VETERANS HEALTH CARE IN MICHIGAN'S UPPER PENINSULA: WHERE ARE WE?

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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CONTENTS

June 20, 2011

VETERANS HEALTH CARE IN MICHIGAN'S UPPER PENINSULA: WHERE ARE WE?

MONDAY, JUNE 20, 2011

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., at the Oscar G. Johnson Veterans Affairs Medical Center, 325 East H Street, Iron Mountain, Michigan, Hon. Anne Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle and Benishek.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. Good morning. It is such a pleasure to be here. My name is Ann Marie Buerkle, and I represent New York's 25th Congressional District, and I'm Chairman of the Subcommittee on Health for the House Veterans' Affairs Committee.

It's wonderful to be here this morning, and I must say this is my first time in the Upper Peninsula (UP). I was just chatting with some folks in the back. I had a daughter who went to the University of Michigan, and we spent a lot of time in Ann Arbor; but this is beautiful. This is beautiful country, and the people here are so nice and so welcoming. It is just a great honor to be here.

I want to begin by thanking all of you for taking time out of your busy schedules to be here this morning. This is a very important hearing, and we're so delighted to have the opportunity to hear from all of you.

I'm honored to serve on the Health Subcommittee and to have your Congressman and my very good friend, Dan Benishek, serving with me.

As you all know, Dan has practiced general surgery in the Upper Peninsula since 1983. He has also worked part time at this veterans' facility for the past 20 years. Dan is an invaluable voice for veterans and brings a wealth of expertise to our Committee. We are really fortunate on our Committee to have health care professionals like him.

My background is in nursing and I worked for a hospital for many years, and Dan is also in medicine. We also have another physician, Dr. Roe from Tennessee. So we are very fortunate from a health care perspective on our Committee.

Our oversight agenda this year has spanned a wide range of topics from patient safety to caregiver's assistance, to meeting the

health care needs of the next generation of veterans from Iraq and Afghanistan.

And throughout each of these discussions, Dan, myself and the rest of the Committee have provided unique insight that only one with health care background and insider knowledge can bring.

The one thing that Dan always talks about is the dedication, the commitment, and the very high level of care that the staff here at this veterans facility provides. So, I want to take this opportunity to commend all of you for your service and for what you do for our veterans. We appreciate it very much, and we thank you.

So I would like to take this opportunity with Dan here to thank all of the employees here. It's good to know that veterans are in good hands at this facility.

I, too, come from a rural district in central New York, so I'm familiar with the topic that we're going to be talking about today and the importance of reaching out and providing access to care for our veterans. This is a very important topic to me, as well as to Dan, and to all of our veterans who live in rural areas.

Congress took a significant step in 2007 when it created a new Office of Rural Health (ORH) in the U.S. Department of Veterans' Affairs (VA). It was formed to address the unique needs of veterans living in rural areas.

In 2009 and 2010, Congress provided this office with over $500 million in additional funds to improve the delivery of health care to rural veterans. That is why it's so very disheartening to read an audit by the VA Office of the Inspector General (OIG), which found that not only has the VA not properly managed the use of these funds, but still continues to lack even a process to assess the needs of veterans in rural areas. I think we can all agree that time is of the essence, and this is not acceptable.

At our hearing today, we will be taking a look at the health care programs provided to local veterans throughout the Iron Mountain VA Medical Center (VAMC), including the use of telemedicine and other technologies.

We want to hear from our witnesses how, if at all, the Office of Rural Health initiatives have improved services for veterans in the Upper Peninsula.

Further, we want to know how VA is going to improve the management of our precious resources, improve access to services and really work towards the goal of increasing access and quality care for rural veterans across our great country.

I think it's important to set the tone here, and I think Congressman Benishek will agree with me. This isn't a witch hunt; this is an effort for our Committee to reach out to Veterans Affairs and work together to lay the groundwork to make sure that our veterans in rural areas have access to good quality care. That's the purpose of this hearing this morning and we are looking forward to hearing from all of our witnesses in that regard.

With that said, I now recognize your Congressman, my colleague and good friend, Dr. Benishek, for his opening statement.

[The prepared statement of Chairwoman Buerkle appears on p. 34.]

OPENING STATEMENT OF HON. DAN BENISHEK

Mr. BENISHEK. Thank you. Good morning, everyone.

It's great to be back here in the UP. I want to thank all the veterans and the veterans service organizations for coming and giving their time today to provide testimony, as well as the administrators who are providing insight on how this system works here in the UP.

I want to thank the staff of the House Committee on Veterans' Affairs for helping set this all up, bringing Congress up here to the UP. I don't think I've ever seen anything like this.

Ann Marie Buerkle was very modest in her comments. She represents, as she said, New York's 25th District. She is a graduate from St. Joseph Hospital School of Nursing, a registered nurse. Then she returned to college and became an attorney, worked as the Assistant New York State Attorney General. It's been a pleasure working with her on the Committee.

It's amazing the accomplishment of so many people that you meet in Congress, how accomplished they are in their past lives; and then they are willing to take their time away from their lives to help serve our country. It's been a privilege meeting her and many others like her. So I appreciate her making the trip up here, and I surely value her leadership and help with the Veterans' Affairs Committee.

You know, I worked here off and on part time for the last 20 years; and I want to be clear that I think that the staff here at the Oscar G. Johnson Hospital is incredibly dedicated, hardworking and a professional group of health care providers. Their commitment to our veterans, their enthusiasm and their expertise is above reproach. I'm proud to have worked alongside them, and I want to take this opportunity to thank them all for their service. Please join me in giving them a round of applause.

[Applause.]

With that said, I wouldn't have dragged Congress all the way up here, and I wouldn't have put Congresswoman Buerkle on a plane to Iron Mountain for nothing. Like everything we do in life, veteran care here in Iron Mountain can use improvement.

You know, at the start of the 112th Congress, I chose the Veterans' Affairs Committee as one of my Committee assignments so I could bring my experience working here at the VA to Congress, and my experience on the Committee has been very encouraging. When you bring a veterans issue to the Committee's attention, they listen; and they work with us to try to find solutions.

That's why we're here today, to get an honest assessment of what needs to be improved within the VA health care system to help our veterans in rural areas.

As I said, based on my experience, it's not because of lack of effort or passion that the VA staff falls short of providing the best care. They're frustrated, I think, by the VA Central Administration. My observations, this frustration is caused by a lack of autonomy in the local VA systems.

Veterans in rural areas face different challenges compared to veterans elsewhere in accessing and receiving health care. As Congresswoman Buerkle can attest, the needs of veterans in this district differ from those in her district in New York or Chairman Jeff

Miller's district in Florida or Ranking Member Bob Filner's in California. One size fits all top-down approach will not address or anticipate every issue or road block to veterans in rural areas. And they often create barriers that waste work and resources in these settings, forcing rural VAs to shift patients at huge costs and patient dissatisfaction.

One point from my personal experience here is that local VA facilities, such as Oscar, lack discretion on how their funds are spent. A facility's budget is divided into three categories: Medical service, medical administration and medical facilities.

Local facilities are not allowed to use funds from one budget style to another. For example, you know, you have money designated to rebuild a wing, you can't hire somebody on the staff with that money. It's always very frustrating to me, being here in Iron Mountain, when they're spending $3 million on a wing here, and we didn't have $40,000 to hire an organization. So that kind of disparity, it's frustrating.

And, you know, that's hopefully something that maybe we can help with. That's one of the reasons for being here. Rural facilities should have the ability to allocate funds, you know, as they deem appropriate.

Another personal frustration I've had here working at the VA was the high rate of hospital directors. I mean, I've been here 20 years, and we've had ten directors. Every 2 years the director turns over. That is very difficult to maintain a continuity of care or an investment in the leadership of this hospital.

So I think that's something I would like to have the Veterans Affairs, the Director, Mr. Rice, address. I think that short tenure provides little incentive to face the issues we have here. I'm not sure of the cause. I mean, apparently it's sort of been isolated to this hospital. It doesn't occur everywhere, but I would like to have that addressed.

Before we turn to the panel, I just want to tell you that I just appreciate the fact to be back here at the VA. When I was here as a physician, I had a lot of fun in the operating room playing my music. You know, I listened to a lot of Elvis on the iPod. You know, I asked the patients what kind of music that they preferred to listen to as they're about to go under anesthesia; and I sort of miss that. I don't get to do that all the time, the opportunity to play my own music.

So that's one of the things that I miss about coming here. Sort of coming back here reminded me of that. I'm not able to do that as much as when I worked here.

So with that, I would yield back to the Chair.

[The prepared statement of Congressman Benishek appears on p. 34.]

Ms. BUERKLE. Thank you very much.

Dolores, maybe we can talk to Chairman Miller about having music piped into the Veterans' Affairs Committee.

We are going to start now with our first panel.

Doctor, would you please introduce our first panel?

And at this time, I would ask that we seat Panel No. 2 as Panel No. 1.

Mr. BENISHEK. Thank you, Madam Chairman.

The first panel is a group of veterans service organizations individuals.

We have Mr. Chuck Lantz. Mr. Lantz served in the Air Force for 10 years and served in Operation Desert Storm, an operation to provide comfort in the Middle East. He's been working with the Dickinson County Office of Veterans' Affairs since 2009, serving as its Director and Veterans Counselor.

Mr. Lantz has also served as the Veterans of Foreign Wars (VFW) Post 3674 Commander and also received the VFW All-State Commander Award in 2008. He's a member of the Sons of American Legion, the VFW, the American Legion.

Additionally, he has served on the National POW MIA Committee. Simply put, Mr. Lantz's service to our veterans has been remarkable; and I want to personally thank him for his dedication in improving the livelihood of our veterans.

Our second person on the panel is Shirley Rentschler. Do I have that right?

Ms. RENTSCHLER. Yes, you do.

Mr. BENISHEK. And she's been a veterans counselor for more than 17 years with the Iron County Department of Veterans Affairs and received accreditation as a Service Organization Representative through the Department of Veterans Affairs.

In 2007, she was chosen as the UP National Service Officer for the Military Order of the Purple Heart (MOPH) and currently works out of this hospital.

Ms. Rentschler has held many memberships with the National Association of County Veteran Service Officers, Michigan Association of County Veterans Counselors, as well as with the American Legion Auxiliary and Veterans of Foreign Wars. She was also a member of the Auxiliary of the U.S. Marine Corps of the Upper Peninsula.

I thank Ms. Rentschler for the service to our veterans and for her participation in today's hearing.

Then we have Mr. Pray—Commander Jack Pray. Mr. Pray was selected in June to be the VFW State Commander for the State of Michigan. He served in the Navy for 22 years, serving in Vietnam. He's been a member of the VFW for the past 35 years. I would like to thank Mr. Pray for his service to our veterans as well.

In addition, we have Mr. Holcomb, who is the Assistant State Service Officer for the VFW under Mr. Pray's direction. Mr. Pray, could you give a brief bio of Mr. Holcomb? I'm not familiar with him.

Mr. PRAY. He's a Navy veteran, electronics technician and served all 20 years in the Navy and currently works as the State Assistant Service Officer, filing claims for veterans of any service with the coalition that we have developed in Michigan.

Mr. BENISHEK. Thank you very much for coming in and taking your time today.

With that introduction, I will yield back to the Chairwoman, Mrs. Buerkle.

Ms. BUERKLE. Thank you, Dr. Benishek.

We will begin by asking each one of our witnesses this morning to give their opening statements. Generally, we limit it to 5 min-

utes, so if you could keep it within that timeframe, that would be helpful. Then we will have more time to ask questions.

Mr. Lantz, if you would like to begin.

STATEMENTS OF CHUCK LANTZ, DIRECTOR, DICKINSON COUNTY OFFICE OF VETERANS' AFFAIRS, IRON MOUNTAIN, MI; SHIRLEY A. RENTSCHLER, NATIONAL SERVICE OFFICER, DEPARTMENT OF MICHIGAN, MILITARY ORDER OF THE PURPLE HEART; PATRICK D. HOLCOMB, ASSISTANT STATE SERVICE OFFICER, DEPARTMENT OF MICHIGAN, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND JACK PRAY, STATE COMMANDER, DEPARTMENT OF MICHIGAN, VETERANS OF FOREIGN WARS OF THE UNITED STATES

STATEMENT OF CHUCK LANTZ

Mr. LANTZ. Congressman, Congresswoman and guests, I would like to thank you for the invitation allowing me to testify today on the big issues of our veterans.

I would like to start out with the subject at hand, which is rural veterans health care.

I think Oscar D. Johnson VA Medical Center and Veterans Integrated Services Network (VISN) 12 has taken many steps for us to extend access to the veterans in the Upper Peninsula, which is one of the most rural areas of Michigan, if not the Nation.

By building many CBOCs, community-based outpatient clinics, in and around the Upper Peninsula and Northern Wisconsin, it allows the veterans to have veterans' health care closer to their community.

However, there are still several issues in regards to the health care of the rural veteran. Number one being transportation. There's many issues with transporting veterans to and from their health care visits.

Yes, we do have volunteer systems out there with AV vans and so forth, but we still have issues where they cannot get to their health care visit.

I'll give you one example today. I do have a 100-percent service-connected veteran today that had to be in Milwaukee for her Social Security disability hearing. I have a volunteer today that took her to Milwaukee for that disability hearing. Yes, it's outside the VA system, but she's still a 100-percent service-connected veteran, still trying to get her Social Security benefit. That needs to be implemented to help those veterans get to these visits so they can better their life.

Better access to mental health caregivers for the veterans having issues with traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD), as well as substance abuse.

Implement a coalition with community agencies so they don't have to travel so far to get substance abuse programs for inpatient care.

Better access—the Veterans Affairs has grown by leaps and bounds, but need to keep thinking outside the box to keep growing and caring for our Nation's veterans. There's still many veterans that cannot get VA health care due to the income threshold, unless

they have been injured while serving or receiving a service-connected injury.

Many of these veterans served voluntarily and need to be cared for as a veteran. Even if they are put in a priority group that requires a co-pay, at least our Nation's veterans would be cared for regardless of their income status.

That being said, I would like to discuss the issue of the underrepresented veteran. Most of the State of Michigan—most of all in the State of Michigan, of the 69 counties in Michigan with CVSOs, which is County Veterans Service Officers, only 37 provide full-time veterans benefit counseling.

Thirty-two counties have part-time veterans' benefit counseling; 14 counties without CVSOs. The veteran population of those 14 counties is 66,525 veterans. They have no veteran representation, other than the veterans service officers (VSOs) that are traveling to those counties.

The veteran cannot establish the benefits alone. The veteran needs an advocate to assist them in the application process of Veterans Benefits Administration (VBA) benefits, as well as the Veterans Health Administration (VHA) health care.

The veteran also needs the advocacies to assist them in gaining those benefits and keeping them in place. It is a consistent struggle for the veteran.

I would like to just point out two counties in Michigan. One being Dickinson County, with a full-time CVSO, as well as childhood VSOs.

Veteran population, 2,671, with a total expenditure of $30,643,000. Of that, $7,830,000 was for compensation and pension, and that being liquid income comes directly back into the rural community.

Now take Antrim County with a part-time CVSO. Veteran population, 2,673, two more veterans than Dickinson County. Their total VA expenditure is $7,109,000. Of that, $4,339,000 was compensation and pension.

So you can see the difference we as CVSOs make advocating for the veteran benefit.

Michigan has changed the grant funding to VSOs; and now with those changes, the number of VSOs had to be reduced. That brings more travel for those VSOs; and that time they are traveling, they're not meeting with the veteran, which is a disservice to our veterans.

Also, with that reduction, no more services were added or changed to take up for the veteran they can no longer reach in a timely manner.

I'm advocating that the State of Michigan and/or the Nation mandate that there be a service officer in each county and each State.

The process, Michigan—The process of the VA benefits is so cumbersome that the veterans cannot accomplish these tasks on their own. They need an advocate to accomplish their struggles with the system.

Why is it that we as a Nation send our soldiers to war with no questions asked, and yet once they come home with injuries, they have to prove without a shadow of a doubt that that injury was due

to their military service. If they do not have any injuries, they have to prove that they are under a certain income threshold to get health care.

Changes need to be made to cover our Nation's veterans, all of them.

The Office of Veterans Affairs serving Dickinson County has a motto: If we send them, we must mend them.

Thank you for allowing me to express the needs of our Nation's veterans and the need for all the veterans' advocates to assist them.

This is a very important job in our Nation, and funding laws need to be established and changed so that our Nation—the Nation and State have the VSOs and the CVSOs to take care of our true American heroes.

For my last comment, I would like to say and challenge Congress to establish CVSOs in each and every county in Michigan and the Nation. Thank you.

[The prepared statement of Mr. Lantz appears on p. 36.]

Ms. BUERKLE. Thank you, Mr. Lantz.

Ms. Rentschler.

STATEMENT OF SHIRLEY A. RENTSCHLER

Ms. RENTSCHLER. I would like to thank you for the invitation to participate in this field hearing.

I believe that the Iron Mountain VA Medical Center is one of the finest facilities serving the veterans of Michigan's Upper Michigan and Northern Wisconsin. Over the past couple of decades that I've been coming through here, I have seen a growth of the veterans' care at this facility, with many veterans saying they feel like they've been treated like royalty.

On some issues that we would like to talk about, the delivery of the health care to rural veterans has been a great addition to the home health care. The home health care and the specialty clinics, especially women's veterans' programs here in health care; and I would like to see—I personally or my veterans would like to see maybe a dermatologist and more hours for our chiropractor here at this facility.

Regarding the recruitment retention of medical personnel, we have some very caring medical personnel at this facility; and I think it's very important when we're recruiting physicians, that they also be fully trained in VA law regarding pension and service-connected disabilities and what is needed when documentation is concerned.

I understand that sometimes when you recruit in a small remote area like Iron Mountain, it is difficult; but we would like to see longevity of our VA providers.

Sometimes the veterans get very frustrated because their providers are changed often.

Most of our Iron Mountain providers here have compassion for our veterans in treating them and listening to their concerns, but we also have a few that do belittle them and are disrespectful; and we understand that we would like to have the providers understand the physical and mental demands of being in the service and understand that.

To our veterans, their conditions are real. And at times the providers will even ask, just making a comment like, "Are you just here for money?" And that's just not right. It's not acceptable.

In regards to our compensation exams, they have greatly improved in this facility; and they are done with efficiency and thoroughness with respect to the veterans in most of the cases.

In mental health, we have a longer waiting time to get appointments for the World War II or Korean or Vietnam veterans, because we are putting the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans first, which is right; but we would really like to see that time shorten up so that all of our veterans having mental issues can be seen on a timely basis.

In regards to mental health, I would also like to see more counselors at the Vet Center. We have a Vet Center in Escanaba, and we would like to see more counselors; and we would like to see the VA recognize that Center more on issues with their claims, you know, that they accept what's written by the veterans' counselors at the Vet Center.

Telehealth Programs: Our veterans would like to see more of this type of service, as it would ease up their VA appointment times here and maybe allow the VA providers more time on a one-on-one with the veteran here to discuss their problems, instead of being more like a number and they're in and out. We would like to see more one-on-one time with that.

The Community Partnerships: More of this partnering would be more cost efficient and effective to help our veterans with the different resources available in our own communities. I would encourage this type of partnership.

You know, like if we have veterans in Iron River and they can't come here, that maybe they could partner with the Iron River Hospital or Northstar, I believe it's called.

I would like to make a few comments on fee basis, such as maybe chemotherapy, physical therapy and maybe chiropractic care.

We have some in the UP. We have a lot of veterans that are driving distances; and if they're coming up here for physical therapy, it doesn't make sense because, you know, driving all those miles kind of undoes what they're doing at the chiropractor. I would like to see that maybe on a fee basis out there more, and I would like to see more outreach treatment for them.

Just on another note, service officers work with veterans every day, of course; but they're dependent also on their surviving spouses. On occasion when a veteran passes away, the physicians need to be more conscious of what their disabilities might be, that they're listed on the death certificate, you know, so that veteran can get what's due her, like the payment for her claim.

And I also would like to see maybe more educating of physicians in our communities, especially when it comes to service-connection disabilities. You know, the documentation that the veteran is telling the doctor or the provider that, you know, his left ankle hurts or something.

I mean, we need that more documented, I think, at this time in support of the claim.

And we need—when we have forms—sometimes I deal with diabetic forms. We send it to the provider. We just ask that it be more thorough.

Oh, on hearing aids, I would like to know why it takes so long in Iron Mountain to get hearing aids for our veterans. Some of them are 8 months out.

I would like to thank you for allowing me to participate in this.

[The letter of Ms. Rentschler appears on p. 42.]

Ms. BUERKLE. Thank you very much.

Mr. Holcomb.

STATEMENT OF PATRICK HOLCOMB

Mr. HOLCOMB. Thank you to the Congressional staff, and thank you to the staff of Iron Mountain for allowing us to speak.

Iron Mountain VA Hospital takes very good care and very personal care to the veterans here, but there is some significant issues we would like to discuss.

Continuity of care. Myself, personally, I have used the VA facility for 6 years. Since I retired, I'm working on my fifth doctor—primary care doctor.

Increasing access to clinics, such as the chiropractic. Chiropractic care is a 3-month wait. And then if you live in Marquette, like myself, you must drive an hour and a half to get to the chiropractic care and go through the care and then drive the hour and one-half back, which null and voids the care that you just received.

Access to compensation pension exams. I personally have a veteran who lives here in Iron Mountain, who is being sent to Marquette for an exam instead of being seen here in Iron Mountain. He has an 8 a.m. appointment, so he must leave here by 5 a.m. or stay overnight, and there is no overnight facilities in Marquette. There is no transportation from Iron Mountain to Marquette for a veteran for care, so his wife must drive them; and there is no additional anything for the spouse to drive a veteran that can't drive because of his service-connected disabilities.

Most all staff here at Iron Mountain are very good, very personal. There are issues with a couple of doctors. One doctor in particular, I will read what one of my veterans wrote up for me.

"In closing, the doctor stated he was just another gray-haired old man that he had to deal with, and he would hope to forget him within a day or two."

That is not how we are supposed to be treating our national veterans. I believe that care should be—and respect should be granted to our veterans. That is not very respectful.

Audiology, like Ms. Rentschler said, is a significant wait, even for a service-connected veteran, anywhere from 4 to 8 months to get a set of hearing aids. They are allowing some fee basis out, but it still comes back to the hospital here; and it is still a significant wait for veterans trying to hear what the doctor is saying to them.

Clarification—or notification of compensation pension exams, letters are being sent out but not being received by the veterans. The veteran that was sent a letter June 9th still has not received notification of his compensation pension exam through the 27th of June. So then when he misses his exam, he is denied service-connection because he didn't show up because he was never notified. Hopefully

we can see what we can do about better notification to the veterans on their exams.

Again, I would like to thank the Iron Mountain staff. They are a very good staff for the most part, and they do treat most of the veterans—most all of them treat the veterans with respect, but there are some issues with them.

Thank you.

Ms. BUERKLE. Thank you, Mr. Holcomb.

Mr. Pray.

STATEMENT OF JACK PRAY

Mr. PRAY. Congressional Chairman, Congressman, Congress Lady, thank you very much for the opportunity to speak.

Naturally, as a veteran service organization, our primary goal is to see that all veterans receive VA assistance in filing claims, reducing backlog of claims, compensation where service-connection is proven beyond a shadow of a doubt, which leads me to the subject of PTSD.

PTSD and TBI are two of our major disabling functions here, especially in this current conflict; and we have to take better care of our veterans and really need more qualified physicians that are able to deal with the ramifications of PTSD.

A lot of symptoms are embedded and not understood. Some of the tests that they use to determine whether a veteran has PTSD or not sometimes are considered to be unfair and often are—basically, they're told a stigma of their imagination, which it may be. But the veteran with PTSD has every right to the health care and should be offered and allotted the maximum flexibility in claiming a disability.

That's about it for me. Thank you very much.

Ms. BUERKLE. Thank you very much, Mr. Pray.

Mr. GRIMES. Madam Chairman, I am not on your agenda, nor am I part of your panel, but my name is Harold Grimes. I'm the Past National Commander of Uniformed Services Disabled Retirees, and I would like to reiterate with all of these ladies and gentlemen have said about this facility. I believe that this facility takes the best care they can of every veteran that comes through the door.

I drive from Green Bay, Wisconsin, every 3 months to come up here for care. I'm a 100-percent disabled veteran, veteran of Korea, Vietnam and all of the brush fires in between: Berlin, Cuba and a few others.

I work very, very closely with veterans across this country, and I get a very good cross section of what's happening in New York State, New Jersey, Wisconsin, Georgia and the rest of this country and veterans with their needs.

I know of a need at this hospital that is not being addressed as far as I am aware, and that is that you have a dental clinic here that the staffing has been understaffed now for 2½ years because of the added influx of veterans into the system.

The service has been pushed out 6 to 8 months because there is not adequate staff. I have been coming to this facility for over 15 years. This staff takes care of me every time I come here. I don't care what the need is.

I would also like to speak to just a little bit about other issues that pertain to veterans, not only in the Iron Mountain area, but veterans that come from Wisconsin into the Iron Mountain VA hospital.

Ms. BUERKLE. Sir——

Mr. GRIMES. Yes.

Ms. BUERKLE [continuing]. I apologize, but we have a format here.

Mr. GRIMES. Okay.

Ms. BUERKLE. And I'm sure we will sit with you afterwards. Dr. Benishek's staff will hear all those concerns——

Mr. GRIMES. Thank you.

Ms. BUERKLE [continuing]. Because they are very important to us. Thank you very much.

I'm going to begin my round of questioning, and then I will yield to Dr. Benishek.

I want to begin by asking all of you. In 2007, there was a recognized need that, we were not reaching all of the veterans in the rural area.

So Congress recognized that need, and then in 2009 and 2010 allocated a specific amount of money, over $500 million to the VA to make that outreach to the veterans in the rural areas, to improve their access, and quality of care.

So I want to ask all of you, during that time since 2009, 2010, have you seen any changes or any improvement from where you sit with regards to access to veterans in the rural areas?

Mr. LANTZ. I started my CVSO position in 2009. From July of 2009 to the present, access has become expanded by about 100 percent, I would say.

Ms. RENTSCHLER. I would agree. We have a lot of veterans, like you said, in the rural area; and they really like the home health care. They like the idea that someone can come to their home, check, you know, with them on their conditions or help them with any administrative things that they may need or referrals; and the counseling has improved, and they really do like that.

Ms. BUERKLE. Mr. Lantz, you mentioned 100 percent. What does that mean? So every veteran in a rural area now has access to health care?

Mr. LANTZ. No, just the veterans that were covered already probably received 100 percent more care and more accessibility to the care.

Ms. BUERKLE. Thank you. Mr. Holcomb.

Mr. LANTZ. Yes, there has been a significant increase in rural care. They have opened up an additional CBOC, and they have provided more mental health out in the CBOCs instead of just here at the hospital. So it has definitely increased the mental health in the rural areas in the combined outreach clinics.

There has been more, but there's still—the Upper Peninsula is still a vast and open area, trying to find local areas to establish the CBOCs, and a lot of the people drive at least an hour to get to one.

Ms. BUERKLE. Thank you. Mr. Pray.

Mr. PRAY. Yes, and I agree that the availability has increased.

We do have a problem with our service officers being on the road as much as they are to file claims. And with that issue, we can

have a coalition where we combine the Purple Heart, the Marine Corps League, the VFW, the Disabled American Veterans; and we split a grant system to pay for our VSO's travel.

So that's kind of limited. If the funds were more readily available, I think it would get more help out to more veterans.

Ms. BUERKLE. Thank you.

One of the charges given to the Department of Veterans Affairs with this rural outreach program was to assess the needs of rural veterans, because in order to treat them, we need to know what their needs are, where they are located, and how we can access them?

To your knowledge, have you been asked or any other veterans service organizations been asked or been a part of assessing the needs of rural veterans? Have you been included in that discussion?

Mr. LANTZ. Personally, I have not.

Ms. RENTSCHLER. Nor have I.

Mr. HOLCOMB. Nor have I.

Mr. PRAY. No, I have not.

Ms. BUERKLE. If you could sit here today in an ideal world—and I would like each one of you to comment on this, what is the most pressing need for rural veterans, and how can we address that need?

We will start with Mr. Lantz.

Mr. LANTZ. One of the biggest issues, I think, is travel, transportation. They have to travel way too far to get to a clinic.

Ms. BUERKLE. And how would you want that need addressed? In this perfect world, what's the answer to that?

Mr. LANTZ. Either fee base it out to the local community hospitals or provide a grant system to provide transportation or more transportation opportunities to get them to their appointments.

Ms. BUERKLE. Thank you.

Ms. Rentschler.

Ms. RENTSCHLER. I would say that transportation is the big issue. I would also say that we need more community partnership, you know, maybe in a fee basis area.

I would like to see more—maybe even another Vet Center if we could or more counselors at that Vet Center because PTSD and some mental health issues are very, very huge here.

Ms. BUERKLE. Thank you.

Mr. Holcomb.

Mr. HOLCOMB. Transportation and the fact that there are several DAV transportation buses or vans that travel to bring people here to Iron Mountain; but if you are on oxygen or in a wheelchair, you don't have access to them. You are not allowed to ride in the vans.

So if you have a veteran that is in a wheelchair or is on oxygen, he still has no availability.

Again, fee-based to their local community so they can, you know, be seen right there or to provide better access in transportation with wheelchair accessibility.

Ms. BUERKLE. Thank you.

Mr. Pray.

Mr. PRAY. Yes, I would agree with the other witnesses that transportation is the main thing. Fee-based availability would be a good answer, too.

Also, the availability of veterans health care facilities in areas that have a large concentration of veterans.

Ms. BUERKLE. Thank you. At this time I will yield to Dr. Benishek.

Mr. BENISHEK. Thank you, Madam Chairman.

Mr. Lantz, as County Veteran Service Officer, you're here in Dickinson County. Are you aware of the situation in some of the other counties up here, like Gogebic County—that's Ironwood. That's a long way from here. I kind of wonder, those veterans over there, do they have an officer in Gogebic County, too?

Mr. LANTZ. Yeah, very minimal and very part time.

I actually provided in my package of my testimony all the counties in the State for you to take a look at as far as comparison, what counties have part time and full time.

Mr. BENISHEK. I mean, I know that Antrim was quite an example you testified to earlier.

Mr. LANTZ. Correct.

Mr. BENISHEK. What concerns me is that those people, those veterans that live in Gogebic County, they don't have access to someone to help them get their benefits?

Mr. LANTZ. Not on a full-time basis. We have VSOs that are traveling to them. However, all that travel time, they're not seeing the veteran.

Mr. BENISHEK. Ms. Rentschler, do you have an opinion on that?

Ms. RENTSCHLER. I know the county counselor in Gogebic County, and he is full time, his name is John Frellow; and he's doing a good job with the Gogebic County veterans. However, when we have to travel there, we are traveling 2 hours and more sometimes to see veterans.

Mr. BENISHEK. Well, it just concerns me that the people in the outlying areas are not getting access to—you know, maybe there are veterans out there that don't have access to the system.

Ms. RENTSCHLER. Mr. Frellow is here today, and he is a full-time service officer in Gogebic.

Mr. BENISHEK. No, I just picked that out as an example.

Ms. RENTSCHLER. Oh.

Mr. BENISHEK. You know, I'm just trying to get an idea of how many veterans out there are having difficulty in getting into the system. Do you have any idea?

Mr. HOLCOMB. There's a lot of them out there that have trouble getting to a Veteran Service Office. I, myself, travel to here, Iron Mountain, Escanaba twice a month, Menominee, Manistique, Houghton and Ontonagon, as well as being in Marquette usually 3 days a week.

So I do a lot of traveling to get out to as much of the outlying areas as possible.

Mr. BENISHEK. Is there a coordination system with the VA here in Iron Mountain to figure how you can do all of that?

Mr. HOLCOMB. Not within the VA but within the coalition I do.

Ms. RENTSCHLER. Can I interrupt?

Mr. BENISHEK. Sure.

Ms. RENTSCHLER. If we go out to rural areas and we know that a veteran has never been seen in this facility or CBOC, we promptly get them in. We help them fill out the application, and then we hand carry them back here to this facility. So we do provide that service.

Mr. BENISHEK. I guess one question I had about this compensation pension exam, what was the story? Do you know why they were not doing the exam here, Mr. Holcomb, or what that was about? That seems kind of odd.

Mr. HOLCOMB. They have less doctors here to do health exams than they do in Marquette. So to get within their timeframe, to get a compensation pension exam done, they send them up to Marquette. They send people from Wisconsin up to Marquette for an exam.

Mr. BENISHEK. All right. Then the audiologist, has that been a long-time problem, or is that something new?

Mr. HOLCOMB. It's a long time. There's only one audiologist here, and they've tried to hire a couple more; and they don't stay very long.

Ms. RENTSCHLER. They will fee base out to maybe Laurie Sario or Laurie LaFleur in Florence, if they're not service-connected. At least that's the story we're getting.

But if they're service-connected, you know, it still takes a long time for them to get the fitting for the hearing aid and then get the hearing aid back to the client. So it's—we're having an issue with that right now.

Mr. BENISHEK. All right. If there's one thing that I want you to comment—there's one thing, the best thing that we can do from this hearing to improve the situation for veterans here and in the Upper Peninsula and Northern Wisconsin, what is the one thing you would like to see, the most important thing. Mr. Lantz.

Mr. HOLCOMB. I would like to see that it's given a better opportunity for that veteran, regardless of income threshold, to be provided care. If he's a veteran, we need to take care of him.

Ms. RENTSCHLER. I guess I would like to see the veterans coming in at a faster pace maybe and more providers, if we could, to come here or even CBOCs. Another CBOC way up in the rural—way up in Houghton Hancock right now or Houghton. Maybe we should have another CBOC in there or something.

Mr. BENISHEK. Mr. Holcomb.

Mr. HOLCOMB. I would like to see more continuity of doctors and the—what you were saying. More continuity of doctors, I guess.

Ms. BUERKLE. Very good. Mr. Pray.

Mr. PRAY. I think it would have to be the availability of transportation to the existing health care facilities, finances to pay travel pay or overnight stays necessary to get these people in to the appointments that they need to go to.

And a lot of it has to do with the armed services themselves, the uniformed services, the education of veterans leaving service as to what services are available. I had no idea. Many of them go to Veteran Service Officers after they leave the service and have no idea what they're entitled to or what their services are. So we need to better educate those people.

Mr. BENISHEK. We've heard that comment before.

Mr. PRAY. I'm sure you have.

Mr. LANTZ. I would like to reiterate one last comment on that. The VA actually provide partnership—more partnerships, like Shirley said earlier, more partnerships within the community for the PTSD and TBI, the substance abuse programs. We have many, many OIF and OEF veterans that come home with PTSD and TBI issues that get involved in substance abuse, get into the court system, need that counseling and struggle to get it.

So if the VA was to do a community partnership where there are substance abuse programs in the community already, they can actually fee base that out or partner with them.

Mr. BENISHEK. Thank you very much.

Madam Chairman.

Ms. BUERKLE. Thank you, Dr. Benishek.

Because Mr. Lantz just raised the issue, we had a hearing last week in full Committee about mental health for our veterans with PTSD and traumatic brain injury. We actually had a veteran testify that he received his services in a different organization outside of the VA because he didn't have success in the VA facility.

So this is on everyone's radar screen and really the presumption is—and Dr. Benishek and I talked about this last night—for anyone who has been involved in an engagement, the presumption should be they're coming home with issues that need to be dealt with.

My concern, as we sit here today, is that there are veterans in the Upper Peninsula who may not even know what services are available to them. How are we going to get to them?

So, I look forward to having our next panel here. We will have the opportunity to ask some questions.

On behalf of Dr. Benishek, myself and the Veterans' Affairs Committee, thank you all very much for coming here today and for sharing your testimony with us. Thank you.

We will seat Panel No. 2 now.

Welcome and good morning, everyone. Thank you for being here this morning.

I'm going to ask Dr. Benishek to make the introductions for us.

Mr. BENISHEK. Good morning, everyone.

Well, first we have Dr. Clifford Smith, the Chief of Mental Health Service at the Oscar D. Johnson VAMC. He's a board certified clinical neuropsychologist by specialty.

And prior to joining the VA in 2008, Dr. Smith served as an Associate Professor of Psychological Science at Rush Medical University, 2001 to 2008.

Dr. Smith's leadership has been pivotal in the significant growth of the VA in the Iron Mountain Mental Health Service and the implementation of mental health services throughout the VAMC area.

Then we have Dr. Dinesh Ranjan. Dr. Ranjan and I have been colleagues here at the VA for a number of years, and he's the Chief of Surgery and the Director of the ICU in this system since 2009.

Prior to that, he was the Chief of Transplant Surgery at the University of Kentucky, where he was also a Professor of Surgery.

Dr. Ranjan received his medical education in India, did his residency training at William Beaumont Hospital in Detroit, St. Agnes

Hospital and the University of Miami and the University of Nebraska.

He received board certifications in general surgery and surgical critical care.

In addition to giving numerous presentations and appearing in peer review literature, Dr. Ranjan is currently the President of the International College of Surgeons, Chair of the Transplant Critical Care Task Force and the Chair of the Rural Surgery Advisory Board for the Veterans Health Administration.

Welcome, Dr. Ranjan.

Mr. Rice, he's a native of Iron River, as am I; and he was appointed as the Medical Staff Director at the Oscar D. Johnson Medical Center in just May of 2011. And prior to assuming this position, Mr. Rice was the Quality Management Officer for the Veterans In Partnership Network of VISN 11, where he was responsible for the development, oversight, coordination and leadership of all quality and performance programs throughout the VISN.

In addition, Mr. Rice served as the Acting Medical Director—Medical Center Director at the Aleda E. Lutz VA Medical Center in Saginaw.

He began his VA career as a Safety Manager at the VA Medical Center in downstate Allen Park, where I actually worked myself.

He's held positions of increasing responsibility at the VA Medical Center in Detroit, at the Veterans In Partnership Network, VISN 11, in Ann Arbor.

Mr. Rice is a 2008 graduate of the 113th Interagency Institute for Federal Health Care Executives and Health Care Leadership Institute for Executive Career Field members. He's also a member of the American College of Health Care Executives. Welcome, Mr. Rice.

Dr. Mary Beth Skupien—Am I saying that right?

Dr. SKUPIEN. Correct.

Mr. BENISHEK. She's the Director of the Office of Rural Health for the Veterans Health Administration. She's the Managing Director of the Rural Health Office of the Department of Veterans Affairs.

She's been responsible for providing leadership for improved access and quality of care for rural and highly rural veterans. This is done by developing evidenced-based policies and innovative practices to support the unique needs of veterans residing in remote areas.

She's got 28 years of experience in previous Federal service, including leadership and management for the Indian Health Service, has achieved success through innovative leadership and knowledge of health care administration at all levels.

She's—you've got many, many accolades here.

She's educated at Johns Hopkins University, School of Public Health, PhD., MS, from the University of Michigan, College of Nursing; BSN from Lake Superior State.

She's a member of the Sault Ste. Marie Tribe of the Chippewa Indians, with her hometown in Newberry. So she's working in DC now, but she started in Newberry, right here in the north, so it's really a pleasure to have you testifying with us here today, Dr. Skupien.

Dr. SKUPIEN. Thank you.
Mr. BENISHEK. You're welcome.
Ms. BUERKLE. Thank you very much.
At this time I would ask each one of our panelists to begin with an opening statement.
Dr. Skupien, if you could begin.

STATEMENTS OF MARY BETH SKUPIEN, PH.D., NATIONAL DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JAMES W. RICE, MA, DIRECTOR, OSCAR G. JOHNSON VETERANS AFFAIRS MEDICAL CENTER, IRON MOUNTAIN, MI, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; DINESH RANJAN, M.D., CHIEF OF SURGERY, OSCAR G. JOHNSON VETERANS AFFAIRS MEDICAL CENTER, IRON MOUNTAIN, MI, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CLIFFORD SMITH, M.D., CHIEF OF MENTAL HEALTH, OSCAR G. JOHNSON VETERANS AFFAIRS MEDICAL CENTER, IRON MOUNTAIN, MI, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF MARY BETH SKUPIEN, PH.D.

Dr. SKUPIEN. Good morning, Madam Chairwoman and Members of the Committee. Thank you for inviting us today to discuss the accessibility and quality of health care for veterans who reside in the Upper Peninsula of Michigan.
I am Dr. Mary Beth Skupien, National Director for the Department of Veterans Affairs, Office of Rural Health. I am a native of the Upper Peninsula, and it is a honor to be here today and to serve the rural and highly rural veterans here and across the country.
My testimony today will provide overview of the Office of Rural Health, discuss the services and outreach we are performing for veterans in rural and highly rural areas and discuss the improvements we are making in the Office of Rural Health.
Mr. Rice stated in his opening written testimony that rural veterans face many, many challenges when it comes to health care; and VA is committed to enhancing the care of rural veterans.
The many successful rural health project outcomes and positive impacts for the veterans as a result of the ORH funding for the Iron Mountain catchment area is a model for other rural VA communities. The Iron Mountain VAMC has been able to measure and demonstrate the positive impact with the rural veterans as a result of the ORH funding.
VA's National Office of Rural Health provides support and funding to ensure veterans living in rural and highly rural areas have access to care and the services they need. Its mission is to improve access and quality of care of enrolled rural and highly rural veterans by developing evidenced-based policies and innovative practices to support their unique needs.
The Office of Rural Health has invested resources to implement projects across the country. Over $500 million was dedicated to

these projects in FY 2009 and 2010, and we have dedicated another $250 million in FY 2011.

These funds supported national and local initiatives in expanding telehealth, home-based primary care, mental health, education and training, rural community-based outpatient clinics and outreach clinics, rural hiring initiatives, VISN-specific initiatives, community outreach, transportation programs and other efforts.

In FY 2011, VA is using ORH funding to expand national telehealth programs, implement Project ARCH, access received close to home and sustain teleradiology services, home-based primary care and support a wide range of initiatives mentioned above.

In FY 2010, VA's Office of Inspector General reviewed ORH and made six recommendations to improve accountability and use of resources. We have concurred with all six recommendations, and the Office of Rural Health has accomplished work to address five of the six recommendations.

ORH has hired nine staff in the past 10 months, including a Director and a Deputy, who have collectively over 60 years of rural health experience.

In FY 2010, the Office of Rural Health realigned the Veteran Health Resource Centers under leadership of myself. ORH is working to complete an updated strategic plan, project tracking system and functional evaluation before the end of 2011.

ORH project monitoring is ongoing, utilizing data collection and aggregation mechanisms, and the work has continued to improve the processes through the development of a Web-based project monitoring system.

Reassessment of the rural health initiatives will be completed by August of 2011, utilizing these assessments and geographic needs assessments for all business, as well as performance and measure of accomplishments and analysis of compliance with the Office of Rural Health, VHA and VA priorities and strategic objectives.

Thank you again for this opportunity to discuss the work of the Office of Rural Health and what we are doing to improve access and quality for veterans living in the Upper Peninsula of Michigan and throughout the Nation.

My colleagues and I look forward to answering your questions.

Ms. BUERKLE. Thank you, Dr. Skupien.

Mr. Rice.

STATEMENT OF JAMES W. RICE

Mr. RICE. Good morning, Madam Chairwoman and Members of the Committee. Thank you for inviting us here today to discuss the accessibility and quality of health care for veterans residing in the Upper Peninsula of Michigan.

I'm accompanied today by Ms.—I'm sorry, Dr. Mary Beth Skupien, National Director for VA's Office of Rural Health; Dr. Dinesh Ranjan, Chief of Surgery at the Iron Mountain VA Medical Center; and Dr. Clifford Smith, Chief of Mental Health at Iron Mountain VA Medical Center.

I would like to address some of the specific efforts we have taken to improve access to quality health care in the Upper Peninsula, including our recruitment retention efforts of qualified health professionals and specialty care programs for veterans.

My colleagues, Dr. Smith and Dr. Ranjan, will discuss other aspects of our work, including our mental health programs and our VA partnerships.

Given our presence in the Upper Peninsula and Northern Wisconsin, much of what we do can mean considerable help.

For the second straight year, we are participating in the Rural Health Professional institute funded by VA's Office of Rural Health, which provides clinicians an opportunity to enhance their skills, with the capacity for delivering health care to veterans in rural and highly rural locations.

We are currently supporting rural health projects through funding from VA's Office of Rural Health, as well as through local resources.

Iron Mountain VA Medical Center has received approximately $7.7 million over the past 3 years to implement and sustain rural health programs.

An example of a project supported by ORH includes expanded telehealth capabilities to include the provision of specialty services to veterans in rural and highly rural areas. We made significant investments in our telehealth programs and have seen remarkable growth in terms of veterans utilizing these services.

In year 2010, we provided specialty care through telehealth to 1,631 veterans, and we expect to increase that number to more than 2,500 this fiscal year. This program has seen a 400 percent increase since 2008.

We have also supported the enhanced rural access network for growth enhancement for the program, which is designed to expand the intensive case management services for veterans with serious mental illnesses and outreach services to homeless veterans.

We've also expanded primary and specialty care services, and we established a home-based primary care program in fiscal year 2008, with an additional location offering services in fiscal year 2009.

Using ORH funding, we opened the Manistique outreach clinic in August of 2009, and rural health funds were used to expand the Hancock clinic.

This year ORH funding has enabled Iron Mountain VA Medical Center to implement on-site cataract surgery, interventional pain management and Ears, Nose and Throat (ENT) clinics.

In addition to these efforts, we are supporting several initiatives to increase outreach, awareness and services in rural and highly rural areas.

The Iron Mountain VA Medical Center helped pioneer the Veterans Directed Home Care initiative, which allows veterans to choose friends and neighbors to assist them with their activities of daily living and to be paid for these services.

We've also expanded suicide prevention teams for increased outreach and coordination of high risk services.

Transportation and lodging are challenges unique to the vast rural and highly rural areas we serve.

The Iron Mountain VA Medical Center spent $1.9 million in fiscal year 2008, growing to $2.4 million in fiscal year 2009 and $3.4 million in fiscal year 2010 for beneficiary travel between facilities, as well as to and from appointments.

In addition, we lodged over 1,800 veterans and their caregivers this past year.

The Iron Mountain VA Medical Center has actively recruited and retained staff, while at the same time improving our relationships with community health providers in the Upper Peninsula and Northern Wisconsin to broaden the continuum of care available to the veterans we serve.

Thank you again for the opportunity to discuss the work VA is doing to improve access of quality care for veterans in the Upper Peninsula of Michigan. I am proud of the work the employees at the Iron Mountain VA Medical Center and CBOC do every day to deliver the best health care possible to American veterans.

My colleagues and I look forward to answering your questions.

[The prepared statement of Mr. Rice appears on p. 43.]

Ms. BUERKLE. Thank you, Mr. Rice.

Dr. Ranjan.

STATEMENT OF DINESH RANJAN, M.D.

Dr. RANJAN. Good morning, Madam Chairwoman and Dr. Benishek. I appreciate the opportunity to be able to participate in today's hearing. I bring a fresh perspective to this, having recently come from a super-specialty practice in a large university setting to basic general surgery practice in a rural setting within this VA facility. I have enjoyed the rewards and challenges of rural practice.

The VA system of health care daily offers many advantages, including a regulated system driven by protocols and policies, a highly functional electronic health record, and the ability to deliver care without the pressures of a fee-for-service model.

That rural health care faces entirely different challenges when compared to metropolitan urban areas has been recognized and discussed in scientific literature and other forums.

The Surgery Program at Iron Mountain has benefited from VA's Office of Rural Health, and we have used ORH funds to establish a cataract surgery program, opened up an ENT clinic and provide much needed support to the interventional pain management service.

Our surgical program has also managed to significantly improve the backlog and waiting time in almost all of our surgical clinics.

I recognize and appreciate the extent of this hearing in identifying areas where we face challenges and see opportunities.

I know that you have a lot of experience with the VA system and Iron Mountain and that you understand the issues specific to rural health care.

Some examples of these challenges include continuing education and academic support, the lack of clinical research opportunities, recruitment and retention of qualified providers, competition with non-VA facilities in the area, support from other VA facilities in the area, transportation of veterans to and from appointments, and logistical support to maintain effective the operations.

I would like to offer a few thoughts on delivery of care to rural settings.

These recommendations are my own, from the perspective of a rural surgeon with input from my surgical team, and do not necessarily reflect the views of the Department.

Additionally, I must note that these comments are independent of my position as the Chair of Rural Surgery Advisory Board. Given the well-recognized uniqueness and challenges faced by rural health care, I believe that some local flexibility and autonomy should be allowed within a standardized system, both in clinical and administrative situations.

A rural VA facility should be allowed to provide services as similar to comparable private facilities with tailored outcomes, if maintained within an acceptable range. The clinical practice should always be evidence-based.

There should be a structured mechanism for educational and academic fulfillment in the rural VA facilities. A mechanism should be developed for facilitating non-basic science research at rural VA facilities to ease participation in clinical trials and perform retrospective and prospective clinical analyses.

Considering that a rural VA is more likely to depend on purchased care, we need a well-defined protocol and clear expectations concerning financial, clinical and geographic variables.

Transportation of veterans from their own community to Iron Mountain and from Iron Mountain to other more advanced facilities should be further facilitated.

While recruitment and retention problems in rural areas have been well publicized, a better understanding of the reasons that may be specific to Iron Mountain and our community may provide a solution to ameliorate this problem.

The funding mechanism and compartmentalization of funding as it pertains to rural VA's should be reviewed to incentivize entrepreneurship and reward performance.

We should reexamine the necessity for standards that are separate from nationally-accepted benchmarks, such as The Joint Commission, Centers for Disease Control and Prevention (CDC) and Health Insurance Portability and Accountability Act (HIPAA).

Finally, in terms of support systems, such as information technology, contracting and human resources should be relocated and administered from within the rural VA facility.

This concludes my prepared remarks. Thank you again for the opportunity to participate in today's hearing.

Ms. BUERKLE. Thank you very much.

Dr. Smith.

STATEMENT OF CLIFFORD SMITH, M.D.

Dr. SMITH. Good morning, Madam Chairwoman. Thank you for the invitation to discuss the accessibility and quality of mental health care for veterans residing in the Upper Peninsula of Michigan.

My testimony today will highlight the services and outreach mental health staff members are performing for veterans in the rural and highly rural areas in the Upper Peninsula.

Specific area of focus will be on improvements to the delivery of rural mental health care, recruitment and retention of mental health personnel, the scope and impact of telemental health pro-

grams; and our collaboration and partnerships with our community providers.

Mental health care is a critical component to overall health, and we understand the importance of ensuring veterans can access this care. With this, we have added 45 mental health providers over the last 5 years, which has improved the ability of veterans to seek appointments and receive the evidence-based treatments they need.

Mental health staff members are available for outpatient psychotherapy at every CBOC. Telepsychiatry services are provided at Sault Ste. Marie, Manistique, Menominee, Rhinelander, Ironwood and here in Iron Mountain.

In fiscal year 2010 and 2011, we added additional outpatient services, including the Veterans' Recovery Health Advisory Council, the Veterans' Justice Outreach Program, the Health Promotion and Disease Prevention Program, Peer Support Programs, the HUD Short-Term Contract Housing, and the Aging and Homeless Programs.

In fiscal year 2010, we provided mental health care to approximately 3,000 veterans through 31,000 encounters, more than a two-fold increase from our services in fiscal year 2006.

The Iron Mountain VA Medical Center Behavioral Health Service has grown tremendously over the past 5 years.

Recruitment has historically—historically, recruitment of qualified psychologists and psychiatrists has been a challenge. Our current staff of 14 psychologists is the largest single group practicing in the Upper Peninsula of Michigan.

We could use recruitment and retention funds to offset costs of moving to rural regions, and we are currently using the Student Loan Repayment Program and the Education Debt Reduction Program as additional incentives for recruitment.

The economic downturn at issue has resulted in significant mental health cuts to State-funded programs. With the decreasing community mental health services available in the Upper Peninsula of Michigan, utilizing ORH funding, we established an Enhanced Range Team in Manistique to serve veterans in the Eastern Upper Peninsula, whose mental health needs cannot be met by typical outpatient psychotherapy and psychiatry.

The E–Range Program has made a significant impact on quality of life, medical and mental health of our rural veterans living with serious mental illness.

Iron Mountain has been one of the Nation's leaders in implementing telemental health services. Currently, we employ three psychiatrists who are physically located at another VA Medical Center or a non-VA facility and who provide telepsychiatric services to the Iron Mountain VA and the CBOCs.

Additionally, our onsite psychiatrists provide telepsychiatric services to our CBOCs on a regular and as-needed basis.

Since fiscal year 2010, we have successfully operated a Telepsychiatry Substance Abuse Addiction Clinic in collaboration with the Madison VA.

To build on this program, we are currently in the process of hiring our own part-time teledivisional psychiatrist, who will be able to provide additional services to both Iron Mountain and the CBOCs.

Again, thank you for this opportunity to discuss these important programs.

Ms. BUERKLE. Thank you very much, and thank you to all of our panelists for your testimony this morning.

I'm going to give myself some time for questions and then will yield to Dr. Benishek.

Dr. Skupien, I wanted to talk to you, first of all, because one of the deficiencies in the report had to do with reaching out to rural veterans and trying to assess their needs.

Congress recognized this need back since 2007, so it's been awhile.

What have you done to correct that? How are you reaching out? How are you assessing the needs of the veterans?

Dr. SKUPIEN. There's a number of things that we implemented just within the last 10 months since my arrival. We are doing a geographic and health-needs assessments across all areas.

Geographic needs assessments were due in May in my office, and the health needs assessments will be done the end of June. That's the first thing.

Ms. BUERKLE. Could I interrupt?

Dr. SKUPIEN. Sure.

Ms. BUERKLE. When you say "geographical assessments," to whom? How are those divided up?

Dr. SKUPIEN. Those are divided up by VISN, and what they're looking at are gaps in services. We look at drive times, we look at the amount of time that the veteran has to spend getting to a facility. So we're looking at access issues.

In addition, the health needs assessment, they look at every aspect of the veteran, what their needs are in relation to their health care.

We look at the partners, who look at facilities available and other resources that are available in the community. That's one thing that happened this year.

Another thing that happened is we really did a robust roll-out of the ORH Web site and the communication system. We published newsletters, we published success stories on our Web site. We have about 3,000 people that got sent to.

In addition, what we're trying to do to assess needs is we're trying to have focus groups in the community of all the veterans and have them reported out by VISN to our office.

We've also been able to—in order to meet the needs, we're looking at, based on these needs assessment, what are the actual needs of the veterans in tailoring our priorities for funding for FY 2012 for the projects that we fund?

So we've done a number of activities this year.

Ms. BUERKLE. One of my concerns is, and you've heard it from our first panel, because I asked each one of them, has your organization been reached out to in order to get needs assessments from the folks who are on the ground at the front lines, and they all said "no."

So I'm wondering, are you reaching out to local veteran groups in each of these rural communities so that you can get a true understanding? There's one thing to talk to this level; but I think if

we're really going to assess needs of veterans, you've got to talk to the veterans service organizations.

Dr. SKUPIEN. I know that we have VISN rural consultants in each VISN, and what they're doing, they're doing the needs assessment, and it varies in VISN.

But many of them have conducted focus groups. They address the needs identified by the veterans. So there's a variety of ways we're doing that, but I understand that there's still a need to really talk to the veterans.

I can say every time I come out on a visit, and I've only been here for 11 months, I make visits to the rural communities with the veterans, I go to the centers that we're funding and talk with the veterans.

So we are really making an effort to really hear what the veterans' needs are.

Ms. BUERKLE. Thank you.

One of the other issues we heard in that first panel was transportation, and some of you have alluded to it today in your testimony as well.

Now they mentioned "fee-based." Is there any fee-based transportation, anything in progress with regards to that?

And, Mr. Rice, in your testimony, you talked about the costs in 2009, 2010, 2011, the cost of transportation. Maybe you could first clarify that for me. That sounded like a lot of money for transportation, if that's what I was hearing.

Mr. RICE. That's been for travel, so that's paying the veteran to come from their home to the nearest CBOC or the campus of care. That just takes care of that cost. But we also have an additional cost where we have a bus that we send down to Milwaukee twice a week to take veterans to specialty care.

I would like to add, one of the programs we just submitted a grant for 2 weeks ago is to start our own transportation program here. I will be putting in a grant to purchase two buses that would hold 19 to 22 veterans.

It would have four staff. We would have a driver on each bus and an LPN; and then we would have five travel routes, so we would hit 19 different cities across the Upper Peninsula and try to bring the veterans here for their care. So we have that, and we are working on that because we recognize that as a need, too.

I would just like to thank the Disabled American Veterans (DAV). They have seven buses and over 146 drivers, so they support the VA Center. Without them, we couldn't do it.

Ms. BUERKLE. Excellent. One of the issues that was brought up this morning was oxygen and wheelchair access. Would they be allowed on these buses?

Mr. RICE. On the buses that we're looking at, yes.

Ms. BUERKLE. Okay.

Mr. RICE. Those buses go to Milwaukee. We would also allow the caregiver to go as well.

Ms. BUERKLE. Okay. Now, it appears to me from the testimony I heard this morning that Iron Mountain seems to have a very good outreach program that is in tune with the needs of rural veterans.

Is the Department of Veterans Affairs using this paradigm and what this hospital is doing for best practices and recommending

some of what they're doing here to other veteran hospitals who may not have such a high level of care?

Dr. SKUPIEN. Yes, we are, and that's not all. We are using our Web site and our newsletters. To get those evidence-based successful programs out, we're using the vignettes.

One of the things that Iron Mountain has done very well, and has been an issue for some other areas, is that they've really been able to demonstrate measures in the number of veterans served, the impact for this community; and that is a model for the Office of Rural Health for any projects that get funded forward that we can track.

Ms. BUERKLE. Thank you.

Dr. Smith, as I mentioned, we had a hearing last week regarding the mental health needs of our veterans and helping them transition out of active duty to veteran status and then making sure they are aware of what services are available.

In your opinion, are we doing a good enough job? Should more be done to reach out to the veterans? Is there a stigma attached to receiving mental health care.

Dr. SMITH. Certainly.

Ms. BUERKLE. Can you speak to that and make some recommendations for us so that we can reach out to veterans and avoid the substance abuse and this downward spiral that many of them are encountering?

Dr. SMITH. Thank you for the opportunity. I would certainly agree there's—as noted previously, there's difficulty with their transition coming out of their service into the VA system. Often they are told in service they're not eligible for services that they really are, and so they never knock on the VA's door.

So again, those DoD/VA collaborations are critical. I know our staff, mental health staff, OEF, OIF and Operation New Dawn (OND) staff make a commitment to visit the demobilization meetings and others throughout the facility, throughout our catchment area. The mental health staff makes an effort to get out to the colleges and the universities, speaking to college students, trying to get in the door to address some of that stigma.

There's often the issues of the adjustment difficulties coming out of a very structured military service into a very unstructured civilian life. Many of our veterans have difficulty during that transition time, and they may be afraid they have PTSD; or they may have some other serious mental illness, when it's really part of that transition.

So opportunities to—where we can normalize the difficult transition may help head off some of those difficult areas.

Ms. BUERKLE. Here in the Upper Peninsula, though, you have almost a double whammy if you have a veteran who is in a remote area and then he's having these feelings. How do you recommend we access those veterans? Because really the burden should be on VA to reach out and to understand. The presumption being that most of these young men and women coming home may very well have some issues, a whole range of issues.

Dr. SMITH. I agree.

Ms. BUERKLE. But that should be the presumption.

So my concern is they go back home, and how are we reaching them? Because the burden should be on VA.

Dr. SMITH. I believe our catchment area is a good model of what it is to live a remote life, where many of our veterans live 2 hours away from even a CBOC.

And if you're up by Lake Superior or down by Lake Michigan, you live by one of nature's greatest snow factors. And when you have 300 inches of snow a year, it's difficult to get into a clinic.

So that those continued opportunities, supporting the VSO, supporting the mental health staff that are able to go out into the community are critical.

There is, as a manager, the staffing difficulties of safety. What that means, we send a single person out 2 miles—or 2 hours away, what does that mean for that staff?

So logistically, it's not a simple solution of just jumping in the car and driving. There may not be cell phone coverage where many of our veterans live. They may not have a land line at their home. So you have lots of things to consider to get to these very remote areas.

To get there costs money; and often in the VA, we have performance monitors. So we are, say, called to be—to use E–85 is a good solution.

While in the Upper Peninsula of Michigan, we have three E–85 gas stations. So in order to work with the VA in that performance measure, we may have to drive extra miles to go get our E–85.

So everything comes at a trade-off. We can get out there, but it's also going to cost us increased miles and things like that.

Ms. BUERKLE. Thank you. I yield to Dr. Benishek for any questions.

Mr. BENISHEK. Thank you, Madam Chairwoman.

You kind of got me distracted there with the E–85. Are you required to use E–85, is that what you're telling me?

Dr. SMITH. We are not required. We are encouraged to use E–85.

Mr. BENISHEK. Well, we will get off that. That will probably be a subject for the hearings in Washington.

But, Dr. Smith, my focus of this meeting is to try to make it better for veterans here; and the fact—Because we have said so much of the centralized control in the VA, that there's little room for innovation or change at the local level.

So, for example, in their mental health services, are there any programs that you are required to do or mandated to do in your department that because of our rural area, it's difficult to do those, the manual things that may be required to do?

Dr. SMITH. Certainly. The VA has the Uniformed Services Package, which outlines the required mental health services for every VA. Many of those may be a challenge for rural facilities in that, you know, we're 4 hours from our sister VA in Milwaukee. We use their residential system, we use their domiciliary (DOM), we use their substance use disorder (SUD)-treatment program, we will use their acute psychiatric facility.

So if I have to hospitalize a veteran living from Sault Ste. Marie, that's a heck of a long drive from the Sault down to Milwaukee. And if Milwaukee is full, we may have to use even a further VA.

So we can provide the services, but they're often at a challenge and a cost.

Mr. BENISHEK. Was it your idea, if you had input to that, would you be able to find an easier way of doing it and then use that?

Dr. SMITH. Well, there I would have to be a VISN/Program Project. I'm also charged to be fiscally responsible to the VA.

And, you know, say, do we build a psychiatric facility here? That's not very cost smart, because for the amount of use that we would have, it would be so cost intensive to hire the psychiatric staff, to maintain it at full capacity, an appropriate capacity, we wouldn't have full utilization.

So there's the balance that we just cannot do some things because we may need it this month, but next month we may not need it. So then what do you do with the staff and the program during that time?

So we find our balance with utilizing both VISN 11 and VISN 12 facilities.

Mr. BENISHEK. Thank you very much.

Some of the VSO guys have the same sort of theme to their answers and, you know, the continuity of doctors was an issue. Well, Mr. Rice is sort of in a spot here, because you've only been here 2 weeks; and that's one of my problems with the system, is that the director turnover has been so rapid.

Having been from Iron River, I know you bought a house, I'm hoping that this means we will maybe have a director that will last a little bit longer with your presence here. But that's something that I want to monitor going forward, because I think the stability of the hospital is so much better.

Can you just address that? If not, then perhaps another gentleman could comment as well as to the continuity. Why is it a problem that while I've been coming here, I've seen six different doctors?

Mr. RICE. Yeah, I would agree. Since I'm new, I will defer to Dr. Ranjan.

But I think in the past 2 years, leadership here has made a commitment to providers. We spent almost $2 million in retention and recruitment bonuses. I know that we have a great doctor in Dr. Ranjan in the Upper Peninsula, and I think this year so far we spent over a million dollars to date. So I think that's the way we're trying to recruit top-notch physicians to the Upper Peninsula.

Mr. BENISHEK. Dr. Ranjan, are there any particular problems with retention of physicians and other important staff to the hospital that you may be able to address?

Dr. RANJAN. Well, as Mr. Rice pointed out, there is—We had seen turnover, and we are taking steps to provide resources.

But for a professional—from a professional perspective, it's important to have an environment where they feel professionally challenged, to meet their educational and professional needs. So that becomes difficult in this facility, especially in a rural facility where the practice may be restricted, so——

Mr. BENISHEK. What about the facility? I mean, I practiced in Dickinson County. We have doctors over there like crazy. What makes this so difficult?

Dr. RANJAN. Well, the policy and procedures sometimes dictate what you can or cannot do. And, therefore, across the street you might have been able to do certain things, we are not allowed to do here.

There may be—and then there are other educational and academic requirement that are needed, and the qualified physician must have that. Being in a rural setting, it is more difficult to get that. Being in private settings, you may have less effort to get that in.

Mr. BENISHEK. Like CME's (continuing medical education) and stuff like that?

Dr. RANJAN. CME. Clinical research out, you know, and go to meetings during the daytime and things like that.

Mr. BENISHEK. Well, you have a localized peer review of your mortality rate here, right?

Dr. RANJAN. Right. We have our own peer review in almost every department, and then we do have a level peer review; but that is different—that's different from what I'm talking about.

Mr. BENISHEK. Dr. Smith, do you have any comments about the continuity of care issue from your Department?

Dr. SMITH. In mental health, it's been spectacular. I've lost very few staff over the 3 years that I've been here. The things that have had an impact on my staff generally have been out of our control and focus on the economy.

Mr. BENISHEK. What do you mean by "out of your control?"

Dr. SMITH. There's a huge housing downturn right now. And many of my staff have—they're not from the area, so they all move here. Many staff have left a home, moved here, and that home has never sold. So after 2 years, they've had to return back home because they cannot sell their house.

Mr. BENISHEK. I see.

Dr. SMITH. There's been several instances where that has been the reason staff have left.

But as a core, I've got a great core of mental health staff that are here for the long-term.

Mr. BENISHEK. Dr. Skupien, I have a question about the local Office of Rural Health.

Dr. SKUPIEN. Uh-huh.

Mr. BENISHEK. My understanding is that it's been up for 3 or 4 years here now, with this trouble with having a director—you haven't had a full-time director there.

Dr. SKUPIEN. The national level?

Mr. BENISHEK. No, no, no, at the local level here. Is that right, or is that not right?

Dr. SKUPIEN. I will let Jim answer that, because that's——

Mr. BENISHEK. Jim doesn't know, I don't think, because he just got here.

Dr. SKUPIEN. Well——

Mr. BENISHEK. I thought there was a problem with there not being a director, or is that at the national level?

Dr. SKUPIEN. The national level.

Mr. BENISHEK. That was the national level?

Dr. SKUPIEN. Yes.

Mr. BENISHEK. Is there a lot of coordination between the Office of Rural Health and the hospital here?

Dr. SKUPIEN. There is.

Mr. BENISHEK. Who do you talk to? Who is in charge of the Office of Rural Health? Is that somebody here in the building?

Dr. SKUPIEN. The Office of Rural Health is coordinated in a number of ways. We have a VISN consultant who works almost daily with Jim and his staff and his leads for rural health. They're in constant communication.

They actually—the local staff develops the projects and the outcomes and measures, and then we monitor it very carefully. Sometimes it's weekly, sometimes it's monthly.

Mr. BENISHEK. Who do you talk to here at the VA? Would it be Mr. Rice's office? Is there anybody in the Mental Health Department or the Surgery Department that you coordinate with?

Dr. SKUPIEN. I would talk to the VISN consultant.

Mr. BENISHEK. Where is he at?

Dr. SKUPIEN. He is in Chicago, and then I would work directly with Jim Rice. If I have a specific issue, I would work directly with him.

Mr. BENISHEK. I just want to be sure that this coordination between what you're doing, what the people at the VA are doing, do you feel that that's going on?

Dr. SKUPIEN. I do feel that. There's a very bottom-up process, especially now where the needs are identified by the local communities. What we do is set priorities.

For example, we have six ORH priorities at the VACO–HQ level, but then we have the local communities here in Iron Mountain, for example, determining what their needs are and setting projects up.

Mr. BENISHEK. So, Dr. Smith, have you had input then into the Office of Rural Health's ability to provide mental health care that may help you then with your services?

Dr. SMITH. They certainly help with my services. My interactions with the Office of Rural Health would be when they put out an opportunity for new funding, I put in my applications.

Mr. BENISHEK. I see. So it's more of a funding issue?

Dr. SMITH. For me.

Ms. BUERKLE. So they're strictly mostly funding when the Office of Rural Health gets involved?

Dr. SKUPIEN. Primarily, but also now because of the measurements that now come, we have assigned liaisons from our office to deal with each of the project coordinators on a quarterly or monthly basis, depending on need.

Mr. BENISHEK. Do you provide funding for somebody like a county-based VSO? Is that within your purview?

Because, I mean, one of the issues that came up in the previous panel was that some of the counties don't have, you know, permanent VSO staff, depending on State funding or county funding.

Would that be within the realm? It seems to me that it would be perfectly within the realm of your agency to provide funding for somebody like that.

Dr. SKUPIEN. At this point, it would have to be—we don't have the mechanism in place. However, there are some models. Like if Iron Mountain decided that they wanted a project funded for trans-

portation, if they had a mechanism for getting that funding or a joint venture, we would consider that as long as everything was above aboard and we were able to do that. So yes, that is a potential.

Mr. BENISHEK. Well, it's just that, you know, with the partnership—you know, the different community organizations and stuff, it seems to me with this of transporting people with so many issues is really a problem. You know, with the distances involved and like a mental health person having to come to Iron Mountain for a mental health session, you know, three times a week is pretty arduous.

So I'm just wondering if there's funding available in your department to help for them to go to a regional outlet? Because I'm not sure that this is happening enough.

Dr. SKUPIEN. I can tell you a couple of things. One is that ORH funded 86 vans—transportation vans, and those were projects submitted by the local communities.

And also, as I noted in my opening statement, we fund a lot of telehealth; and that seems to have worked very well in rural communities where we're using telehealth or mental health services for every type of specialty care.

Mr. BENISHEK. Dr. Smith, how does this mental health work then? Do you put a computer in somebody's house then and you have a consultation over the Web or what?

Dr. SMITH. Currently, my process is all veterans go to a facility, so either Iron Mountain or one of the CBOCs. My psychiatrist may be set up with a computer—a teleconferencing computer, either at another VA facility, where we are using one of their rooms, or out of a non-VA facility, out of a private office.

And in VISN 20, they are currently piloting programs with veterans and their own computer and their own Web setup from their private homes. I have not implemented or moved towards that at this point.

Mr. BENISHEK. That makes a lot more sense, doesn't it?

Dr. SMITH. Clinically, it may or may not. If I were to implement that, I would want a case manager in that home, because from a mental health standpoint, what happens if there's a problem?

Mr. BENISHEK. Right.

Dr. SMITH. So if it's just the veteran and there's a power outage and the line goes dead, you know, that may have been at a critical moment.

Mr. BENISHEK. Yeah.

Dr. SMITH. So I certainly use lots of "tele" out into the facilities. My E-range team will provide transportation, will pick up a veteran in their home and bring them to the CBOC for that telepsychiatry session.

Mr. BENISHEK. Thank you. How are we with our time situation?

Is there anything else that we should be addressing? Is there something that the Committee can do for you, Dr. Smith, that would be the biggest, best thing that we can do to help your service move forward? This is your opportunity to help the people upstairs.

Dr. SMITH. Well, I think I could probably—you know, I would think about that both as an administrator, as the leader of my department, in my staff meetings and then as a clinician for the veterans' needs.

I think the challenge for my staff is—Often comes down to getting Washington to understand that we cover a pretty big area, and a lot of the expectations for performance are a challenge when the veteran lives 4 hours away.

And, you know, if a veteran is discharged from Milwaukee yesterday and now they're back home, you know, 3 hours away, is it respectful to that veteran to mandate that they come back to the Medical Center to have their 24-hour follow-up appointment? Now there's the challenge.

Now we want to get them in. That's good continuity of care, but then we also have to understand that veteran may have just been on a very long bus to get home.

As a clinician, the challenge is, you know, certainly providing good care in the community. We are provided the same level of funding to hire as a facility in Chicago.

Yet for me to hire, that person is going to have to move say to Hancock, which is a very remote area. It costs more money than if you lived in Chicago and you could just recruit from your pool.

Here in Iron Mountain, I have one community psychiatrist who does not work for the VA. He works for me part time. That's all I have to recruit from. It's not like a community pool.

So we have to pull people up. I think, as the administrator, that's the frustrating part is when I get the call from someone in Central Office asking me, you know, "What's the local cab company?" What is the local cab company? You know, that's the challenge.

Mr. BENISHEK. Dr. Ranjan, is there anything else we can do as far as your perspective is concerned?

Dr. RANJAN. From my perspective, I think we are growing, and so some of what we have already touched on is quite relevant.

If I could point one thing out, I would say probably the uniqueness of the rural practice. That is different from urban practice and providing mechanism for some growth in autonomy and flexibility to the out patient's need and our veterans.

Mr. BENISHEK. Mr. Rice, do you have any comment on that?

Mr. RICE. No, just your continued support.

Mr. BENISHEK. You know, that's been my impression coming from here going to Washington, is the fact that it's been so frustrating to me, like I pointed out before with these funding cycles, it doesn't leave any room for innovation on a director's part to have your different funding cycles.

If you had an option of taking some of that money and maybe you didn't spend it all, maybe it's kind of left over for the next year to spend it in an area where you're able to innovate a little bit, I mean, to provide an extra nurse or an extra case worker if you didn't need to have that, you know, $3 million wing or—you know, those 50 extra computers.

You know what I mean? Or vice versa, if you needed the money. I think that that's important. I think that addresses Dr. Ranjan's concern.

You know, our needs up here are so different than the needs in Chicago. And for the rules to be the same, you know, for both hospitals is just not realistic.

To have the local guy, which hasn't been here but for 2 years, to realize better than, you know, the VISN Director or the people

in Washington; that there was room for variability amongst the hospitals. They don't have to be exactly the same throughout the country.

And your testimony here and the testimony of the VSO people, I think verified my opinion in that regard.

So that's going to be my goal going back to Washington as I report to the full Committee these hearing results—we're not wasting money, we're trying to make the situation better, to allow flexibility within the VA to address concerns, not only for your system, but maybe urban centers might have an idea that might suit them better than the average setting.

So I appreciate your coming forward today and doing your best to inform us what's happening, and I want to thank you all very much.

With that, I will yield back to Chairwoman Buerkle.

Ms. BUERKLE. Thank you very much. And I echo Dr. Benishek's appreciation. Thank you, all of you, for being here this morning for your testimony.

It's been an honor and a pleasure to be here and to conduct this hearing in Iron Mountain.

Before we conclude, though, I would ask all of the veterans in this room as well as upstairs in the two overflow rooms to please stand up. Let us express our appreciation to you for your service.

[Applause.]

Ms. BUERKLE. Thank you.

Yesterday the Secretary of Defense, Robert Gates, was giving one of his exit interviews, and he mentioned about the military that one of the hardest parts for him leaving his position was the fact that he was leaving a group of men and women who are capable and dedicated and extraordinary. And I think we need to recognize that those capable, dedicated, extraordinary people become veterans; and that's the population we serve.

So we want to be sure to let you know how much we appreciate your service to this country. The United States of America is the greatest Nation in the history of mankind, and it is because of our military, our men and women who so honorably served this Nation.

Thank you for your service.

At this time, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks, including extraneous materials. Without objection, so ordered.

Ms. BUERKLE. At this time, this hearing will be adjourned. Thank you.

[Whereupon, at 11:54 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Ann Marie Buerkle, Chairwoman, Subcommittee on Health

Good morning. It is a pleasure for me to be here in beautiful Iron Mountain, Michigan. This is my very first time in the Upper Peninsula (U.P.) and I am so very grateful to you for allowing me to join you this morning despite my questionable "troll" status.

In all seriousness, I want to thank each of you for taking the time out of your busy lives to spend the morning with us.

I am honored to serve as the Chairwoman of the House Veterans Affairs Subcommittee on Health and to have your Congressman, and my friend, Dr. Dan Benishek, serving on the Committee with me. As I am sure you know, Dan has practiced as a general surgeon in the U.P. since 1983. He has also worked part-time at this VA facility for the past 20 years. Dan is an invaluable voice for veterans and brings a wealth of expertise to our Committee to help guide our efforts to improve VA care for veterans residing here in Iron Mountain and across the country.

Our oversight agenda this year has spanned a wide range of topics—from patient safety to caregiver benefits to the health needs of our newest generation of veterans from Iraq and Afghanistan—and throughout each of those discussions, Dan has provided a unique insight that only one with his "insider" knowledge can bring.

One thing he is always sure to stress about his time at the Oscar G. Johnson VA Medical Center is the high caliber of employees who dedicate themselves day in and day out to providing Michigan veterans with quality care and services.

I know he has the utmost confidence in the men and women who work at this facility and it is a comfort to us both to know that veterans are in such good hands up here in Iron Mountain.

To all of the VA employees joining us this afternoon—thank you for all you do each day to care for those who have so honorably served our Nation.

Coming from a rural district myself in Central New York, I am familiar with the struggles veterans living in rural communities, like yourselves, face in accessing the care and benefits you earned.

Congress took a significant step in 2007 when it created a new Office of Rural Health within the Department of Veterans Affairs (VA) to address the unique needs of veterans living in rural areas. In 2009 and 2010, Congress provided this office with over $500 million in additional dedicated funds to improve the delivery of health care to rural veterans. That is why it is so very disheartening to read a recent audit by the VA Office of the Inspector General (IG) which found that not only has the VA not properly managed the use of these funds, but still continues to lack even a process to assess the needs of veterans in rural areas. I think we can all agree that this is unacceptable.

At our hearing today, we will be taking a look at the health care programs provided to local veterans through the Iron Mountain VA Medical Center, including the use of telemedicine and other technologies. And, I want to hear from our witnesses how, if at all, the Office of Rural Health initiatives have improved services for veterans in the U.P. Further, moving forward, I want to know how VA is going to improve the management of our precious resources to meet the goal of increasing access and quality of care for rural veterans across our great country.

With that said, I now recognize your Congressman and my colleague and friend, Dr. Dan Benishek, for an opening statement.

Prepared Statement of Hon. Dan Benishek

Thank you, Chairman Buerkle. Good morning, everyone. It's good to be home. I would like to thank all the veterans and their guests who are in attendance. I would

like to thank our local Veteran Service Officers who have given their time today to participate in this hearing, as well as the VA administrators who will provide us insight on how to improve health care for our veterans. Additionally, I want to thank the staff of the House Committee on Veterans' Affairs for their hard work bringing Congress all the way up here to Michigan's U.P.

I would also like to introduce the Chairman of the Veterans Subcommittee on Health, Congresswoman Anne Marie Buerkle. Congresswoman Buerkle represents the people of New York State's 25th Congressional District. She graduated from St. Joseph's Hospital School of Nursing as a Registered Nurse and went to work in New York City's Columbia Presbyterian Hospital. In 1991, she returned to college, this time to earn her law degree, and worked as an Assistant New York State Attorney General representing the State of New York on behalf of Upstate Medical University. It has been a pleasure working with Congresswoman Buerkle on the Committee thus far. I greatly appreciate her making the trip up here and I value her contributions to the Veterans Committee and her leadership.

Ladies and gentlemen, I worked at this hospital for 20 years, and let me be clear: the staff at the Oscar G. Johnson Hospital is an incredibly dedicated, hardworking, and professional group of health care providers. Their commitment to our veterans, their enthusiasm, and their expertise are beyond reproach. I am proud to have worked alongside these men and women, and I want to take this opportunity to thank them for their service. Please join me in applauding these men and women.

With that said, I wouldn't have dragged Congress all the way up to the U.P., and I wouldn't have put Congresswoman Buerkle, an admittedly fearful flyer, on a propeller plane from Detroit to Iron Mountain for nothing. Like everything we do in life, veteran health care in Northern Michigan needs improvement.

At the start of the 112th Congress, I chose the Veterans' Affairs as my committee assignment so that I could bring my experience working in the VA health care system to Congress. So far, my experience on the Committee has been very encouraging. When you bring a veterans' issue to the Committee's attention, they listen, and work with you to find ways to remedy problems. And that is what we are here to do today: to get an honest assessment of what needs to be improved within the VA health care system to help our veterans in rural areas. As I stated, based on my experience, it is not for lack of effort or passion that VA health care providers fall short in providing quality service to our veterans, rather, on occasion, despite their best efforts, they are frustrated by the VA's central administration. From my observations, this frustration is caused in part by a lack of autonomy among VA health care facilities in rural areas.

Veterans in rural areas face different challenges compared to veterans elsewhere to accessing and receiving quality health care. As Congresswoman Buerkle can attest, the needs of veterans in this district differ from those in her district in New York, or Chairman Jeff Miller's district in Florida, or Ranking Member Bob Filner's in California. A one-size fits all, top-down approach will not address or anticipate every issue or roadblock to veterans in rural areas, and often they create barriers that waste work and resources in these settings, forcing rural VAs to shift patients at huge costs and patient dissatisfaction. One point from my personal experience that might help illustrate this point is that leadership at local VA facilities such as this hospital lack discretion on how their funds are spent; a facility's budget is divided into 3 categories: medical service, medical administration and medical facilities. Local facilities are not allowed to use funds from one budget "silo" for other necessities; for example, a hospital cannot use money designated for facility repairs to hire more staff, even if the repairs are unnecessary and the hospital is understaffed. It seems to me that rural facilities should have the ability to allocate funds as they deem appropriate.

Another personal frustration I had working in the VA system was the high turnover rate of hospital directors at this facility. During my time here, I worked with no fewer than 10 directors, a new one for every 2 years. Two years is simply not enough time to understand the unique challenges of a VA facility in a rural area, and such a short tenure provides little incentive to face these challenges and improve them. I'm not sure the cause for such a high turnover rate, but if a hospital such as this one hopes to improve their quality and access to health care, it needs stable leadership. In addition to his prepared testimony, I would request that Director James Rice speak to these issues.

Before we turn to the panel, I would like to share a short personal story that I believe highlights the many great doctor-patient relationships you see at this hospital.

And with that, I yield back the Chair.

Prepared Statement of Chuck Lantz, Director, Dickinson County Office of Veterans' Affairs, Iron Mountain, MI

Congressman, Congresswoman, and guests, I would like to thank you for the invitation and allowing me to testify today on this big issue of our Veterans today. I would like to start out with the subject at hand which is Rural Veterans health care. I think Oscar G. Johnson VA Medical Center and VISN 12 has taken many steps forward to extend access to the Veterans in the upper peninsula which is one of the most rural areas of Michigan if not the Nation. By building many CBOCs (community based outpatient clinics) in and around the Upper Peninsula and northern Wisconsin, it allows the Veteran to have Veterans health care closer to their community. However, there are still several issues in regard to the health care of the rural Veterans, 1. Transportation, 2. Better access to mental health caregivers for the veterans having issues with PTSD and TBI, and the related health issues that come with that, 3. Better access to substance abuse programs due to the PTSD issues. Veterans Affairs has grown by leaps and bounds but needs to keep thinking outside the box to keep growing and caring for our Nation's Veterans. There are still many Veterans that cannot get VA health care due to the income threshold laws unless they have been injured while serving and receiving a service-connected injury. Many of these Veterans served voluntarily and need to be cared for as a Veteran. Even if they are put in a priority group that requires co-pays, at least our Nation's Veterans would be cared for regardless of their income status.

Next I would like to discuss the issue of the underrepresented Veteran, most of all in the State of Michigan. Of the 69 counties in Michigan with CVSOs (County Veterans Service Officers) only 37 provide full time VB counseling, 32 counties have part time VB Counseling, 14 Counties without CVSOs. The Veteran population of 66,525 has no Veteran representation in those 14 Counties. The Veteran cannot establish their benefits alone, the veteran needs an advocate to assist them in the application process of VBA benefits as well as VHA benefits. The Veteran also needs that advocacy to assist them in gaining the benefits and keeping them in place; it is a constant struggle for the Veteran. I would like to just point out a comparison of 2 Counties in Michigan, one being Dickinson County with a fulltime CVSO, Veteran population of 2,671 with a total VA expenditure of $30,643,000.00 and of that $7,830,000.00 was compensation and pension, and that being liquid income comes directly back into the local Dickinson County community. Now take Antrim County with a part time CVSO. Veteran population 2,673 (2 Veterans more than Dickinson County), their total VA expenditure of $7,109,000.00 and of that $4,339,000.00 was compensation and pension. So you can see the difference we as CVSOs make advocating for the Veterans Benefits. Michigan has changed the grant funding to VSOs (Veterans Service Officers) and now with those changes, the number of VSOs had to be reduced. That brings more travel for the VSOs, and the time they are traveling they are not meeting with the Veteran which is a disservice to our Veterans. Also, with that reduction, no more services were added or changed to take up for the Veteran they can no longer reach in a timely manner. I am advocating that the State of Michigan and/or the Nation mandate there be Service officers in each county of each State. The process of the VA Benefits is so cumbersome that the Veterans cannot accomplish these tasks on their own; they need an advocate to accomplish their struggles with the system. Why is it that we as a Nation send our soldier to war with no questions asked and yet once they come home with injuries they have to prove without a shadow of a doubt that injury was due to their military service and if they do not have any injuries they have to prove they are under a certain income threshold to get health care. Changes need to be made to cover our Nation's Veterans, ALL OF THEM.

Office of Veterans Affairs (serving Dickinson County) has a motto: IF THEY SEND THEM WE MUST MEND THEM. Thank you for allowing me to express the needs of our Nation's Veterans and the need for all the Veteran advocates to assist them. This is a very important job in our Nation and funding and laws need to be established and changed so that our Nation and State has the VSOs and CVSOs to take care of our true American heroes. For my last comment I would like to say and challenge Congress to establish CVSOs in each and every county of Michigan and the Nation.

Thank you.

Counties' Commitment

- To assist veterans and their dependents in obtaining any and all Federal, State, and local veterans benefits to which they are entitled.

- This service is best provided through a local veterans office where the veterans' programs and assistance are consolidated into an easily accessible "one-stop shopping" location.

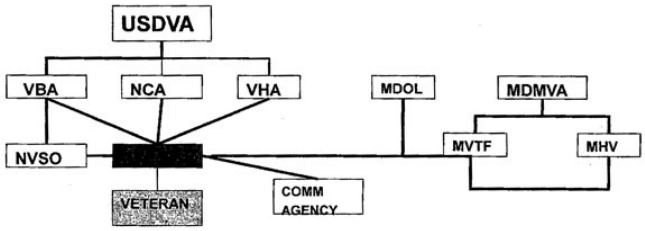
Enabling Legislation

- Public Act 214 of 1899 (MCL 35.21–35.27)
  - An Act to provide relief outside of the soldiers' home for honorably discharged indigent soldiers, sailors, Marines, nurses and members of women's auxiliaries and the indigent wives, widows and minor children of such . . . .
- Public Act 235 of 1911 (MCL 35.801–35.804)
  - An Act to provide for the payment and reimbursement by counties, in certain cases upon application therefor, of expenses incurred in the burial of bodies of honorably discharged members of the armed forces of the United States and their spouses . . . .
- Public Act 9 of 1946 (MCL35.601–35.610)
  - An Act to create the Michigan veterans' trust fund, and to define who shall be eligible to receive assistance therefrom; to provide for the disbursement . . . .
  - Public Act 192 of 1953 CMCL–35.621–35.624)
  - An Act to create a County Department of Veterans Affairs in certain counties, and to prescribe its powers and duties; and to transfer the powers and duties of the Soldiers Relief Commission in such counties. . . .
- Board of Commissioners Resolution/Letter of Agreement

Other Enabling Legislation

- Public Act 156 of 1851 (MCL 46.12b)
  - Excerpt from the Act to create County Boards of Commissioners regarding "Local councils of veterans affairs; appropriation by board of supervisors for operation."
- Public Act 77 of 1945 (MCL 35.11)
  - An Act to provide for local councils of veterans' affairs; and to authorize appropriations by counties, cities, villages and townships.
- Public Act 139 of 1973 (MCL 45.554)
  - An Act to provide forms of county government; to provide for county managers and county executives and to prescribe their powers and duties;
- Trained and accredited county counselors . . . .
  - Initiate, develop and prosecute claims for Federal, State and local veterans benefits.
  - Assist veterans to enroll in the USDVA medical care system.
  - Administer the county veterans burial allowance program and assist with other death benefits for veterans' survivors.
  - Utilize and coordinate emergency assistance from the Michigan Veterans Trust Fund and County Veterans Relief.
  - Refer veterans and their families to other appropriate programs.
  - May host part-time service from related veterans agencies and other community services.

Network



CVSO—County Veterans Service Office

MDMVA—Michigan Department of Military & Veterans

MVTF—Michigan Veterans Trust Fund

MHV—Michigan Homes for Veterans

MDOL—Michigan Department of Labor

NVSO—National Veterans Service Organization

USDVA—U.S. Department of Veterans Affairs

VBA—Veterans Benefits Administration

VHA—Veterans Health Administration

NCA—National Cemetery Administration

Of the 69 Counties with CVSO
37 provide full time VB Counseling

- Alpena
- Barry
- Berrien
- Branch
- Calhoun
- Cheboygan
- Chippewaw
- Clare
- Clinton
- Dickenson
- Eaton
- Genesee
- Gladwin
- Gogebic
- Grand Traverse
- Hillsdale
- Huron
- Ingham
- Isabella
- Jackson
- Kalamazoo
- Kent
- Lapeer
- Leelanau
- Lenawee
- Livingston
- Macomb
- Midland
- Monroe
- Oakland
- Ogemaw
- Sanilac
- St. Clair
- Tuscola
- Washtenaw
- Wayne

32 have part-time VB Counseling

- Alcona
- Allegan
- Alger
- Antrim
- Baraga
- Benzi
- Cass
- Charlevoix
- Delta
- Emmet
- Gratiot
- Houghton
- Ionia
- Iosco
- Iron
- Kalkaska
- Mackinaw
- Manistee
- Mecosta
- Menominee
- Montomrency
- Newaygo
- Ontanogan
- Otsego
- Ottawa
- Presque Isle
- Roscommon
- Schoolcraft
- Shiawassee
- St. Joseph
- Van Buren

14 Counties without CVSO

- Arenac
- Bay
- Crawford
- Lake
- Luce
- Marquette
- Mason
- Missaukee
- Montcalm
- Muskegon
- Oceana
- Osceola
- Oscoda
- Saginaw

Veterans Represented by CVSOs

- Counties with Full time Offices:
  - 532,650 veterans plus their families
- Counties with Part time offices
  - 104,795 veterans plus their families
- Counties without CVSOs
  - 66,525 veterans plus their families

* * * *703,970–VA estimated Michigan veteran population for 2010, which represents a decrease of 100,041 since 2006.* * * *

Commitment to Maintain CVSO Training

- State of Michigan
  - $50,000 Training Appropriation (revoked 4/12/07)
- Counties
  - Registration/Conference Costs
  - VBC salary/leave time
  - Host training conferences
- Individual
  - Personal time
  - Miscellaneous expenses

Accreditation & CEU Training

- Approximate 65 Veterans Benefits Counselors attend the Spring Training Conference each year.
- Training conferences provide:
  - USDVA accreditation training and/or continuing education unite training
  - Reference materials
  - Opportunities to network collaborate and cooperate with other County Counselors, USDVA and MDMVA staff and Veterans Service Officers.

Benefits/Outcome

- **For the Veteran/families**
  - **Financial**
    - Service-connected Compensation
    - Non-service-connected disability pension
    - Dependency and Indemnity Compensation
    - Death pension
    - USDVA and County Burial Benefits
    - State and County Emergency Financial Relief
  - **Health**
    - USDVA Medical Centers
    - Community Based Outpatient Clinics
    - Vet Centers
  - **Education**
    - Various USDVA Veterans and Dependents Education benefits
    - -Vocational Rehabilitation
    - -MI Children of Veterans Tuition Grant
  - **Quality of Life**
    - National Cemetery Burial
    - Military Records
    - Michigan Veterans Homes

Benefit to Michigan Veterans
For the Community, County, State

- Economy
  - USDVATotalFY 2010ExpendituresforMl-$2.4Billion
    - Compensation and Pension-$1.1Billion
  - State/Local monetary/non-monetary benefits
- Health
  - USDVA Medical Care (5 VA Medica1Center (16 CBOCS)
  - Vet Centers
- Quality of Life
  - Federal Non-monetary Benefits
    - Government Marker, U.S. Flag, Military Records
  - National Cemeteries
    - Fort Custer
    - Great Lakes National Cemetery
  - State Veterans Homes

MACVC Challenge to you:

. . . is to help us accomplish our mission which is to provide *consistent* and *professional* veterans services through out every county in our great State of Michigan

Glossary

DoD ESGR—Dept of Defense—Employment Support Guard & Reserves
GLNCAC—Great Lakes National Cemetery Advisory Council
JVC—Joint Veterans Council
MAC—Michigan Association of Counties
MDMVA—Michigan Department of Military and Veterans Affairs
MDOL—Michigan Department of Labor
MHV—Michigan Homes for Veterans
MVTF—Michigan Veterans Trust Fund
NACVSO—National Association of Veterans Service Officers
NCA—National Cemetery Administration
NVSO—National Veterans Service Organization
TAP—Transitional Assistance Program
USDVA—U.S. Department of Veterans Affairs
VBA—Veterans Benefits Administration

VHA—Veterans Health Administration
VISN 11 & 12—Veterans Integrated Services Network
& MAC—& Management Assistance Committee

FY 2009 GEOGRAPHIC DISTRIBUTION OF VA EXPENDITURES (GDX)

MICHIGAN
Expenditures in $000s

County/ Congressional District	Veteran Population*	Total Expenditure	Compensation & Pension	Construction	Education & Vocational Rehabilitation/ Employment	Loan Guaranty#	General Operating Expenses	Insurance & Indemnities	Medical Care	Unique Patients**
ALCONA	1,675	$ 6,938	$ 4,145	$ -	$ 97	$ -	$ -	$ 51	$ 2,646	510
ALGER	1,617	$ 5,148	$ 3,047	$ -	$ 161	$ -	$ -	$ 86	$ 1,854	351
ALLEGAN	8,520	$ 20,814	$ 10,320	$ -	$ 1,161	$ -	$ -	$ 454	$ 8,880	1,400
ALPENA	3,050	$ 11,126	$ 5,460	$ -	$ 392	$ -	$ -	$ 80	$ 5,193	963
ANTRIM	2,673	$ 7,109	$ 4,339	$ -	$ 201	$ -	$ -	$ 146	$ 2,424	487
ARENAC	1,639	$ 6,204	$ 3,193	$ -	$ 160	$ -	$ -	$ 79	$ 2,832	370
BARAGA	968	$ 4,372	$ 1,891	$ -	$ 100	$ -	$ -	$ 20	$ 2,361	302
BARRY	5,060	$ 16,320	$ 7,448	$ -	$ 756	$ -	$ -	$ 198	$ 7,919	959
BAY	9,241	$ 29,980	$ 14,997	$ -	$ 1,399	$ -	$ -	$ 483	$ 13,081	1,955
BENZIE	1,845	$ 5,410	$ 3,298	$ -	$ 179	$ -	$ -	$ 161	$ 1,772	380
BERRIEN	12,028	$ 36,932	$ 17,471	$ -	$ 1,983	$ -	$ -	$ 643	$ 16,836	2,929
BRANCH	3,735	$ 12,824	$ 6,379	$ -	$ 409	$ -	$ -	$ 82	$ 5,965	776
CALHOUN	11,438	$ 79,221	$ 29,249	$ -	$ 1,912	$ -	$ -	$ 792	$ 47,268	3,221
CASS	4,611	$ 11,338	$ 5,662	$ -	$ 464	$ -	$ -	$ 185	$ 5,027	1,143
CHARLEVOIX	2,830	$ 5,674	$ 2,908	$ -	$ 166	$ -	$ -	$ 234	$ 2,246	847
CHEBOYGAN	2,659	$ 10,177	$ 6,593	$ -	$ 307	$ -	$ -	$ 83	$ 3,209	715
CHIPPEWA	3,821	$ 14,786	$ 8,637	$ -	$ 928	$ -	$ -	$ 403	$ 4,828	828
CLARE	3,874	$ 15,517	$ 7,304	$ -	$ 417	$ -	$ 1,153	$ 253	$ 6,390	928
CLINTON	4,981	$ 10,494	$ 6,173	$ -	$ 1,273	$ -	$ -	$ 311	$ 2,737	551
CRAWFORD	1,790	$ 5,248	$ 2,741	$ -	$ 175	$ -	$ -	$ 55	$ 2,278	391
DELTA	4,074	$ 23,471	$ 10,528	$ -	$ 725	$ -	$ -	$ 221	$ 11,997	1,394
DICKINSON	2,871	$ 30,663	$ 7,630	$ 407	$ 326	$ -	$ 1,800	$ 201	$ 20,209	1,292
EATON	8,499	$ 22,317	$ 12,584	$ -	$ 1,999	$ -	$ -	$ 444	$ 7,289	1,155
EMMET	3,081	$ 7,552	$ 4,330	$ -	$ 283	$ -	$ -	$ 171	$ 2,799	564
GENESEE	31,231	$ 86,183	$ 47,849	$ -	$ 5,933	$ -	$ -	$ 1,618	$ 30,983	4,064
GLADWIN	2,836	$ 10,677	$ 5,548	$ -	$ 273	$ -	$ -	$ 71	$ 4,785	669
GOGEBIC	2,132	$ 9,986	$ 4,389	$ -	$ 271	$ -	$ -	$ 205	$ 5,131	791
GRAND TRAVERSE	7,495	$ 21,894	$ 12,947	$ -	$ 1,890	$ -	$ -	$ 638	$ 6,524	1,452
GRATIOT	3,009	$ 10,977	$ 5,832	$ -	$ 429	$ -	$ -	$ 89	$ 4,627	627
HILLSDALE	3,621	$ 12,785	$ 6,297	$ -	$ 483	$ -	$ -	$ 188	$ 5,827	807
HOUGHTON	2,935	$ 13,388	$ 5,949	$ -	$ 1,145	$ -	$ -	$ 240	$ 6,054	891
HURON	2,980	$ 9,820	$ 4,804	$ -	$ 255	$ -	$ -	$ 253	$ 4,508	684
INGHAM	16,855	$ 47,138	$ 24,849	$ -	$ 5,009	$ -	$ -	$ 1,001	$ 15,577	2,558

MICHIGAN
Expenditures in $000s

County/ Congressional District	Veteran Population*	Total Expenditure	Compensation & Pension	Construction	Education & Vocational Rehabilitation/ Employment	Loan Guaranty#	General Operating Expenses	Insurance & Indemnities	Medical Care	Unique Patients**
IONIA	4,388	$ 12,222	$ 6,215	$ -	$ 1,066	$ -	$ -	$ 212	$ 4,729	674
IOSCO	3,863	$ 13,514	$ 7,440	$ -	$ 253	$ -	$ -	$ 187	$ 5,635	1,015
IRON	1,389	$ 11,282	$ 4,210	$ -	$ 93	$ -	$ -	$ 74	$ 6,904	669
ISABELLA	3,832	$ 12,090	$ 6,163	$ -	$ 1,550	$ -	$ -	$ 180	$ 4,196	718
JACKSON	12,410	$ 41,814	$ 22,237	$ -	$ 2,137	$ -	$ -	$ 799	$ 16,641	2,650
KALAMAZOO	15,071	$ 60,021	$ 23,097	$ 148	$ 5,024	$ -	$ 4,217	$ 1,374	$ 26,164	2,988
KALKASKA	1,631	$ 6,264	$ 3,468	$ -	$ 164	$ -	$ -	$ 84	$ 2,558	413
KENT	35,894	$ 110,665	$ 57,404	$ -	$ 10,602	$ -	$ -	$ 2,784	$ 40,115	7,570
KEWEENAW	303	$ 919	$ 453	$ -	$ 10	$ -	$ -	$ 20	$ 437	115
LAKE	1,318	$ 5,578	$ 3,200	$ -	$ 94	$ -	$ -	$ 21	$ 2,263	339
LAPEER	7,321	$ 16,147	$ 9,868	$ -	$ 1,069	$ -	$ -	$ 282	$ 4,927	1,048
LEELANAU	2,580	$ 5,259	$ 3,406	$ -	$ 222	$ -	$ -	$ 149	$ 1,488	447
LENAWEE	8,518	$ 28,751	$ 14,425	$ -	$ 1,507	$ -	$ -	$ 298	$ 12,523	1,888
LIVINGSTON	12,694	$ 32,179	$ 15,792	$ -	$ 2,393	$ -	$ -	$ 1,208	$ 12,785	1,842
LUCE	753	$ 2,180	$ 1,437	$ -	$ 45	$ -	$ -	$ 16	$ 671	103
MACKINAC	1,099	$ 4,735	$ 2,818	$ -	$ 215	$ -	$ -	$ 38	$ 1,663	291
MACOMB	60,071	$ 157,229	$ 83,749	$ -	$ 12,217	$ -	$ -	$ 3,772	$ 57,490	7,641
MANISTEE	2,634	$ 8,671	$ 4,891	$ -	$ 240	$ -	$ -	$ 118	$ 3,323	612
MARQUETTE	6,707	$ 33,870	$ 19,989	$ -	$ 2,335	$ -	$ -	$ 308	$ 11,338	1,832
MASON	3,043	$ 8,291	$ 4,804	$ -	$ 465	$ -	$ -	$ 104	$ 2,918	485
MECOSTA	3,834	$ 9,201	$ 5,349	$ -	$ 1,045	$ -	$ -	$ 58	$ 2,750	578
MENOMINEE	2,729	$ 14,005	$ 6,841	$ -	$ 381	$ -	$ -	$ 86	$ 6,665	1,026
MIDLAND	6,204	$ 20,642	$ 9,743	$ -	$ 1,104	$ -	$ -	$ 383	$ 9,402	1,232
MISSAUKEE	1,359	$ 5,430	$ 2,956	$ -	$ 199	$ -	$ -	$ 56	$ 2,238	297
MONROE	12,165	$ 32,510	$ 15,573	$ -	$ 1,978	$ -	$ -	$ 600	$ 14,380	1,888
MONTCALM	6,060	$ 13,478	$ 7,759	$ -	$ 869	$ -	$ -	$ 201	$ 4,648	859
MONTMORENCY	1,091	$ 4,625	$ 2,696	$ -	$ 89	$ -	$ -	$ 38	$ 1,801	318
MUSKEGON	14,623	$ 36,519	$ 23,054	$ -	$ 2,557	$ -	$ -	$ 721	$ 13,187	2,848
NEWAYGO	4,335	$ 13,314	$ 7,656	$ -	$ 591	$ -	$ -	$ 86	$ 4,970	948
OAKLAND	70,715	$ 187,821	$ 107,413	$ 3,334	$ 12,942	$ -	$ 1,570	$ 7,349	$ 55,202	10,015
OCEANA	2,518	$ 5,802	$ 3,816	$ -	$ 263	$ -	$ -	$ 87	$ 1,637	395
OGEMAW	2,533	$ 9,966	$ 4,856	$ -	$ 215	$ -	$ -	$ 123	$ 4,774	672
ONTONAGON	993	$ 5,976	$ 2,768	$ -	$ 106	$ -	$ -	$ 7	$ 3,096	411

MICHIGAN
Expenditures in $000s

County/ Congressional District	Veteran Population*	Total Expenditure	Compensation & Pension	Construction	Education & Vocational Rehabilitation/ Employment	Loan Guaranty#	General Operating Expenses	Insurance & Indemnities	Medical Care	Unique Patients**
OSCEOLA	2,167	$ 7,185	$ 3,865	$ -	$ 274	$ -	$ -	$ 78	$ 2,972	469
OSCODA	1,134	$ 4,712	$ 2,555	$ -	$ 100	$ -	$ -	$ 42	$ 2,016	291
OTSEGO	2,321	$ 6,814	$ 3,960	$ -	$ 156	$ -	$ -	$ 140	$ 2,558	494
OTTAWA	16,206	$ 32,837	$ 17,291	$ -	$ 3,895	$ -	$ -	$ 944	$ 10,707	2,099
PRESQUE ISLE	1,944	$ 5,086	$ 2,929	$ -	$ 196	$ -	$ -	$ 59	$ 1,902	449
ROSCOMMON	2,854	$ 11,191	$ 5,847	$ -	$ 333	$ -	$ -	$ 240	$ 4,971	701
SAGINAW	15,046	$ 65,977	$ 25,851	$ -	$ 2,421	$ -	$ 2,653	$ 490	$ 34,854	3,636
ST. CLAIR	14,120	$ 37,334	$ 21,488	$ -	$ 2,188	$ -	$ -	$ 808	$ 12,852	2,755
ST. JOSEPH	4,508	$ 11,987	$ 5,626	$ -	$ 732	$ -	$ -	$ 302	$ 5,328	896
SANILAC	3,801	$ 12,282	$ 6,330	$ -	$ 534	$ -	$ -	$ 165	$ 5,253	976
SCHOOLCRAFT	1,033	$ 4,010	$ 2,161	$ -	$ 48	$ -	$ -	$ 18	$ 1,792	304
SHIAWASSEE	5,700	$ 16,806	$ 8,855	$ -	$ 1,270	$ -	$ -	$ 270	$ 6,411	910
TUSCOLA	4,703	$ 15,784	$ 7,670	$ -	$ 737	$ -	$ -	$ 178	$ 7,299	963
VAN BUREN	6,219	$ 18,323	$ 9,210	$ -	$ 1,086	$ -	$ -	$ 327	$ 7,700	1,066
WASHTENAW	17,385	$ 106,170	$ 20,278	$ 1,106	$ 8,612	$ -	$ 9,832	$ 1,806	$ 58,735	3,012
WAYNE	112,004	$ 466,792	$ 175,780	$ 20,186	$ 19,455	$ -	$ 31,092	$ 6,894	$ 213,384	22,141
WEXFORD	2,786	$ 10,437	$ 5,696	$ -	$ 641	$ -	$ -	$ 51	$ 4,049	657
MICHIGAN (Totals)	703,970	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CONG. DIST (01)	70,118	$ 301,827	$ 150,634	$ 407	$ 10,438	$ -	$ 1,800	$ 3,841	$ 134,908	19,684
CONG. DIST (02)	54,268	$ 141,333	$ 79,791	$ -	$ 9,919	$ -	$ -	$ 2,544	$ 49,080	10,116
CONG. DIST (03)	43,148	$ 134,788	$ 68,785	$ 90	$ 11,903	$ -	$ -	$ 3,103	$ 50,857	8,739
CONG. DIST (04)	58,675	$ 180,776	$ 95,400	$ -	$ 10,395	$ -	$ -	$ 2,877	$ 72,104	11,418
CONG. DIST (05)	46,355	$ 157,722	$ 76,457	$ -	$ 8,419	$ -	$ 2,553	$ 2,343	$ 67,949	7,958
CONG. DIST (06)	48,530	$ 154,569	$ 68,021	$ 55	$ 10,023	$ -	$ 4,217	$ 3,141	$ 68,212	10,070
CONG. DIST (07)	62,868	$ 210,686	$ 96,629	$ 9	$ 9,644	$ -	$ -	$ 2,960	$ 101,444	10,969
CONG. DIST (08)	49,200	$ 116,803	$ 61,643	$ 1	$ 11,611	$ -	$ -	$ 3,204	$ 40,144	8,144
CONG. DIST (09)	39,939	$ 99,127	$ 65,810	$ 3,334	$ 8,520	$ -	$ -	$ 4,810	$ 29,833	4,847
CONG. DIST (10)	48,387	$ 138,838	$ 80,218	$ -	$ 9,877	$ -	$ -	$ 3,018	$ 45,390	8,403
CONG. DIST (11)	39,711	$ 122,399	$ 67,004	$ 82	$ 9,863	$ -	$ 1,149	$ 3,968	$ 50,334	8,237
CONG. DIST (12)	50,044	$ 140,448	$ 73,875	$ 3	$ 8,636	$ -	$ 1,569	$ 3,271	$ 53,144	7,008

Iron Mountain, MI
June 16, 2011

The Honorable Congressman Dan Benishek
500 South Stephenson—Suite 500
Iron Mountain, MI 49801

RE: Veterans Affairs Field Hearing

Thank you for your invitation to participate in your Veterans Affairs Field Hearing on Monday, June 20, 2011 at the Iron Mountain VA Medical Center. I believe that our Iron Mountain (Oscar G. Johnson) VA Medical Center is one of the finest facilities serving the veterans of Michigan's Upper Peninsula and Northern Wisconsin. Over the past couple of decades, I have seen the growth of veterans' care at our VA Medical Center with many veterans saying they feel like they are being treated like royalty.

Regarding the issues addressed in the House letter of June 8, 2011, I offer the following comments:

- ***Delivery* of *health care* to *rural veterans* . . .** has been great with the addition of the home health care, specialty clinics, women veterans' programs. I would like to see a dermatologist and more hours for our chiropractor.
- ***Recruitment and retention* of *medical personnel including leadership*** . . . we have some very caring medical personnel at our facility and I think it's important that when recruiting physicians, that they also be fully trained in VA law regarding pension and service-connection disabilities and what is needed when documentation is concerned. I understand that sometimes recruiting to a small remote area like Iron Mountain is difficult, but would like to see longevity of providers. Sometimes, the veterans get frustrated because their providers are changed often. Most of our VAMC providers have compassion for our veterans when treating them and listening to their concerns, but we also have a few that do belittle them, are disrespectful, not understanding the physical and mental demands of being in the service. To our veterans, their conditions are real. At times, their providers would even ask 'are you just looking for some more money?' This is unacceptable. In regards to most compensation exams, they have greatly improved, are done with efficiency and thoroughness with respect to the veterans.
- ***Mental Health*** . . . longer wait time to get appointments especially for WW–I1, Korean and Vietnam veterans because OEF/OIF veterans have preference at this time. Would like to see more providers or outreach facilities as well more counselors at the Vets Center in Escanaba as well.
- ***Telehealth programs*** . . . Our veterans would like to see more of this type of service as it would ease up VAMC's appointment slots and workload to allow the VAMC providers more *time* with individuals to discuss their medical problems and concerns. This would also be more cost effective for the veterans.
- ***Community partnerships*** . . . More of this partnering would be more cost efficient and effective, and to help our veterans with the different resources available in their own communities; I would encourage more of this type of programming.

I would also like to make a couple of comments regarding . . .

- ***Fee Basis*** . . . such as chemotherapy, physical therapy and chiropractic care. In the U.P. of Michigan, it is sometimes impossible for the veteran to drive to Iron Mountain for chemo treatment especially when he or she is taking numerous medications. The same thing for physical therapy as the long drive into Iron Mountain is sometimes an aggravation of their condition. I would like to see more outreach for these types of treatments to ease the pain for the veterans.
- ***VA and/or VAMC forms*** . . . Service Officers work with veterans, of course, but also with their dependents and/or surviving spouse. On occasion, when a veteran passes away, the physicians should be more conscious about all the veteran's conditions when they fill out the death certificate as it could result in a grant or denial for spousal benefits. This would also be a good subject for educating our physicians in our community partnerships. At times, it is also necessary to have the VAMC provider fill out forms that would support the veteran's claim and we would request thoroughness for each form to eliminate another request.

Thank you for allowing me to participate in this hearing for the House Committee on Veterans' Affairs Subcommittee on Health.

Respectfully,

Shirley A. Rentschler
National Service Officer
Military Order of the Purple Heart
Department of Michigan

Prepared Statement of James W. Rice, MA, Director, Oscar G. Johnson, Veterans Affairs Medical Center, Iron Mountain, MI, Veterans Health Administration, U.S. Department of Veterans Affairs

Good Morning, Madam Chairwoman and Members of the Committee. Thank you for inviting us here today to discuss the accessibility and quality of health care for Veterans residing in the Upper Peninsula of Michigan. I am accompanied today by Dr. Mary Beth Skupien, National Director for the Department of Veterans Affairs (VA) Office of Rural Health, Dinesh Ranjan, M.D., Chief of Surgery at the Oscar G. Johnson (Iron Mountain) VA Medical Center (VAMC), and Clifford Smith, M.D., Chief of Mental Health at the Iron Mountain VAMC.

My testimony today will describe the work done at the Iron Mountain VAMC, and then review the services and outreach we provide to Veterans in the rural and highly rural areas here in the Upper Peninsula. Specific areas of focus will be improvement in mental health and rural health care, recruitment and retention of medical personnel, the scope and impact of telehealth programs, and our collaboration and partnerships with community providers.

About Iron Mountain VAMC

The Iron Mountain VAMC provided care and services to almost 20,000 Veterans in fiscal year (FY) 2010 with an operating budget of $106.9 million and more than 580 employees. The facility oversees community-based outpatient clinics (CBOC) in Michigan (Ironwood, Hancock, Marquette, Sault Ste. Marie and Menominee) and Wisconsin (Rhinelander) that serve 15 counties in Michigan and 10 counties in Wisconsin. It also operates a rural outreach clinic in Manistique, Michigan. The Iron Mountain VAMC has the largest geographic patient service area east of the Mississippi River, home to approximately 53,000 Veterans, 23,863 of whom are enrolled in VA's health care system.

The Iron Mountain VAMC is a primary and secondary level care facility with 13 medical/surgical beds and four intensive care unit (ICU) beds. Its Community Living Center has 40 beds. The Iron Mountain VAMC provides limited emergency and acute inpatient care in a geographically rural area, and collaborates with larger health care facilities in Veterans Integrated Service Network (VISN) 12 to provide higher level emergency and specialty services. It employs state-of-the-art telehealth technologies and is a leader in the delivery of health care to rural Veterans. The Iron Mountain VAMC provides ambulatory and acute primary and secondary health care, as well as surgery, psychiatry, physical medicine and rehabilitation, neurology, ophthalmology, ear/nose/throat (ENT), podiatry, orthopedics, oncology, dentistry, geriatrics, and extended care.

In FY 2011 to date, the Iron Mountain VAMC is providing more than 99.7 percent of patients' primary care appointments within 14 days of their desired date, exceeding the VA benchmark. At all of our facilities, more than 99.5 percent of patients seeking a specialty care appointment are scheduled within 14 days of their desired date. Our patients are satisfied with the quality of care they receive as evidenced by the Medical Center's patient experience data, which exceeds the VA's national score for both inpatient and outpatient care. More than 82 percent of our Veterans would recommend Iron Mountain to their friends and family.

We have made great strides in the quality of care we provide by reducing readmission rates for patients with heart failure, developing better screening and surveillance processes for colo-rectal cancer, improving the timeliness of placing patients discharged from acute care into the Community Living Center, developing Patient Aligned Care Teams (PACT), and expanding teleretinal services and care. This year, we are making further enhancements to our telehealth services and their availability at our CBOCs; we currently support telemedicine programs for Pulmonary, Rheumatology, Endocrine, Cardiology, Prosthetics, Diabetes, Infectious Disease, Weight Management Program (i.e., MOVE!), Healthy Heart, Behavioral Health, Teleretinal Imaging Program and Telepathology.

Improvement to the Delivery of Rural Health Care

Rural Americans, including rural Veterans, face many challenges when it comes to health care, and VA is committed to enhancing the care rural Veterans receive. Given our presence in the Upper Peninsula, much of what we do can be considered rural health care. For the second straight year, we are participating in the Rural Health Professional Institute, which provides clinicians an opportunity to enhance their skills and capacity for delivering health care to Veterans from rural and highly rural locations. We are currently supporting rural health projects through funding from VA's Office of Rural Health (ORH), as well as through local resources.

ORH Funded Projects

VA's national ORH provides support and funding to ensure Veterans living in rural and highly rural areas have access to the care and services they need. Its mission is to improve access and quality of care for enrolled rural and highly rural Veterans by developing evidence-based policies and innovative practices to support their unique needs. ORH has invested resources to implement projects across the country. Over $500 million was dedicated to these projects in FY 2009 and 2010, and another $250 million in FY 2011. These funds supported national and local initiatives in expanding telehealth, home-based primary care, mental health care, education and training, rural CBOCs, rural hiring initiatives, a rural fee-basis pilot, VISN-specific initiatives, community outreach, transportation programs, and other efforts. In FY 2011, VA is using ORH funding to further expand national telehealth programs, implement our Project Access Received Closer to Home (ARCH), sustain teleradiology services, and support a range of VISN initiatives.

In FY 2009 and 2010, VISN 12 received approximately $15 million to support projects serving Veterans in rural and highly rural areas. Iron Mountain received approximately $7.4 million dollars over the past 3 years to implement and sustain rural health programs. Examples of projects supported by ORH in the Iron Mountain region include expanded telehealth capabilities to include the provision of specialty services to Veterans in rural and highly rural areas; the Enhanced Rural Access Network for Growth Enhancement (E–RANGE) Program, which is designed to expand intensive case management services for Veterans with serious mental illness and outreach services for homeless Veterans; expanded primary and specialty care services; panic alarm installation; and home-based primary care with the Lac Vieux Tribe to address issues of access and quality of care for some of our most medically complex Veterans. Using ORH funding, the Manistique outreach clinic was opened in August 2009 to improve access for Veterans residing in the eastern Upper Peninsula. In the first full operational year, the clinic provided 2,042 patient care encounters. This fiscal year, the clinic already has provided 2,320 encounters to 470 Veterans. Rural health funds were also used to expand the Hancock CBOC. The 1,550 square foot expansion has enhanced patient flow, improved Veteran privacy, and facilitated a 19 percent increase in telehealth visits.

This fiscal year, ORH funding enabled Iron Mountain VAMC to implement on site cataract surgery, interventional pain management, and ENT clinics. To date, we have completed 20 cataract procedures, 658 pain management procedures, and 460 ENT encounters.

Locally Funded Projects

In addition to these efforts, we are supporting several initiatives to increase outreach, awareness and services in rural and highly rural areas. Iron Mountain VAMC helped pioneer the Veterans Directed Home Care Initiative, which allows Veterans to choose friends and neighbors to assist them with their activities of daily living and to be paid for their services. There are currently 31 Veterans receiving care through this program. We also expanded our Suicide Prevention Team for increased outreach and coordination of high risk services.

Transportation and lodging are challenges unique to the vast rural and highly rural areas we serve. Iron Mountain VAMC spent $1.9 million in FY 2008, growing to $2.4 million in FY 2009, and $3.4 million in FY 2010 for beneficiary travel between facilities, as well as to and from appointments. We lodged over 1,800 Veterans and their caregivers this past year to provide treatment without undue travel hardship. Our 35 passenger bus transports Veterans two times weekly to the Milwaukee VAMC for specialty care appointments, and our partners at Disabled American Veterans operate a shuttle program that logs more than 360,000 miles annually bringing over 5,200 Veterans to and from the main facility in Iron Mountain VAMC for appointments.

We have specific outreach efforts for Veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND). We send letters and place phone calls to recently discharged servicemembers, conduct site visits to demobilization sites, and attend job fairs, Yellow Ribbon Events, local Universities, Post-Deployment Health Reassessments and Welcome Home Events. We reach out to members of the National Guard and Reserve Units and assess all newly enrolled OEF/OIF/OND Veterans for community resource needs and care management. In addition, Veterans are referred into our program and to our Caregiver Support Coordinator as needed. Iron Mountain VAMC has more than 1,800 unique OEF/OIF/OND patients.

Recruitment and Retention of Medical Personnel

We understand the importance of offering proper incentives to ensure we have quality health care providers capable of delivering care to Veterans in rural areas. Nationally, there are several new incentives and training programs designed to provide our medical residents and other health professions trainees with educational opportunities in rural areas through collaboration with our academic affiliates. The Iron Mountain VAMC maintains active affiliations with Bay de Noc College for licensed practical nurses (LPN), registered nurses (RN), and phlebotomy students; with Northern Michigan University for RN, nurse practitioners, and social work students; with Northeast Wisconsin Technical College for RN; with Central Michigan University for physician assistants; with Michigan State University for social work students; and with Northeastern Wisconsin Technical College for phlebotomy students.

The Iron Mountain VAMC has actively recruited and retained staff while simultaneously improving relationships with community health care providers in the Upper Peninsula and Northern Wisconsin to broaden the continuum of care available to the Veterans we serve. In a rural, sparsely populated area, few facilities are able to offer the full range of services normally available in larger metropolitan areas. Strong collaborations with multiple health care providers, both public and private, are essential in meeting the needs of patients. Iron Mountain has grown from 499 staff employed in FY 2008 to 572 staff at the end of FY 2010, an increase of 73 positions and almost 15 percent. Of that increase, 67 of those positions are in direct patient care. Recruitment and retention incentives for clinical providers of over $2 million in 2010 and over $1 million in 2011 affords the Iron Mountain VAMC the opportunity to procure top notch clinical staff in multiple areas including but not limited to general surgery, internal medicine, emergency medicine, and primary care. The staffing increase accompanied a 31 percent increase in outpatient visits from FY 2008 through FY 2010, and an overall increase of 6 percent in unique Veterans served. During this same period, the Iron Mountain VAMC treated 54 percent more OEF/OIF/OND Veterans.

Telehealth Programs

We have made significant investments in our telehealth programs and have seen remarkable growth in terms of Veterans utilizing these services. Telehealth uses information and telecommunication technologies to provide health care and increased access to care. It refers broadly to any encounter that involves the use of information and telecommunications technologies to deliver services in situations in which patient and health care provider are separated by geographical distance. VISN 12 was the first Network in VA to implement diagnostic telepathology, and it has been used between the Iron Mountain and Milwaukee VA Medical Centers since 1996, allowing the Iron Mountain VAMC access to multiple pathologists.

Expanded telehealth services have brought specialty expertise to Veterans in the Upper Peninsula. In FY 2010, we provided specialty care through telehealth to 1,631 Veterans and we expect to increase that number to more than 2,500 Veterans in FY 2011. This program has seen a 400 percent increase since 2008. More than half of these Veterans will only have to travel to the nearest CBOC to receive this specialty care. Work is progressing on the development of additional clinics including audiology, speech, spinal cord injury, and anesthesiology for pre-surgical clearance of Veterans receiving surgical procedures in Milwaukee, and a nephrology clinic that is scheduled to begin June 27, 2011. Current projections are that there will be more than 6,800 encounters completed in these programs in FY 2011, exceeding the FY 2011 target by 96 percent.

We initiated a teleretinal imaging program at the beginning of FY 2011. This program is focused on providing timely and convenient evaluation of retinal degenera-

tion related to diabetes. Through May 2011, 109 patients had retinal images taken and forwarded to specialists at the Madison VAMC for evaluation.

Delivery of Mental Health Care

Mental health care is a critical component to overall health, and we understand the importance of ensuring Veterans can access this care. We have added 45 mental health providers over the last 5 years, which has improved the ability of Veterans to seek appointments and receive the evidence-based treatments they need. Mental Health staff (social worker and psychologist) is available for outpatient psychotherapy at every CBOC but Ironwood where a social worker is available. Telepsychiatry services are provided to Sault Ste. Marie, Manistique, Menominee, Rhinelander, Ironwood, and Iron Mountain. New FY 2010 and FY 2011 outpatient services include a Veterans Consumer Board, E–RANGE, Veterans Justice Outreach, Health Promotion/Disease Prevention, Peer Support Programming, and Homeless Programs (Housing and Urban Development-VA Supportive Housing, Short-Term Contract Housing, and Aging and Homelessness Program). In FY 2010, we provided mental health care to 3,217 Veterans through 31,000 encounters. This is more than twice as many Veterans as received care from Iron Mountain VAMC mental health programs in FY 2006.

VA ensures that treatment of mental health conditions includes attention to the benefits as well as the risks of the full range of effective interventions, with emphasis on all relevant, evidence-based modalities, including psychopharmacological care, psychotherapy, peer support, vocational rehabilitation, and crisis intervention. VA is focused on providing patient-centered, effective care by ensuring that when there is evidence for the effectiveness of a number of different treatment strategies, the choice of treatment should be based on the Veteran's values and preferences, in conjunction with the clinical judgment of the provider. We have integrated mental health care delivery into the primary care setting to improve access and reduce the stigma that some perceive in seeking mental health care. The two exposure-based psychotherapies for which evidence has found an especially strong support for treatment of post-traumatic stress disorder (PTSD) are cognitive processing therapy (CPT) and prolonged exposure (PE). VA has trained more than 3,400 clinicians nationwide in the use of these treatments. Currently, we have certified seven clinicians and we are in the process of certifying 12 additional clinicians at the Iron Mountain VAMC in these treatments. Additional VA endorsed evidenced-based psychotherapies include Acceptance and Commitment Therapy (ACT), Social Skills Training, Cognitive-Behavioral Therapy-Depression (CBT–D), Cognitive-Behavioral Therapy-Insomnia (CBT–I), and Motivational Interviewing. We have 12 additional providers either certified or in process of completing these certifications.

Recruitment and Retention of Mental Health Professionals

The Iron Mountain VAMC Behavioral Health Service has grown tremendously over the last 5 years. Historically, recruitment of qualified psychologists has been a challenge. Our current staff of 14 psychologists is the largest single group in the Upper Peninsula of Michigan. Due to the rural setting, most staff recruited to the Department moved to the area from some distance. The poor housing market has adversely impacted many qualified providers' ability to sell a home and move to the area. Recruitment and retention funding has been used to offset costs of moving to a rural region, which has increased our ability to bring on and keep qualified providers. Additional efforts at retention include utilization of the Student Loan Repayment Program for psychologists, but recruitment of qualified onsite psychiatry remains a challenge.

ORH Funded Mental Health Programs

With decreasing community mental health services available in the Upper Peninsula of Michigan, the E–RANGE team was established in Manistique to serve Veterans with seriously mental illness (SMI) in the Eastern Upper Peninsula (Marquette and Escanaba to the West, Sault Ste. Marie to the East). With one full-time social worker, one part-time social worker, one RN, and one peer support specialist, the E–RANGE team serves Veterans with mental health needs that cannot be met by typical outpatient psychotherapy and psychiatry. While stationed away from the Iron Mountain VAMC, the staff members utilize CBOCs community agencies (as available) for primary care and mental health (psychiatry) services. Assisting with medical and mental health care, social skills training, and recovery programming, the E–RANGE program has made a significant impact in the quality of life and medical health of our rural Veterans living with serious mental illness. For example, significant improvements in medical (e.g., improved glucose control), social (e.g.,

stabilized housing and community involvement), and mental health (e.g., medication compliance and significant reduction in psychiatric hospitalizations) have been attained. ORH funding has been utilized to expand CBOC space in anticipation of adding additional E–RANGE teams as funding is available. Current challenges include significant driving distances (7,500–8,000 miles per month), decreasing community-based resources, limited recovery and recreational activities available in rural regions, limited support from community hospitals, and maximized enrollment.

ORH funding is being used to provide biofeedback training and machines to each CBOC and the Iron Mountain VAMC. Biofeedback devices and stand-alone computers for data processing have been issued to each site, and the psychologists have completed the initial certification training. The trained psychologists continue to meet as a team for biofeedback program development. The addition of biofeedback to our Behavioral Health Service offers increased treatment options for Veterans living with anxiety, chronic pain, and hypertension, as well as many other medical and mental health conditions.

Telemental Health Program

Iron Mountain has been one of the Nation's leaders in implementation of telemental health services. Currently, we employ two full-time psychiatrists and one part-time psychiatrist who are physically located at other VA and non-VA facilities and provide telepsychiatric services to the Medical Center and CBOCs. Our two full-time onsite psychiatrists and one part-time onsite psychiatrist provides telepsychiatric services to our CBOCs on a regular and as-needed basis. Since FY 2010, we have successfully operated a telepsychiatry substance abuse/addiction clinic with Madison VAMC. We are in process of hiring a part-time addiction psychiatrist, who will provide teleaddiction services to the Iron Mountain VAMC and CBOCs. In 2008, we averaged approximately 75 unique telepsychiatry appointments per month; currently, we are averaging 650 unique telepsychiatry appointments a month. Additional teleservices provided by Behavioral Health staff include: emergency clinic coverage, PTSD groups, gender-specific psychotherapy, evidence-based psychotherapies, and staff training and education. Current challenges include scheduling, coordinating care, supporting staff, managing cases, and balancing between the critical need for onsite services and demand for increased teleservices.

Escanaba Vet Center

Vet Centers are another venue through which VA provides Veterans with necessary counseling and support. Vet Centers provide community outreach, professional readjustment counseling for war-related readjustment problems, and case management referrals for combat Veterans. Vet Centers also provide bereavement counseling for families of servicemembers who died while on Active Duty. In the Upper Peninsula, VA operates the Escanaba Vet Center, and in FY 2010, provided readjustment counseling services to 390 Veterans and their families (3,071 encounters). Mobile Vet Centers provide outreach and direct readjustment counseling at active military, Reserve, and National Guard demobilization activities. Since beginning operation in 2009, the Escanaba Mobile Vet Center has completed 50 outreach events. The Iron Mountain VAMC Behavioral Health Service provides face-to-face and telesupervision to Vet Center staff. Teleconferencing is available at the Vet Center for clinical (psychiatry) and administrative (supervision) needs. Additionally, Iron Mountain VAMC has initiated peer support programming in collaboration with Vet Center staff to develop a Co-Occurring Recovery Program located at the Escanaba Vet Center.

Home-Based Primary Care

Not all Veterans are able to routinely travel to see their primary care provider at the Iron Mountain VAMC or the nearest CBOC. In FY 2008, the Iron Mountain VAMC started a Home-Based Primary Care program, and we added an additional location in FY 2009 in Watersmeet, Michigan. These programs take primary care to the patient's home, expanding access to care and benefits, and providing health education to this unique Veteran population. The two programs have made tremendous progress since they opened and have served more than 200 Veterans. The Veterans served by these programs have seen a 16.9 percent reduction in inpatient admissions and a 76.3 percent reduction in inpatient bed days of care. There are currently 74 Veterans enrolled in the Home-Based Primary Care program. Through May 2011, 118 Veterans have received care through this program. This is more than

three and a half times the number that were cared for in 2008 when the program started.

Partnerships with Community Providers

We provide exceptional care in the VA system, but understand there are times when a Veteran needs services that are not available in our facilities. As a result, we maintain robust partnerships with a range of community providers to ensure Veterans receive the care they have earned. These partnerships include collaborations with other governmental organizations, as well as with the private sector. We also utilize community providers in the private sector to deliver care to Veterans in the community.

Iron Mountain remains committed to providing the care Veterans deserve not only from our main facility and related CBOCs but also by purchasing care from Upper Peninsula and Northern Wisconsin facilities and providers. We purchased over $12 million worth of care in FY 2008, $18 million in FY 2010, and we are on pace to purchase $16 million worth of care this fiscal year. Currently, we have six fee basis providers from within the community to supplement care in areas such as ophthalmology, orthopedics, general surgery, podiatry, and behavioral health.

As previously mentioned, Iron Mountain has a passenger bus that travels to the Milwaukee VAMC two times a week. The bus is used to carry enrolled Veterans and their caregivers to specialty care appointments. It has the capacity to carry 35 passengers, and the average number of travelers per trip is 25. We have an ambulance contract with a local ambulance company that is utilized to transfer and pick up patients to and from other facilities as needed for care. We also have a contract with a local company to provide transportation services for those enrolled Veterans that do not require an ambulance to be used to transport them.

We coordinate with all VISN facilities to transfer patients who need services and care we cannot provide. If VISN facilities are not available, we utilize Dickinson County Health care System in Iron Mountain; Bellin, St. Vincent, Aurora Bay Care and St. Mary's in Green Bay, Wisconsin; and Marquette General Hospital in Marquette, Michigan. For Behavioral Health issues we utilize Milwaukee VAMC, Tomah VAMC, Madison VAMC, Battle Creek VAMC, and at times Marquette General Hospital and War Memorial Hospital in Sault Ste. Marie, Michigan.

For pharmacy coverage after hours, we utilize the pharmacy staff at the Milwaukee VA to review all orders. Pharmacy is staffed at the Iron Mountain VAMC from 7 am until 10 pm.

We recently accepted a bid from Dickinson County Health care System to dock our magnetic resonance imaging unit at their campus until the construction of the second floor of our outpatient department is completed. We began using our MRI at that location earlier this month.

We have purchased care agreements in place with local hospitals for each CBOC to complete mammograms and any urgent diagnostic tests. In Iron Mountain, we utilize Dickinson County Health care System and the local Marquette General outpatient clinic for mammograms, the Veteran decides where they prefer to go. We have a telehealth contract to provide services to read x-rays, computed tomography images, ultrasounds, and other radiological studies on off-tours and weekends.

Using ORH funds, the Home- and Community-Based Care program was significantly expanded. We purchased services from approximately 50 home health agencies and other community providers in our service area to provide care to our enrolled Veterans. The program went from serving 111 unique Veterans in FY 2008, to 418 in FY 2009, and 456 in FY 2010. This initiative targets Veterans who are most at risk for institutional long-term care and helps them function as independently as possible in the comfort of their own homes. When necessary, we collaborate with 10 local community nursing homes and one adult day care to provide services for Veterans that permit them to be close to family and friends.

Conclusion

Thank you again for the opportunity to discuss the work VA is doing to improve access and quality care for Veterans in the Upper Peninsula of Michigan. I am proud of the work the employees at the Iron Mountain VAMC and its CBOCs do every day to deliver the best health care possible to America's Veterans. My colleagues and I look forward to answering your questions.

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