DIRECTOR, OFFICE OF VETERANS AFFAIRS, ALASKA DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

General MCMANUS. Thank you, Senator Begich. It is my privilege and honor to be able to be here today and to appear in front of the Committee Members and to be able to address our rural health care issues in reaching out to our veterans.

I would like to draw your attention to the map of Alaska. As you can see, Alaska is the largest State, it is one-fifth the size of the continental United States, and has five times the coastline. Over 5 percent of Alaskans speak one of the 22 indigenous languages.

We look at the 2000 Census and how they distinguish between urban areas, urban clusters, and rural areas. We only have two locations that are urban areas and that is Anchorage and Fairbanks, with Anchorage being the largest. Over 250,000 folks live there from the Census Bureau. Then we have Fairbanks with over 50,000. So, that is about 300,000 of Alaskans that live in urban areas.

Then they have urbanized clusters, and these are defined as those densely populated areas that have over 2,500 people, and in Alaska, the 348 localities, 17 of them are identified as clusters. I would like to point out that only about 11 of those clusters do not even reside on the Anchorage road system, as you can see the road system there. There is less than 5,000 paved miles reported by the Department of Transportation.

Then we have those non-urbanized areas which the term is typically referred to as rural. I would like to use the term "remote" when we address Alaska because those are off the road system. You can reach them by air, and that is on a good day and it is weather-dependent, seasonal-dependent, with a lot of communication barriers. Some of our villages, they may not even have phone access and do not have Internet access. They have a subsistence lifestyle, so they may not have regular stores in which you can go to shop for goods.

You can see out of those that are not one of the two urbanized area clusters, that leaves about 350,000 Alaskans. The veteran population, as the good Senator said, is the largest per capita in the country. So the veteran population is dispersed similarly.

There are some projects. The VA, they are active in that area. Of course, Anchorage, our largest area, they have a large outpatient clinic. They just opened a new one in May which is attached to the Elmendorf Military Treatment Facility. It is a wonderful facility, very large and very welcoming to women veterans and also to families. Our younger veterans like to bring their families in to serve with them.

The CBOCs up at Fairbanks, Wasilla, Kenai, the more populated areas, off the road system, they have also opened some outreach clinics. In Homer, they use the Kenai CBOC staff to staff that on Mondays and they provide outreach services to those veterans in that area. Also, in Juneau we expect an outreach clinic to be opened in the fall. In Juneau, they have a population of about 3,000 veterans and it is designed to reach veterans along the inter-island ferry system, which is excellent.

Also, we have talked about the Rural Health Care Pilot Areas. There are seven of those areas and they are also on this map. The rural population resides typically around the coast and the inland areas around the river system.

What we have found to be most successful is our Yellow Ribbon Reconnecting Veterans Outreach Program. This was a program initiated by the Alaska National Guard, which we did receive a Federal grant of $500,000. The goal is to reach out to the IA recognized villages and the incorporated cities and towns. It is a year program which will be expiring in July, and we only have, like, 30 more locations; and we are visiting locations today.

So what has been very successful is to go out there and ask, where are our veterans? Then they want to know how do they know they are a veteran, so we explain that. We take out the paperwork and we help them fill out their paperwork. Many of them have said that, oh, yes, we have received those packages from the Veterans Administration in the mail. We just don't know what to do with it and we don't know what it means. Even if we were to

fill out this paperwork, what does it mean for us? So that has been very instrumental, to help them complete that paperwork.

Members of this team understand that if a veteran reaches 30 percent disability, that enables them to receive travel benefits to travel to one of these VA health care locations. And we work with them on that initial health exam through funds within the Alaska National Guard and other creative ways. We reach out to NGO's, veteran organizations that will help fund some of our rural veterans to come into those locations for care. We also let them know that they are eligible for military gravestones, and they are eligible for military funeral honors. ANG also talked to some of the National Guard retirees that may not have filled out the paperwork for their benefits, and to our ATG members to help them fill out applications.

So, that has been a very successful effort and we would like to be able to continue that, but it will take another grant. We got a lot out of that $500,000 grant because we have folks that are really dedicated, part of the community and want to reach out to these folks.

[The prepared statement of General McManus follows:]

PREPARED STATEMENT OF BRIG. GEN. DEBORAH C. MCMANUS, DEPUTY ADJUTANT GENERAL—AIR, JOINT FORCES AND COMMANDER, ALASKA AIR NATIONAL GUARD

I am truly honored I was invited to testify before the Senate Veterans' Affairs Committee.

My first experience managing the complex issues regarding our Alaska National Guard (AKNG) members in remote Alaska was in 2006 when we were faced with mobilizing 600 soldiers in October for Operation Iraqi Freedom (OIF). This was the largest AKNG deployment since WWII. At that time, I was the Director of Manpower and Personnel for the AKNG. We were faced with providing services to over 100 soldiers and their families from 26 remote Alaskan native villages throughout western Alaska. These soldiers were ready and anxious to serve in combat. They grew up as hunters with proven survivor skills. The 297th Regimental Crest worn by this Infantry Battalion displayed a Tlingit motto, Uyh Yek that translates to "Be on Watch. Ready to fire." The challenge was preparing their remote communities and families for their 15-month absence. Ms Jan Myers, the Family Readiness leader was instrumental in this process. Before the deployment, we conducted a workshop in the village hub of Bethel. The AKNG sponsored the travel of soldiers and their families to ensure maximum participation. Among the entities represented were the Association of Village Council Presidents, faith leaders, Indian Health Services, state legislatures, TriWest, and local government. Issues included maintaining the subsistence lifestyle while many of the healthy males deployed, continuing use of Indian Health Services (IHS) ILO remote TRICARE since civilian practitioners were practically non-existent, and communication with families during the deployment since some did not even have phones or spoke English.

The next challenge became preparing for their return and ensuring access to veteran benefits in the remote native villages. In August 2007, only two months before the return of our rural veterans, a historic MOU was signed between the Alaska Veterans Affairs (VA) Healthcare and Benefits Administrations (VHA/VBA) and the Alaska Department of Military and Veterans Affairs (DMVA) to ensure access to the full spectrum of Veteran benefits with an emphasis on healthcare. Key goals included:

- Seamless Delivery of Healthcare Services to Rural Veterans
- Home Station Reunion and Reintegration Workshop for Returning GWOT Veterans to include Post Deployment Health Reassessments (PDHRA)
- Multidisciplinary Mobile Outreach Teams

The MOU was based are two primary assumptions: 1) Statistics reflected that up to 30–35% of returning Veterans will seek at least one psychological health visit within the first year after returning home. Such unresolved emotional disturbances as a result of a Veteran's combat experience could be extremely detrimental to a small, remote Alaskan community; and 2) Due to lack of access to a VA facility for

healthcare, rural Alaska Native Veterans will probably utilize the Alaska Tribal Health System.

The following initiatives were identified. Today, there is continuing progress.

- Telemedicine and teleradiology capability at 235 sites around the State and a multi-year home telehealth monitoring project through Alaska Native Tribal Healthcare Consortium (ANTHC).
- A VA Tribal Veterans Representative Program to train tribal representatives on VA policy, procedures, eligibility, and rules.
- A VA education program for the Alaska Tribal Health Organizations on VA eligibility and clinical information regarding Post Traumatic Stress Disorder and other Veteran readjustment issues.
- Vet Centers participation in outreach services.
- Coordination of access to care through flexible case management services that recognize the individual and family needs of veterans. These services or "pathways of care" would become a link of services that connect rural Alaska with Anchorage and Anchorage with Puget Sound.
- Work with state and Federal agencies, civic organizations, and faith-based agencies to ensure a wide variety of benefits for Alaska Veterans. All agencies will identify key individuals and commit resources to address/work issues.
- DMVA will conduct Post Deployment Health Reassessments (PDHRAs) on-site vice a telephone or web-based format.

The Post Deployment Health Reassessments (PDHRAs) were vital in providing VA services to veterans returning from OIF living in remote western Alaska. We made it mandatory for these assessments to be conducted in-person in Anchorage to ensure access to a multi-disciplinary support team that included representatives from NGB, VHA, VBA, Vet Centers, TriWest, and Family Readiness. Since the soldiers were in an official status, their travel was sponsored by the AKNG. Our goal was to generate referrals to the maximum extent possible so the costs of further diagnosis and treatment at the Anchorage MTF were absorbed by the military. Typically, the seven permissible appointments were adequate to address those medical issues that presented themselves upon return from the deployment.

However, mental health problems may have a delayed onset or veterans delay seeking treatment. Reports on our OEF/OIF veterans document substantial mental health distress and adjustment difficulties among military personnel returning from combat operations in Iraq and Afghanistan. They are discovering problems with depression, Post Traumatic Stress Disorder, and alcohol misuse are common particularly among National Guard and Army Reserve soldiers. Screening efforts to identify mental health concerns in the months following return from combat suggest that up to 42% of National Guard and Army Reserve troops require mental health treatment, but that relatively few actually get care (<10%). Many redeployed soldiers express concerns about interpersonal conflict (14–21%), highlighting the potential impact of war on the well-being of family members, as well as friends and employers. Why? The Reserves typically return to the civilian community and do not have the same access to military support networks. To better assist returning reserve veterans, many support programs have been developed. Typically, the AKNG has had to modify such programs to ensure outreach to the remote areas of Alaska.

In May 2005, the National Guard's Transition Assistance Advisor (TAA) Program was initiated to assist Servicemembers in accessing Veterans Affairs benefits and healthcare services to include obtaining entitlements through the TRICARE Military Health System and access to community resources. Mirta Yvonne Adams, the TAA for the AKNG brought 8 years TriWest experience to the position in addition to her countless years as a voluntary military spouse in Family Readiness groups. Mirta uses the AKNG integrated support network to better ensure seamless delivery for our Servicemembers. This network includes the following services: education, Employer Support of the Guard and Reserve (ESGR), Military Funeral Honors, Yellow Ribbon Program, Military Family and Life Consultants, Survivor Outreach Services, Military One Source, Family Readiness, Chaplain, Director of Psychological Health, and Family Programs.

In 2008, the National Defense Authorization Act required the Secretary of Defense to establish a national combat veteran reintegration program to provide National Guard and Reserve members and their families with sufficient information, services, referrals, and proactive outreach opportunities throughout the deployment cycle. Although the AKNG had already established a well-functioning reintegration program, the four full-time resources associated with the Yellow Ribbon program were a welcome addition. However, once again, funding for travel throughout remote Alaska was inadequate.

Providing veteran services throughout Alaska is extremely challenging. Alaska is #1 per capita of veterans in the Nation, making up about 17% of the state's population as compared to the national average of about 11%. The 2000 Census recorded our population to be 650,000 (now is ~686,300) with only two urbanized areas and 17 urbanized clusters. Out of 348 census localities, 52% have less than 250 people. Of the roughly 77,000 vets in the state, approximately 20% live in "remote" Alaska. I personally define remote as areas inaccessible by the road system with very small populations with very limited healthcare typically through an Indian Health Services (ISH) health aide.

In the first ever effort to personally connect with Alaska veterans in remote areas, the AKNG has funded a one-year temporary Yellow Ribbon Reconnecting Veterans Outreach Program at $500K to visit every BIA recognized village and incorporated city, visiting approximately 250 locations. The objectives are to locate and assist every veteran to apply for benefits they have earned from either the National Guard or the Veterans Administration, to assist families of deceased veterans apply for Veterans Headstones and Honor Guard Military Memorial Service, and to assist completing Alaska Territorial Guard applications. This team understands a veteran is eligible for government sponsored transportation to a VA medical facility upon receiving a disability rating of ≥30%, thus, they work diligently with veterans to complete the required paperwork. Village administrators have indicated a willingness to learn more about veteran benefits and the forms as well as ways to access the system. A report will be published in the October to November 2010 timeframe. Although this is the first program to have a significant impact in obtaining benefits for our remote Alaskan veterans, it will be expiring soon.

The Team Leader, Ms. Alice Barr, M.Ed., LPC, LMHC, has shared tentative insights as listed below. In summary, the primary barriers to receiving benefits are communication (use of indigenous languages and reliance on the spoken word), obtaining ID cards, understanding/completing paperwork, and access to healthcare.

- Negative reactivity to Federal entities and their subordinates who may not understand or have the patience to deal with remote challenges such as language, finances, travel issues, and the accompanying emotional problems.
- The high cost of traveling to urban areas to seek medical care due to agency financial inability to "travel" the veteran in for care.
- The team has also encountered issues with those veterans who are not able to finance a trip into the nearest ID card facility. These members are having issues with their TRICARE entitlement, as they do not have a valid military ID.
- Education, home loan guarantee and SGLI/VGLI questions have also been a hit with these visits.
- Evidence of post war trauma in veterans who served in the Vietnam Conflict, Korean Conflict, Aleutian Campaign and OEF/OIF.
- Vietnam Vets are finally applying for benefits after years of personal neglect and who now find themselves riddled with the after affects of their service and accompanying Agent Orange complications while residing outside medical service areas.
- This team has encountered many female veterans—primarily National Guard, Navy, Air Force, and Army. Typically, the female veterans were afraid to report issues of gender discrimination, sexual harassment or assault due to their awareness that they would be stigmatized in the service and that their situations could in fact become worse. Many choose to serve their time and get out rather than make appropriate reports.
- Often, female veterans who did not think they deserved any benefits. They wanted to make sure that all the male veterans were in line first. Some of the female Veterans had injuries they kept quiet for so long a time and were now suffering very severe arthritis problems.
- Male and female veterans experience sexual trauma in their early lives. For some this impacts the way they experience and handle trauma as adults. For the Alaskan veterans this impact is doubled due to the lack of counseling services in their local areas.
- AKNG retirees and those within two years of their 60th birthday do not understand the how to apply for retirement benefits, the importance of the SBP, and converting from SGLI to VGLI to continue life insurance.
- Extreme dental problems secondary to remote living and lack of dental care.
- Economic problems stemming from the expense of remote living as well as lives as hunters and trappers in an effort to escape modern living.

The Alaska VA has fully partnered with the AKNG in seeking innovative solutions to serve our rural veterans. Recognizing the large number of AKNG OIF veterans in remote western Alaska, they established a Rural Veterans Liaison position

in the Bethel "hub" last year. The liaison, Irene Washington, was perfect for the position. She had joined the active duty Army in 1979, transferred to the AKNG where she retired in 2005 and started working with the VA. Her military background and Yupik language enabled her to assist the regional veterans in understanding and obtaining the veteran benefits they had earned. Many had previously been receiving VA documentation in the mail and had never responded due to lack of understanding.

In July 2009, a one-year VA pilot program went into effect to allow non-native veterans in remote Alaska to be provided healthcare through the Native Health Care network with VA reimbursement. This program involved seven remote census areas (Bethel, Dillingham, NW Arctic Borough, Cordova, Bristol Bay Borough, Nome, and West Hampton. Often, the Indian Health Services is the only provider in remote Alaskan locations. A report is anticipated within a few months after the program's completion.

Additionally, the VA is extending medical facilities/services within the Great State of Alaska. A VA Outreach Clinic was opened in Homer in December 2009 using Kenai CBOC staff to provide services one day/week. Out of 582 veterans who live in this area, 328 are provided care through this clinic. A new VA Outreach Clinic in Juneau will open this fall with anticipation of eventually reaching veterans along the inter-island ferry system.

I also have the privilege to serve as the Alaska State Women Veterans' Coordinator. As we know, women veterans are one of the fastest growing segments of the veteran population. Today, women comprise ~7% of the veteran population which is expected to be doubled in five years as a result of OEF and OIF. Within Alaska, the female population is actually 10%. Of the 8,250 women veterans within Alaska, approximately 16% are located in remote Alaska. In this position, I work closely with the Alaska VA's Women Veteran Program Manager (WVPM). In 2008, VAs were funded for the WVPM to be a full-time position.

In November 2009, the AKNG sponsored the first Alaska State Women Veterans Outreach Campaign at several locations on the more populated "road system". At that time, VA statistics revealed only 3,000 or 36% of Alaska female veterans were enrolled with VA and only 1200 were using VHA services.

Like their male counterparts, many women veterans feel frustrated and disappointed by the complex bureaucracy of the Veterans Affairs health system. And, they are more reluctant to seek out the help of the Veterans Administration and utilize the benefits they've earned, possibly because of a lack of knowledge of their eligibility. This is especially acute when a veteran has suffered Military Sexual Trauma (MST). Once they finally gain the courage, they often feel victimized again when subjected to the cumbersome, impersonal process. I have a friend Andrea who was raped twice in 1987 while in the active duty Army and never reported it for fear of retribution. She retired from the Air Force Reserve in 2005 with 24 years of service. After attending the November 2009 Alaska Women Veterans Outreach Campaign, she finally sought help and was diagnosed as PTSD. When applying for compensation, she received a medical opinion that her PTSD most likely began due to abuse in childhood and adolescence and exacerbated by the two rapes. However, she characterizes her childhood as normal. Although she had not received her "rating", she still felt victimized all over again. Nationally, we must simplify the application process for MST victims.

The Alaska VA has expanded women veteran services significantly over the past few years. Services now include:

- Full-time Women Veterans Program Manager
- The Women Veterans Health Strategic Health Care Group sponsors a special campaign each month and the Alaska VA Healthcare System has been using the materials to promote the attention to women Veterans; monthly campaigns: August—Domestic abuse, September—Flu Prevention, October—Breast Health, November—Stop Smoking, December—Mental Health Awareness, February—Healthy Heart, March—Homelessness. For these campaigns, posters are printed and distributed to service areas, Vet Centers and CBOCs. Poster displays are created for some of these in the lobby of the main Anchorage VA Outpatient Clinic.
- Provide written materials: Tri-fold describing services available to women veterans and a booklet with greater detail about services available to women Veterans.
- Conduct a monthly Environment of Care Assessment to ensure an environment in which women feel welcomed, safe and cared for.
- An active Women Veterans Advisory Committee composed of VA healthcare staff, Veterans Benefits staff, Vet Center, active duty military, OEF/OIF staff, Military Sexual Trauma staff, women Veterans Health Provider, and Women Veterans Program Manager, representatives from the 3MDG, and State Veterans Affairs Women's Coordinator that meet monthly.

• September 11, 2010—First annual Women Veterans Retreat to include keynote speakers, educational events, lunch, and a closing ceremony.
• Two Primary Care Providers (PCP) from the Anchorage VA Outpatient Clinic and one PCP from the Fairbanks VA Community Based Outpatient Clinic (CBOC) attended the VA sponsored Women Veterans Primary Health Care Mini-Residency in Seattle to improve their proficiency in women's health care. More VA sponsored Women Veterans Mini-Residencies are planned for FY 2010 where PCPs from the Alaska VA will be able to participate.
• The Women's Health Clinic at the Alaska VA expanded services to treat women with abnormal pap smear results rather than referral to non-VA providers.
• At the new VA clinic location in Anchorage which opened May 10, 2010, women veterans are able to come to the Comprehensive Care Clinic where they may receive Primary Care and Women's Health Care from one PCP as well as evaluation and treatment by Social and Behavioral Health providers in an integrated clinic setting.
• Women's Comprehensive Health Care Implementation Plan (W-CHIP) has moved ahead with PCPs at the Anchorage VA Outpatient Clinic, the Fairbanks VA CBOC, Kenai VA CBOC, Mat-SU VA CBOC and the VA Domiciliary for Homeless Veterans. Each of these locations has PCPs who are trained, interested and credentialed to provide comprehensive Primary Care and Women's Health care to their patients.
• Basic benefits available to women include but are not limited to:
  – Comprehensive Women's Health Exams
  – Mammograms
  – Contraception Counseling
  – Bone Density Testing
  – Maternity Benefits
  – Gynecology Surgery
  – Menopause Diagnosis
  – Mental and Addiction Treatment
  – Military Sexual Trauma Counseling

I sincerely appreciate this opportunity to testify before the Committee. It is such a privilege and honor to serve our country and the state of Alaska.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO BRIG. GEN. DEBORAH C. MCMANUS, ASSISTANT ADJUTANT GENERAL–AIR, ALASKA

Question 1. As the Alaska State Women Veterans' Coordinator, I know that you have been working on ensuring that women veterans receive the access to care; I have heard that they are not offered the same level of information about benefits, what do you see as the problem and solutions?

Response. Like their male counterparts, some feel frustrated and disappointed by the complex bureaucracy of the Veterans Affairs health system. And, women veterans are more reluctant to seek out the help of the Veterans Administration and utilize the benefits they've earned, possibly because of a lack of knowledge of their eligibility. This is especially acute when a female veteran has suffered Military Sexual Trauma (MST). They often remain embarrassed, alienated, and ashamed. The military is trying to reduce the stigma of seeking help for MST through increased awareness, education and guaranteeing confidentiality to victims reporting such crimes. To help our Alaska women veterans understand they are veterans too, the AKNG sponsored the first Alaska State Women Veterans Outreach Campaign in November 2009 at four locations on the more populated "road system". Since then, enrollment has increased by 300 and those using VHA services increased by 400. We must continue these efforts at all levels.

Question 2. What are some of the problems with female veterans enrolling, with on 36% of Alaska female veterans enrolled and only 1200 using VHA services?

Response. Please refer to answer to Question 1.

Question 3. The Yellow Ribbon Reconnecting Veterans Outreach program to reach out to 250 locations in rural Alaska to locate and assist every veteran to apply for benefits. This program will be expiring soon, would you give this Committee a quick summary of the results.

Response. In the first ever effort to personally connect with Alaska veterans in remote areas, the AKNG has funded a one-year temporary Yellow Ribbon Reconnecting Veterans Outreach Program at $500K to visit every BIA recognized village and incorporated city, approximately 250 locations. The objectives are to locate and assist every veteran to apply for benefits they have earned from either the National Guard or the Veterans Administration, to assist families of deceased veterans apply

for Veterans Headstones and Honor Guard Military Memorial Service, and to assist completing Alaska Territorial Guard applications. This team understands a veteran is eligible for government sponsored transportation to a VA medical facility upon receiving a disability rating of >30%, thus, they work diligently with veterans to complete the required paperwork. Village administrators have indicated a willingness to learn more about veteran benefits and the forms as well as ways to access the system. A report will be published in the October to November 2010 timeframe. Although this is the first program to have a significant impact in obtaining benefits for our remote Alaskan veterans, it will be expiring soon.

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Question 4. Can you give me an example of how an IHS beneficiary living in a small village whose spouse is a member of the National Guard deployed would access care? How about a non-beneficiary?

Response. My experience is the IHS beneficiaries continue using the IHS. Although they are automatically enrolled in TRICARE Prime Remote (TPR) when their spouse deploys, there are simply no civilian or TRICARE network providers in these areas. It is typical for non-beneficiaries to also access the IHS since their policy is to provide care to anyone requesting their services with the expectation of reimbursement. There are simply no other healthcare options in remote Alaska.

Question 5. In your experience, what have you witnessed as challenges for rural veterans?

Response. The biggest challenge for our rural veterans is access to VA medical services. However, before one can be granted access, you must complete the bureaucratic paperwork. The Yellow Ribbon Reconnecting Veterans Outreach Program discovered many veterans had received VA "packages" but did not understand the entitlements or the paperwork. This outreach program provides that one-on-one assistance along with training community liaisons. Once a veteran is determined 30% disabled, they become entitled to travel benefits. Communication is often a barrier in

remote Alaska—both language and technological. To help overcome such cultural barriers, while recognizing the large number of AKNG OIF veterans in remote western Alaska, VA established a Rural Veterans Liaison position in the Bethel "hub" last year. The liaison, Irene Washington, was perfect for the position. She had joined the active duty Army in 1979, transferred to the AKNG where she retired in 2005 and started working with the VA. Her military background and Yupik language enabled her to assist the regional veterans in understanding and obtaining the veteran benefits they had earned. Such outreach programs are the result of innovative problem solving among multiple governmental and non-governmental agencies and organizations. We must ensure a continuous funding source for innovative outreach programs.

Question 6. As for transition from the Guard to the VA system, how does that work for someone living in a rural area?

Response. In May 2005, the National Guard's Transition Assistance Advisor (TAA) Program was initiated to assist Servicemembers in accessing Veterans Affairs benefits and healthcare services. Within the AKNG, all members separating from the Guard are required to process through this program to understand their entitlements and complete the necessary paperwork. We even sponsor travel for our remote veterans to receive their initial VA exam.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO BRIG. GEN. DEBORAH C. MCMANUS, ASSISTANT ADJUTANT GENERAL–AIR, ALASKA

Question 1. In your testimony you reference the MOU between the Alaska VHA/VBA and the Alaska Department of Military and Veterans Affairs, would you explain how that works and if you feel it has been beneficial to veterans?

Response. This historic August 2007 MOU was to ensure access to the full spectrum of Veteran benefits with an emphasis on healthcare for the 100+ soldiers returning to 26 remote Alaskan native villages throughout western Alaska upon their return from OIF. Key goals included: Seamless Delivery of Healthcare Services to Rural Veteran, Home Station Reunion and Reintegration Workshop for Returning GWOT Veterans to include Post Deployment Health Reassessments (PDHRA), and Multidisciplinary Mobile Outreach Teams

The MOU was based are two primary assumptions: 1) Statistics reflected that up to 30–35% of returning Veterans will seek at least one psychological health visit within the first year after returning home. Such unresolved emotional disturbances as a result of a Veteran's combat experience could be extremely detrimental to a small, remote Alaskan community; and 2) Due to lack of access to a VA facility for healthcare, rural Alaska Native Veterans will probably utilize the Alaska Tribal Health System.

The following initiatives were identified. Today, it's still a work in-progress.

- Telemedicine and teleradiology capability at 235 sites around the State and a multi-year home telehealth monitoring project through Alaska Native Tribal Healthcare Consortium (ANTHC).
- A VA Tribal Veterans Representative Program to train tribal representatives on VA policy, procedures, eligibility, and rules.
- A VA education program for the Alaska Tribal Health Organizations on VA eligibility and clinical information regarding Post Traumatic Stress Disorder and other Veteran readjustment issues.
- Vet Centers participation in outreach services.
- Coordination of access to care through flexible case management services that recognize the individual and family needs of veterans. These services or "pathways of care" would become a link of services that connect rural Alaska with Anchorage and Anchorage with Puget Sound.
- Work with state and Federal agencies, civic organizations, and faith-based agencies to ensure a wide variety of benefits for Alaska Veterans. All agencies will identify key individuals and commit resources to address/work issues.
- DMVA will conduct Post Deployment Health Reassessments (PDHRAs) on-site vice a telephone or web-based format.

Senator BEGICH. Thank you very much, General.

General MCMANUS. You are welcome.

Senator BEGICH. Verdie, were you going to speak, or did you have——

Mr. BOWEN. If you want me to speak, sir, I am more than——

Senator BEGICH. I wasn't sure if you had testimony you wanted to give.

Mr. BOWEN. Well, I can provide testimony. I had not had time to write one and present one to you.

Senator BEGICH. Let me hold you there, then, and I will probably have some questions for you.

Mr. BOWEN. Thank you, sir.

Senator BEGICH. Dan?

STATEMENT OF DAN WINKELMAN, VICE PRESIDENT FOR ADMINISTRATION AND GENERAL COUNSEL, YUKON-KUSKOKWIM HEALTH CORPORATION, ALASKA

Mr. WINKELMAN. Good morning, Mr. Chairman. The Yukon-Kuskokwim Health Corporation has been contracting with the Indian Health Service to provide health care services for over 20 years. Today, in remote Western Alaska, we provide comprehensive health care to 28,000 people, largely Yupik Eskimos across a roadless area the size of the State of Oregon, where the average per capita income in our region is about $15,000 on an annual basis.

Our unemployment rate in our villages is over 20 percent. Gas in our main hub city of Bethel is $5.34 per gallon. In our villages, it is $6 to $8 a gallon, about the same price we pay for a gallon of milk. Many homes in our region are without piped water and sewer, and over 6,000 homes in rural Alaska do not have safe drinking water.

When considering the high energy, food, and personnel costs against an IHS appropriation that does not allow for mandatory medical inflation increase, providing health care to our 58 tribes on a daily basis is an extraordinary challenge, especially when you consider the enormous health disparities in our region.

For example, Alaska Natives' leading cause of death is cancer. The Alaska Native cancer mortality rate is approximately about 26 percent higher than U.S. Caucasians. While cancer mortality for the rest of Americans is decreasing, it is dramatically increasing for Alaska Natives. Particularly disturbing is our region's high suicide rates. Unfortunately, our age-adjusted suicide rate for teens, 15 to 19-year-olds, is 17 times the national average.

This is the environment where many Alaska Native veterans were born and raised and then return to after serving our great country. For Alaska Native American Indian veterans who serve at the highest rate per capita of any U.S. race, to lack access upon their return from duty to culturally appropriate and quality health care services by the Veterans Administration is a shame.

In Alaska, highly rural veterans must break through several barriers in order to receive care. There are almost no VA facilities in rural Alaska. The existing IHS and tribal facilities managed by Tribal Health Organizations like YKHC are underfunded, according to the IHS, by approximately 50 percent. Last, the Alaska VA Health System's Rural Health Pilot Project is not statewide and needs dramatic improvement.

I have three recommendations. The first is to establish a VA clinical encounter rate for the IHS and tribal facilities. Instead of building new VA health care infrastructure in rural Alaska, the VA

should increase its collaboration with Tribal Health Organizations and use the existing Alaska Tribal Health System infrastructure that already exists for rural veterans' care. The Alaska Tribal Health System provides quality services. We are nationally recognized and we are fully accredited by the Joint Commission. However, due to the IHS's chronic underfunding, it is important that the VA reimburse tribal facilities that provide care to veterans and their eligible family members.

The creation of a VA clinical encounter rate to reimburse IHS and tribally-operated facilities should include multiple types of services, such as primary, emergent, behavioral health, and telemedicine services. Non-native veterans should also be able to access these services through this encounter rate, as well, since in rural Alaska these facilities are the only ones available.

My second recommendation is that in the alternative of establishing a VA clinical encounter rate for IHS and tribal facilities, the Committee should review, redesign with tribal input, and redeploy the Statewide Alaska Rural Health Care Pilot Project. The Committee should review how the pilot was developed, the extent of tribal participation in the pilot's design prior to deployment, and its scope of services offered versus the actual need, whether the pilot was effectively communicated to our highly rural veterans and tribal partners, its billing processes, and the number of veterans who, quote, "opted in" and utilized services.

As for the pilot itself, it could have been designed and deployed more effectively. Instead, it seemed to be an afterthought. For example, although care is rendered in tribal facilities, veterans must first self-enroll with a different agency, the VA. We have no control over that enrollment process. This process is called opt in. Why are veterans required to fill out additional paperwork in order to participate in the pilot when they should already be deemed eligible by virtue of their service record? Our veterans deserve better than having to research how they and their eligible family members can opt in for health care services. After all, our veterans opted in when they signed over their lives to serve our country.

Another opportunity for improvement is to do away with limiting the scope of health care services a veteran may utilize within a 6-month time period. I do not know anyone, as I am sure you don't either, who can plan ahead of time when to have their illnesses take place, especially in a 6-month timeframe. To require our highly rural veterans to jump through additional barriers to receive only limited services is bureaucratic and ineffective to improve access to care.

My third recommendation is to monitor appropriations to the Office of Rural Health Care to ensure that all rural and highly rural veterans are adequately served. According to a June 3, 2009, letter by Senator Murkowski to VA Secretary Shinseki, Alaska's rural or highly rural veterans were initially going to receive zero dollars of last year's historic $250 million appropriation to the Office of Rural Health. Senator Murkowski wrote, quote, "I first learned of this project on Friday, May 22, after I expressed concern that none of the $215 million in Office of Rural Health Projects announced that week would have any significant effect on Alaska's access problems."

Obviously, we have received the pilot since then, and, Mr. Chairman, I see I have run out of time. May I have a few more seconds just to wrap up?

Senator BEGICH. Wrap it up very quickly.

Mr. WINKELMAN. Thank you. But it is unacceptable for America's most remote rural veterans living in remote bush Alaska to be forgotten by the VA and the ORH, whose mission is to ensure highly rural veterans have access to quality health care resources, especially with such an historic appropriation.

In conclusion, any rural or highly rural veteran should be able to go to any IHS or tribal facility and receive the care they need from that facility and that facility should be fully reimbursed by the VA for providing such services. In your own words, Senator Begich, I think it was last year you said it is all Federal monies, regardless of which Federal agency is providing that care, the IHS or the VA.

And last, I would like to give an example. For a veteran that is living in one of our areas, the reality is that if you are seeking behavioral health care services, it might mean waking up in the early morning hours to leave your home, let us say along the Bering Sea Coast in the Village of Kotlik via a small single-engine plane and flying a half-an-hour to the next village, which is Emmonak, which is near the mouth of the Yukon River, transferring to another small plane, flying another hour and a half to Bethel, and then transferring to a regional airliner to fly the last 400 air miles to Anchorage, all for an appointment the following day. That is a big deal.

Those are some major barriers, and those are the types of situations that we need to improve on, and Congress is entirely in power to solve those problems. Thank you, Mr. Chairman.

[The prepared statement of Mr. Winkelman follows:]

PREPARED STATEMENT OF DAN WINKELMAN, VICE PRESIDENT, ADMINISTRATION & GENERAL COUNSEL, YUKON-KUSKOKWIM HEALTH CORPORATION, BETHEL, ALASKA

Good morning, Mr. Chairman and Members of the Committee:

I. INTRODUCTION

The Yukon-Kuskokwim Health Corporation (YKHC) has been contracting with the Indian Health Service (IHS) to provide health care services for over twenty years. Today in remote Western Alaska we provide comprehensive health care to 28,000 people, largely Yupik Eskimo across a roadless area the size of Oregon, where the average per capita income is $15,000. Our unemployment rate in our villages is over 20%. Gas in our main hub city of Bethel is $5.34 per gallon, and in our villages it is $6–8 per gallon, the same price we pay for a gallon of milk. Many homes in our region are without piped water and sewer and over 6,000 homes in rural Alaska do not have safe drinking water. When considering the high energy, food and personnel costs against an IHS appropriation that does not allow for mandatory medical inflation costs, providing health care for our 58 tribes is a daily and extraordinary challenge.

Especially, when considering the enormous health disparities our region faces. For example, Alaska Natives' leading cause of death is cancer. The Alaska Native cancer mortality rate is approximately 26% higher than U.S. Caucasians. While cancer mortality for the rest of Americans is decreasing, it is increasing dramatically for Alaska Natives. Particularly disturbing is our region's high suicide rates. Our age-adjusted suicide rate for 15–19 year olds is 17 times the national average.

This is the environment where many Alaska Native veterans were born and raised and then return to after serving our great Country. For Alaska Native/American Indian veterans, who serve at the highest per capita rate of any U.S. race, to

lack access upon their return from duty to culturally appropriate and quality health care services by the Veterans Administration (VA) is a shame.

In Alaska, highly rural veterans must break through several barriers in order to receive care. There are almost no VA facilities in rural Alaska. The existing IHS and tribal facilities, managed by tribal health organizations like YKHC, are underfunded according to the IHS by approximately 50%. Last, the Alaska VA Health System's, "Rural Health Pilot Project" is not statewide and needs improvement.

II. RECOMMENDATIONS

I have three recommendations.

1. Establish a VA Clinical Encounter Rate for IHS and Tribal Facilities.

Instead of building new VA health care infrastructure in rural Alaska, the VA should increase its collaboration with tribal health organizations and use the existing Alaska Tribal Health System infrastructure for rural veterans care.

The Alaska Tribal Health System provides quality services and our facilities are nationally accredited by the Joint Commission. However, due to the IHS's chronic underfunding, it is important that the VA reimburse tribal facilities that provide care to veterans and their families.

A VA clinical encounter rate is needed. The creation of a VA clinical encounter rate to reimburse IHS and tribally operated facilities should include multiple types of services, such as primary, emergent, behavioral health and telemedicine. Non-native veterans should also be able to access care through this encounter rate since tribal facilities are often the only provider available in rural Alaska.

2. In the Alternative of Establishing a VA Clinical Encounter Rate for IHS and Tribal Facilities, the Committee Should Review, Redesign with Tribal Input and Redeploy Statewide the Alaska Rural Health Pilot Project.

I ask the Committee to review, redesign with tribal input and redeploy statewide the Alaska Rural Health Pilot Project. The Committee should review how the Pilot was developed, the extent of tribal participation in the Pilot's design prior to deployment, its scope of services offered versus actual need, whether the Pilot was effectively communicated to highly rural veterans and tribal partners, its billing process and the number of veterans who "opted-in" and utilized services.

The Pilot could have been designed and deployed more effectively, instead it seemed to be an after-thought. For example, although care is rendered in tribal facilities, veterans must first self-enroll with a different agency, the VA. This process is called "opt-in". Why are veterans required to fill out additional paperwork in order to participate in the Pilot when they should already be deemed eligible by virtue of their service record? Our veterans deserve better than having to research how they and their family members can "opt-in" for health care services. After all, our veterans "opted-in" when they signed over their lives to serve our Country.

Another opportunity for improvement is to do away with limiting the scope of health care services a veteran may utilize within a six-month period. I do not know anyone who can plan ahead of time when to have their illnesses take place, let alone in a six-month time period. To require our highly rural veterans to *jump through additional barriers to receive limited health care services* is bureaucratic and ineffective to improve access to care.

3. Monitor Appropriations to the Office of Rural Health to Ensure All Rural and Highly Rural Veterans are Adequately Served.

According to a June 3, 2009 letter by Senator Murkowski to VA Secretary Shinseki, Alaska's highly rural veterans were initially going to receive zero dollars of last year's historic $215 million appropriation to the Office of Rural Health (ORH). Senator Murkowski wrote:

> I first learned of this project on Friday May 22 after I expressed concern that none of $215 million in Office of Rural Health projects announced that week would have any significant effect on Alaska's access problems.

It is unacceptable for America's most remote rural veterans living in roadless Bush Alaska to be forgotten by the VA and the ORH whose mission is to ensure highly rural veterans have adequate access to quality health care resources, especially with such an historic appropriation.

III. CONCLUSION

Any rural or highly rural veteran should be able to go to any IHS or tribal facility and receive the care they need and that facility should be fully reimbursed by the

VA for providing service. In the words of Senator Begich, "it's all Federal monies" regardless of which Federal agency provides the care, the VA or the IHS.

Unfortunately, since last year's appropriation of $215 million in Office of Rural Health projects, little has changed for Alaska's highly rural veterans. Hopefully Chairman Akaka's recent landmark legislation, the Caregivers and Veterans Omnibus Health Services Act will be able to address some of these concerns.

Ultimately, for tribal organizations like YKHC, being able to systematically improve access to quality services for our highly rural veterans is more than a priority, access can dramatically improve the lives of our veterans and their families.

The reality for a highly rural veteran seeking behavioral health services is that it might mean waking in the early morning hours to leave their home in the coastal community of Kotlik via a small single-engine plane and flying a half-hour to Emmonak located near the mouth of the Yukon River. Transferring to another small plane and flying another hour and a half to Bethel. Then transferring to a regional airline to fly the last 400 air miles to Anchorage that evening. The round-trip ticket cost alone is currently over $1,000. All to make an appointment the following day at a VA facility in Anchorage. Whew!

Instead, improving access could mean the veteran not having to leave their community at all. That same veteran could wake-up and walk from his or her house to YKHC's Kotlik Village Clinic, and receive quality telepsychiatric care via high-definition video. It is obviously far more efficient and less costly for the VA to use existing IHS and tribal facilities for serving rural and highly rural veterans. Ultimately, it is simply the ability for a highly rural veteran to receive quality care closer to home and it is a matter entirely within Congress's power to address!

Thank you for the opportunity and honor to address your Committee today.

Senator BEGICH. Thank you, Dan. Let me move to Dr. Schoenhard. Thank you very much again for visiting Alaska. Thank you for being here today. I will turn to you.

STATEMENT OF WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH, OPERATIONS AND MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. SCHOENHARD. Sir, I do not have any testimony to give but am happy to answer any questions.

Senator BEGICH. Very good. Verdie, that gives you a few minutes if you want to say any additional comments before I start going through a series of questions.

STATEMENT OF VERDIE BOWEN, DIRECTOR, OFFICE OF VETERANS AFFAIRS, ALASKA DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

Mr. BOWEN. Thank you, sir, and thank you very much for inviting me to this Committee.

I believe that in Alaska, we have come a long way. We still have a long way to go to provide health care to our rural veterans. As I travel throughout the State I see different issues, and a lot of them really deal with something that Dan just touched on and it deals with the reality of travel time it takes to get from one place to another to another in order to get adequate health care. Sometimes, if the veteran could just stop by the local Native Health Office for a simple blood test instead of spending 2 days or 3 days to get to Anchorage to do the same thing, it would be a wonderful thing for them.

As I was in Ketchikan a couple of weeks ago, some of those guys were spending 3 days just to come up for simple blood tests and X-rays that could have been done at their local hospital. I think there are probably better ways that we could utilize our money and this is a good point that we should be able to take care of. I think

through partnerships with Indian Health Service and other local hospitals throughout the State, we will be able to treat every single veteran that we have.

Several things that have been touched on, and this is the last thing I will say, is that we have a hard time getting most of our veterans to register within the VA system. I have heard several times today talk about getting everyone registered. I am not really sure what the answer is. The Yellow Ribbon Team by the end of this month will have hit every populated center in the State of Alaska, which is well over 300. In that effort, we were only able to sign-up 2,000 additional veterans within the VA Health Care System.

I think that more will come as we move along, but if you look at the State of Alaska's Permanent Fund Dividend Form that is filled out each year by all Alaskans so that they can receive those royalty funds, only 700 have checked the box saying that they are veterans. So I am not quite sure what the answer is to get them to register besides going out and doing one-on-one visits with each and every one of them, which is what we have pursued.

The one request I do have for this Committee is that the Yellow Ribbon Team in our National Guard goes out and treats all veterans. It doesn't matter what war, whether they are National Guard, whether they are—lately, they have been reaching out to a lot of Vietnam-era veterans. They are working on a budget of about $500,000 for their travel expenses currently, and between the State of Alaska and them, we have partnershipped in order to reach all of these communities, and those funds will be up in October. It would be very nice if we can continue on and do follow-up visits next year because we might be able to take that 2,000 to 77,000. That should be all of our goal.

Thank you.

Senator BEGICH. Very good. Thank you very much.

I am going to follow up on that regarding people signing up. I know, General, with your work with women veterans, the coordination that you are doing there, even within women veterans, there is a small—I want to say it is about one-third of them signed up or taking advantage. Can you elaborate a little bit of what you think, and maybe following up on Mr. Bowen's comments regarding how difficult it is to register them. I know it is a concern for me. I know it is a concern for Senator Murray. What are you finding specifically in the area with women veterans? Give me a little bit of thought on that please.

General MCMANUS. Well, when we look at our female women veteran population, a lot of them are from the older wars and I think there is a cultural issue there in which many of them were in subordinate roles or support roles and their service was not as greatly appreciated when they returned to the States.

Also, a lot of them experienced military sexual trauma, whether it is rape, sexual assault, or harassment. So there was a fear of seeking help through the system, so a lot of them just faded away. However, I think it is different with our current OEF/OIF veterans, that there are mechanisms so that they can report the trauma and receive help.

A lot of times, women do not recognize that they are veterans, as women have traditionally been in a caregiver role. So I think there is a cultural issue, and there is an education issue. When we had the women veterans outreach campaign in November 2009, last year, we did see an increase in enrollment and use of services. Three hundred women additionally enrolled and 400 were seeking services. So I think a routine education system that lets women know they are vets, too, they have earned these rights and these are their benefits—a lot of them have female-specific health care needs. So now they understand the VA facilities can provide services in those areas, as well.

Senator BEGICH. Very good. Let me move over to this side to either one of you who would answer, is there more that the VA can do? An example was just given how the outreach was done to increase the amount of women who recognize that they have benefits available to them but may not be taking them for a variety of reasons just described. Do you have any thoughts on that? Dr. Jesse?

Dr. JESSE. A couple. I think the issues that have been brought up are really important. We have historically on the health care side measured access by wait times to clinic visits, wait times——

Senator BEGICH. How many came through? And how long they waited?

Dr. JESSE. How long they waited. And all that is irrelevant if they don't know that they are entitled to services; they can't access those services; they can't get to us; or we are not connected to them in one way or another. Particularly as we move to our new models of care, if you will, where we are not talking about episodic access as a driving function but actually connectivity, that front-end engagement becomes absolutely crucial.

So we have an awful lot of effort going on trying to understand this now. Why don't people declare themselves as veterans on forms? Why can we repeatedly send people information and they just don't act upon it? Our assumption is, well, we sent it to you. You should have acted on it. And the simple answer is, people should probably be enrolled when they swear into the military and make that very—we talk about seamless transition and there is a lot of discussion going on between VA and the Department of Defense as to how do we best affect that. I can only say that, again, this is one of the Secretary's top priorities and he understands these issues probably better than any of our leadership in prior years.

So we are trying to understand this. We are trying to make it easier. But there are complex issues here.

In terms of the women's issues, this gets, again, really interesting, because historically, we measure what we do in health care statistically. We look at all of these statistically. But whenever we look at women's health issues, the numbers aren't big enough to make sense of the statistics. What we have really learned from this is we have to treat each individual as a man of one and really try and understand how we can manage their health care needs in a much more specific manner.

So the VA over the past several years has done a lot. Every VA facility now has Women's Health Coordinators. We do have an Office for Women's Health Issues that is very proactive in trying to

develop these. The issues of military sexual trauma are extremely complex. Just to see them coming forward, I think, is happening because the discussion is coming out into the open. Again, we are willing to accept any help, any advice. We see these as very important issues and are trying to deal with them.

Senator BEGICH. So obviously, if the General has some ideas, she will be able to share them with you and you will—that is good. I will leave that to you two going forward.

Let me kind of narrow in on one subject and that is the Rural Health Project. Mr. Winkelman laid out some concerns, and I know you have heard from me more than once on this issue. I think you had three suggestions, but I want to take it a little broader, and maybe if, Dr. Schoenhard, you could respond to this, and that is—I may be a little bold here. The effort and idea is good. I don't think anyone disagrees with that. The implementation is the struggle. And it sounds like, based on the testimony, there might have been some linkages in the front end that might not have been put together as well and now we are trying to kind of patch it as we move along.

I am wondering if it is better to kind of freeze-frame on it for a second and say, OK, let us sit down with our rural health care providers who have been in the business for years and have figured out how to deliver to the most remote areas in the world; learn how to restart it rather than, I think, what is happening. The sense I get, and I may be wrong about this, but I hear from so many different people that it is almost like we are trying to patch a little issue here and patch a little issue when really maybe we should just freeze-frame it, stop, step back. What is the right approach? Bring some of the people who have been in the field and ask, what should we do differently?

Just the fact that you have to go get opt-in through another type of system before you are really in, you know, I can only tell you from my experience, and Dan has much more experience around this, for rural individuals who lived in rural Alaska most of their lives, that is just another piece of paper they are not going to respond to. They are just—I don't want to say give up, but they do less.

Is that too bold or—I am just trying to—it seems like every time I talk about this issue, it is always like almost starting, then not, then moving, then not. So give me your thoughts on that.

Mr. SCHOENHARD. Yes, Senator. I think the numbers on the rural pilot really speak for themselves. We obviously are struggling with getting veterans to sign up for this program. At this point, only 21 percent in the pilot have signed up, and of that, very few have asked for primary care authorizations for mental health consultations. So I think the numbers speak for themselves. We need to improve.

We have hired a company to do a focus group to understand better why we haven't had more success in enrolling veterans, but I welcome what Mr. Winkelman and Mr. Bowen have shared today. We need to sit down and understand together, because IHS has assets on the ground. They are in the communities. They understand well what is needed there, much better than anyone else that would be in a distant location, whether they are with VA or any-

where else. We should collaborate; and I think your suggestion that we freeze-frame—we were talking a little bit during the recess——

Senator BEGICH. That was strategically done. You know that, don't you?

Mr. SCHOENHARD. Yes, sir. [Laughter.]

We had a good conversation and I would certainly welcome undertaking the discussion of the three recommendations that were shared to see how we can better serve and better get veterans engaged with IHS in these locations.

Senator BEGICH. The consultant that you are using, do you know if the list of folks they are consulting with or getting input from include some of the delivery systems within the consortium, the Native Health Care Consortium? Do you know if that is part of the list of who they are kind of—not just veterans, I assume they are talking to veterans in their focus groups, but also the current providers of other health care—do you know if they are doing that?

Mr. SCHOENHARD. I do not know. My impression is that it is primarily veterans that we have not reached, but I think, hearing what we have heard today, we should reach out and certainly have them also talk to the providers.

Senator BEGICH. I appreciate that.

Second, is that consultant responsive to you, or who are they——

Mr. SCHOENHARD. To the VA.

Senator BEGICH. OK, to the VA organization. So there is one or two below you that kind of manage that in some form?

Mr. SCHOENHARD. Yes, sir.

Senator BEGICH. I would ask this, and I don't know if you can commit to this. I believe in these kind of Committee meetings we can make all kinds of speeches or we can get some work done and I would like to get work done. Is there a way that you would be willing to commit your level, some of the folks you just heard some testimony from, to say, we are going to sit down in the next month or two and kind of do the freeze-frame, make sure the consultant is actually touching bases with the right people to hear that input, and then maybe just restart the program. Would you be willing to say, we will commit to this in an aggressive way? Because I think the concept is—I mean, you heard a little bit earlier, I think everyone wants to see this work.

Mr. SCHOENHARD. Right.

Senator BEGICH. And the delivery capacity is huge. But it seems like we are just—something is missing in the mix. I guess in our State, which you have heard me say before, if you can do it in Alaska, you can do it anywhere. If you can deliver services to the most remote areas in the world in Alaska, the rest of the country will be a piece of cake.

Do you feel that is a commitment you could give now, or do you need to have a conversation back with the VA and more of an administrative discussion before you commit to sit down within a very short period? Maybe it is a month or two, say, we are going to engage at this different level with the consultant and some of the stakeholders, which we would obviously be happy to provide you with some of those names. Any thought from there?

Mr. SCHOENHARD. Sir, I would not hesitate to make that commitment. I think we should do that.

Mr. SCHOENHARD. Excellent. Dan, if I can swing back over to you and to the General, are you prepared, if there is a time table set up to put the resources on the table to have that discussion, to work through some practical implementations? First, to Mr. Winkelman.

Mr. WINKELMAN. Yes. You bet, Senator. There is already precedent for this. There was a Memorandum of Understanding that was signed way back in February 2003 between the VA, HHS, and IHS that said they would collaborate together on how to provide better access and how to develop better processes and systems of care for both of their constituents. So there is an agreement already there. I would suggest that it be used; and that there be a high-level meeting to show that there is a commitment with IHS at the table, VA at the table, and then also the Tribal Health Organizations which have the compact and contracts that run the health care in Alaska between us and the Indian Health Service.

Senator BEGICH. General, any comment from you on that?

General MCMANUS. Yes, sir. We also did a MOU in 2007 working with the VA to prepare for the returning 100 soldiers that were coming out of rural Alaska, 26 villages. In that, some of the assumptions were that these folks would continue to access care through the Indian Health Services available in their villages. So some of the initiatives surrounded good collaboration between VA Health Care Services and the Alaska Native Tribal Health Care Consortium, such as providing telehealth services and educating the health aides at the villages to identify some of these illnesses associated with deployments and serving in combat, such as PTSD, and how to best serve them.

Senator BEGICH. Dr. Jesse, did you have a comment? I wasn't sure if you——

Dr. JESSE. Yes, a couple of things. First is that the VA is committed to working with IHS. I know that there is a refresh of the 2003 MOU in process. I can't tell you exactly where that is right now. We have the new Director of the Office of Rural Health coming on board actually on July 6, who is at an SES level but comes to us with 20-some years of experience in IHS, which I think will be——

Senator BEGICH. That will be great.

Dr. JESSE [continuing]. Extraordinary for developing and strengthening those relationships. So we are extremely excited about that.

Just one other comment about what Mr. Schoenhard mentioned. He said the numbers speak for themselves. You know, if you look at why we do pilots, it is because we want to be sure we do things right. When we set up the rural pilot in Bethel, there were some boundaries around the extent of services that could be accessed. I wasn't privy to that, but my sense is that it was done because we didn't want to overwhelm a system. Well, we have, in fact, underwhelmed the system. You know, we sent letters out to 548 people. We enrolled 20 percent, and only ten have asked for things. Clearly, we haven't done something right, and your comment that there are issues here that, clearly, we don't understand, and to step back, to have a stand-down and—I mean, I don't say stop the program.

Senator BEGICH. Correct.

Dr. JESSE. That was——

Senator BEGICH. That is why I suggest a kind of freeze-frame.

Dr. JESSE [continuing]. But we need to revisit what is going on here and try and get a better understanding about why people aren't jumping at the service and what we need to do to open this up. We would commit to doing that.

Senator BEGICH. Excellent. I will say this, and I appreciate that, because I know when you do these programs, sometimes you want to just keep going down the path, but this is a moment, I think, where we can make a shift, reexamine it, and probably have a much more successful program. Actually, the fact that you have MOUs tells me that paper is good, but action is better. So it sounds like we have plenty of MOUs. Now, how do we collaborate?

Again, I think why we selected this panel the way we did was specific, because I knew the diversity that was going to be here was going to be just right to have this discussion. It is an important program. Again, if we can be successful in Alaska, I really, truly believe we can do this all across the country in other more remote rural areas that are having a difficult time receiving services.

Let me end with a couple of other quick questions and a couple more comments here with respect to the new facilities that Alaska is getting—again, this is specific for the VA—the one in Anchorage, which again, Dr. Schoenhard, thank you for being there. That is a great new facility that I think is going to have a great impact to our veterans, no question about it. Again, this is very parochial, but can you give me any update on the Juneau facility? That has always been kind of in the churn and it seems like it gets pushed back, and I am just wondering, how are you doing on that one? If you don't know, you can provide that for the record.

Mr. SCHOENHARD. If I can check and get that back to you on the record, sir, just to be sure, but we are currently open part-time. We anticipate moving to permanent space by the summer of 2010, and the summer of 2010 is very close, so let me get more specific——

Senator BEGICH. I was going to say, we are in it.

[Laughter.]

Mr. SCHOENHARD. Yes. So let me get back with the specific opening there.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MARK BEGICH TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS

Context of Inquiry: During the June 16, 2010 Senate Veterans' Affairs Committee hearing on rural health, Senator Begich requested an update on the status of the Juneau, AK, VA clinic.

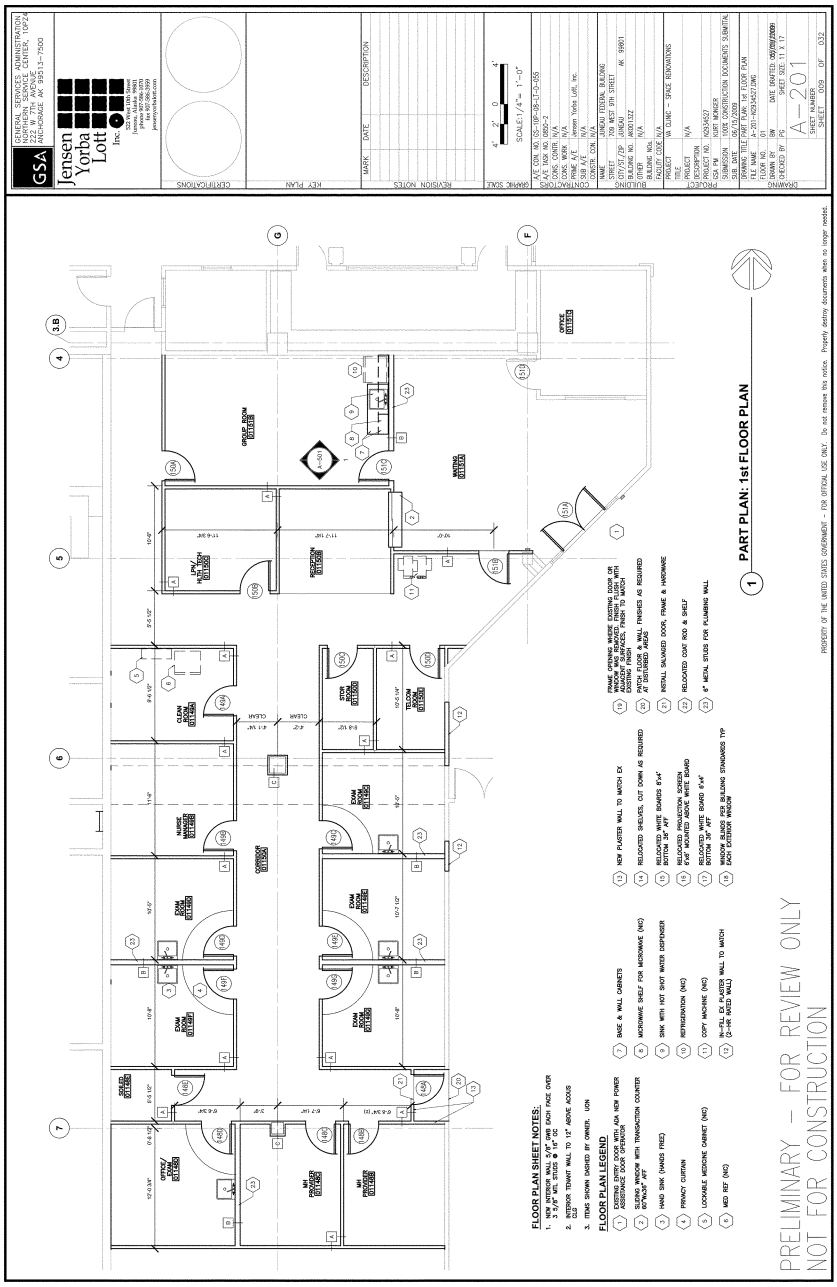
Response. Space is currently being renovated on the first floor in the Juneau Federal Building to house the Juneau VA Outreach Clinic. The square footage of the clinic will be 3,566 square feet. There have been delays due to unforeseen asbestos abatement requirements in the space allocated for the clinic. The projected construction contract completion date is August 31, 2010. Furniture and equipment delivery and installation is scheduled for mid-September, and an early October clinic opening date is anticipated.

The Alaska VA Healthcare System continues to operate a one day per month clinic with staff from the Anchorage VA Outpatient Clinic traveling to Juneau to see patients in the US Coast Guard clinic, also located within the Federal Building. This will continue until the permanent VA clinic is operational in October.

The outreach clinic will support an annual appointment volume of 2,640 which equates to approximately 1,000 patients. If demand exceeds that number, the clinic space will allow for expanded staffing. Primary Care and Mental Health Care will be the services provided within the outreach clinic.

The clinic nurse manager has been hired and is on-board. Selections have been made for a psychiatrist, medical support assistant, health technician, and social worker. We are currently recruiting for a licensed practical nurse and a primary care physician.

Please see the file below for the clinic's preliminary floor plan.



Senator BEGICH. OK. That would be great.

Dan, if I can ask you one general question, you have heard the discussion about the capacity. Does the Health Care Consortium have—I think I know the answer to this, but I want to just feel comfortable in saying it—if there is a kind of freeze-frame and it

gets altered in the sense of a new idea of how to improve rural health care, does the consortium have the capacity in the areas from the small villages on up to meet probably what you might perceive as the need of the veterans?

Mr. WINKELMAN. Yes, we do. We have over 200 village clinics out in the remotest of the remote areas, which is oftentimes what we call home.

Senator BEGICH. That is right.

Mr. WINKELMAN. You know, some people like to say it is in the middle of nowhere. I like to say, well, that is my home. [Laughter.]

But we have that infrastructure in place and we also have subregional clinics. Many of our Tribal Health Organizations throughout the State of Alaska really have a three- or four-level tier plan of care, and it starts out in our villages with emergent primary care happening in the clinics with our community health aide practitioners.

Then, if a higher level of care or referral is needed, it usually goes to some sort of subregional clinic. I know for YKHC, we have five of those and we staff those with mid-level providers. They are usually physician assistants or nurse practitioners. We also have master's level behavioral health clinicians that work with our hospital, as well, and we have care teams around that. We also have dental health aide therapists there, who are essentially mid-level within the dental structure. And we also have community health aide practitioners with lab and X-ray capabilities, digital X-ray.

Then anyone who needs an additional level of care are often referred to our hospital, and those are all regional hospitals, as you know and have visited.

Then the fourth level of care is the Alaska Native Tribal Health Consortium in Anchorage, which runs, in conjunction with South Central Foundation, the Alaska Native Medical Center.

So we have multiple levels of care, an infrastructure that is already in place. We are willing and waiting to give all our veterans, whether they are rural or native or non-native, to open our doors. Our doors are always open. It is just essentially, for a non-native veteran an issue of payment. With the rural native veteran, they are going to be able to come to us and have their payment taken care of by us, so it is not really an issue.

Senator BEGICH. If I can interrupt you, that was actually a question we had back in Anchorage, and you have just answered it, I think. One concern that we had was when a non-native veteran entering a facility that is Indian Health Service-funded through the consortium, that someone who is a non-native veteran, as long as there is a payment stream——

Mr. WINKELMAN. Yes.

Senator BEGICH [continuing]. That handles them, you can take care of them.

Mr. WINKELMAN. Yes, Mr. Chairman. Our doors in Alaska are open to anyone, regardless of race or whoever they are. But what is really important for non-native veterans who are in highly rural areas in Alaska is that for the first time, they have a reason to go and use our services because there is payment provided by the VA through this pilot program. Now, in areas such as in Southeast Alaska and other areas in Alaska where the pilot is not available,

or if they are not opted-in and signed-up and received their preauthorization, they are not going to be able to do that. But if we can deal with those barriers with a meeting and talk about processes, I think we will be able to see our enrollments go up.

Senator BEGICH. Very good. Now, my last general question is about telemedicine. Would you say your system is a fairly good system, a robust system? How would you measure it?

Mr. WINKELMAN. I would say our system is probably the best in the United States. We are again, in the remotest of the remote areas. I know our Federal partnership, they have various measures—I don't have them in front of me today, but the AFHCAN Partnership, who are in charge of telemedicine, have various measurements that demonstrate how effective it is and how it can be used.

For instance, we have radiologists that are down in Ohio. Someone can go get a reading in the Village of Kotlik or in another village along the mouth of the Yukon River, and through telemedicine we can get them read in less than a day. It will go from there all the way down to Bethel, then it will go from Bethel to Ohio and then back. So we have really quick turnaround times using that sort of digital process which we are really proud of. But I think our utilization rates could be higher. That is something that we need to focus on, especially at YKHC. That is something that we are working on right now.

Senator BEGICH. Very good. Let me end there and just say again, thank you, first to the whole panel. Thank you to the two folks from the VA for your willingness to kind of take this to a higher level, at least in this initial stage of discussion. Like I said, Dr. Jesse, it is not to stop the program, it is to freeze-frame it for a moment to kind of do a little reanalysis, especially while you have a consultant online, which is a very valuable asset. You are spending resources there. You have some Alaskan experience here that is anxious to advise in any capacity they can, and your acceptance to acknowledge that, I think is great. So I just want to say thank you for your willingness to do that.

Thank you to the Alaskans who have traveled a great distance. Sorry for the humidity. That is an adjustment you will have to make, and I know you are anxious to get back on the plane to get back to home, no matter how small the village may be. Again, thank you all for being here today and testifying in front of the Committee.

That ends the Committee hearing for the day. It is adjourned.

[Whereupon, at 11:59 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WALTER G. SAMPSON, VIETNAM VETERAN,
FORMERLY OF NOORVIK, AK

My name is Walter G. Sampson, son of the late Mildred and Stephen Sampson of Noorvik, Alaska. I was traditionally, adopted and raised by my grandmother Effie K. Sampson. She instilled Inupiaq values in me as I was growing up. Inupiaq values are love, sharing humility, hard work and respect for others. Noorvik is a small community of 400 people located in Northwest Alaska and is 40 miles east of Kotzebue. Kotzebue is 549 miles northwest of Anchorage, and 30 miles above Arctic Circle. Noorvik is one of the 11 village communities in the NANA Region, a region that is approximately the size of Indiana and was created by the Alaska Native Claims Settlement Act.

When I was growing up the only school in Noorvik was a Bureau of Indian Affairs (BIA) school that provided an education up to the 8th grade. In 1962, I graduated from the 8th grade in Noorvik and then I attended Kotzebue Friends High, for a year and half. In January of 1965 my grandmother, Effie K. Sampson, became ill, so I quit high school and went home to spend the last two months of her life with her. To date I don't regret quitting high school for that period of time.

In 1965 I applied for Chemawa Indian School in Oregon to complete my high school education and was accepted. In 1968, shortly after I graduated from high school, the service board notified me that I needed to have a physical. I volunteered for the draft into the United States Army in September of 1968. I took basic and advanced individual training in Fort Lewis, Washington. In March of 1969, I was shipped over to Vietnam. My Military Operation Specialty was 11B, which is infantry. I spent 12 months up in the northern I Corps area. During my time in Vietnam, I spent 9 ½ months in the field; including a month and a half carrying grenade launcher, three days on machine gun, and 8 months with a radio on my back.

After returning from Vietnam in March of 1970, I was stationed in Fort Carson, Colorado for my last 5 months in active duty. After my active duty was over, I was honorably discharged from the regular Army and served in reserve status with the Alaska National Guard for 4 years. In 1973 I went to work for NANA Regional Corporation, one of the 12 Alaska Native regional corporations created by the Alaska Native Claims Settlement Act. Since then I have been

working for NANA as the Vice President of Regional Affairs. Over the last 37 years it has been a challenge for me to get services from the Department of Veterans' Affairs.

Three years ago I thought I was having a heart problem. Using my private insurance, provided by my employer, I made an appointment to see a cardiologist at Providence Medical Center in Anchorage, Alaska to get checked out. The end result was not that I had a heart problem, but a pulled muscle in my chest. However, through the process of testing I learned that I did have some problems with cholesterol. The doc recommended that I take medication to address the cholesterol problem. Knowing that the medication was going to be expensive, I thought it would be an opportune time to take advantage of my veterans' health benefits. So I went t to the Veterans' Affairs office in Anchorage to see if I could have Veterans' Affairs pay for my medication for at least a year. The Veterans' Affairs office interviewed me and basically asked me two questions. "Did you see our doctor?" My answer to that was "No." The second question was, "how much money do you make?" Based on those two questions, I did not qualify to receive any assistance with my medication. I felt that I was discriminated against for working and making money, and for seeing one of the best cardiologists in the State.

Later on, I tried to get Veterans' Affairs assistance within the NANA Region for some of my comrades who also had some problems and did not know the process to get assistance from Veterans' Affairs. One of the issues I raised to the Veterans' Affairs office is that there is no presence in the NANA Region for veterans in rural areas. Rural veterans like Wilson Tickett from Kobuk or Bobby Smith from Selawik do not know the process to get a hold of the Veterans' Affairs office in Anchorage if they need assistance. In fact, if I should call Anchorage Veterans' Affairs office today, I would have to go through 4 machines before I could get an answer from a human being.

At one point, one of my comrades had a mental problem. I attempted to get counseling for him for his suicide attempts. Having been in a similar combat situation as my comrade and as a veteran, I know what he was going through. It is hard for someone to have these experiences. The guilt feeling that gets built up in you is what causes the problem with suicide. Yes, at one point, I thought the only way out was to commit suicide so I would not have to deal with the guilt. That very same feeling my comrade went through, eventually caused him to commit suicide. A week after he committed suicide, a counselor came from the Anchorage Veterans' Affairs office. My response to him was, "What are you doing in town? You're a week late. Is this the type of services we are going to get for veterans in our community?" There were no answers to my questions.

Today we continue to have problems accessing veterans' health benefits. For instance, rural veterans have to travel to Anchorage to access any veterans' health services, even though we have the Maniilaq Health Center in Kotzebue. Unfortunately, there is no way our rural veterans

in the NANA Region can utilize veterans' health benefits at the Maniilaq Health Center in Kotzebue. (The Maniilaq Health Center contracts with the Indian Health Service to provide services to Alaska Natives in our Region and is the only hospital in our region.) All veterans within our region have to fly to Anchorage and pay for travel out of pocket with no opportunity for reimbursement. The cost of transportation from Kotzebue to Anchorage alone is very expensive. It costs about $640 for a roundtrip plane ticket to Anchorage from Kotzebue, then approximately $200 per night for hotel, then meals and transportation, which totals about $1000 for a trip to Anchorage for veterans located in Kotzebue. It could cost rural veterans from the rest of our villages in the region another $200 to $300 more dollars just to get to Kotzebue. Rural veterans in our villages often lead a subsistence lifestyle, where they survive by living off the land. Many veterans in rural Alaska don't have the financial resources to fly to Anchorage to be seen.

For the past two years, we have attempted to work through the Alaska Federation of Natives, an Alaska Native advocacy organization, to push for the opportunity to have Maniilaq Health Center contract with the Department of Veterans' Affairs to provide veterans' health services in Kotzebue. At this point there is no agreement for veterans to utilize the Maniilaq Health Center for veterans' health services.

For veterans on the road system, which does not reach the majority of rural communities and rural veterans, the Veterans' Affairs has a service on wheels based out of Anchorage. This system brings veterans' health services to veterans on the road system. Veterans on the road system that drive to Anchorage can be reimbursed per mile driven to get services in Anchorage. Though this is a good program, it demonstrates that there is no equity whatsoever for a rural veterans who are not on the road system. Rural veterans, as mentioned, are completely financially responsible for transporting themselves to Anchorage to receive veterans' benefits.

The Veterans' Affairs office does visit Kotzebue. However, they come only periodically and sit in the Kotzebue Post Office lobby hoping to see veterans. I don't think any veteran is going to go to a public facility, like the Post Office lobby, and answer personal health questions. If I am going to be asked the personal questions about my background, then I would prefer to be asked those questions in a private setting, not a public setting. If any health services are going to be provided to veterans, certainly something like a hospital setting with a private room would be an appropriate place to be seen.

One way to solve many of the problems I have mentioned is to set up a Veterans' Affairs rural services office in each region throughout the state. By providing these regional offices throughout the state, rural veterans will be able to access their veterans' health benefits and other benefits offered by the Department of Veterans' Affairs more readily.

I think it is time that the government looks at services to ensure equal access for all veterans including those veterans in rural communities. I have committed myself to the U.S. Government when I was called to duty in 1968. With no regret I went in to serve. Today I am proud to say that I have served my Country, I have served Alaska, I have served the NANA Region and I have served my people. My hope is that the federal government will live up to the commitment they made to provide health services to veterans who committed to serve our great country, just like I lived up to my commitment when I took that oath in 1968,to serve my country in the military services. I am proud to serve this great nation called the United States. When I see the American flag, that red white and blue waiving freely in the wind, I feel proud that I was part of the service so everyone can freely make their choices. I hope each and every one of you that serves veterans will work to ensure there is adequate service for all veterans throughout the country. Thank you very much for the opportunity to share my concerns with the Committee.

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