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CLOSING THE HEALTH GAP OF VETERANS IN RURAL AREAS: DISCUSSION OF FUNDING AND RESOURCE COORDINATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED ELEVENTH CONGRESS

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CLOSING THE HEALTH GAP OF VETERANS IN RURAL AREAS: DISCUSSION OF FUNDING AND RESOURCE COORDINATION

THURSDAY, MARCH 19, 2009

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

The Subcommittee met, pursuant to notice, at 10:11 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Teague, Rodriguez, Donnelly, McNerney, Halvorson, Perriello, Stearns, and Moran.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the Subcommittee on Health back to order.

I would like to thank everyone for participating in the hearing. I would ask, while I give my opening remarks, for our first two witnesses to please come forward.

The purpose of today's hearing is to provide oversight of U.S. Department of Veterans Affairs' (VA's) rural health funding, spending, and resource coordination. The hearing will explore whether resources are used efficiently to narrow the health disparity of veterans living in rural areas.

In general, we know that nearly two million veterans reside in rural areas. This includes nearly 80,000 veterans who live in highly rural areas.

According to the VA Health Services Research and Development Office, rural veterans have worse physical and mental health-related issues.

I commend the VA for their efforts in improving rural health. This includes building new Community-Based Outpatient Clinics (CBOCs), rural outreach clinics, and Vet Centers in rural and highly rural areas. It also includes pilot programs such as the Traveling Nurse Corps, the mobile health care pilots, which are in place in four mobile clinics and 24 predominantly rural counties in Colorado, Nebraska, Wyoming, Maine, Washington, and West Virginia.

I also applaud the advances made in telehealth through the numerous pilot programs that have been implemented today.

To help the VA efforts, the Appropriation Committee provided $250 million in September of 2008 to establish and implement new rural health outreach and delivery initiatives.

Through today's hearing, we seek to better understand how the VA has allocated and plans to allocate this $250 million. The hearing will also address concerns about the lack of coordination and duplicative efforts by various offices in the VA that deal with rural health.

On today's first panel, we have the Disabled American Veterans who will share their thoughts on VA's progress in improving rural health. We also will hear from the South Carolina Office of Rural Health about local challenges and recommendations for closing the rural health gap.

Finally, the VA Office of Care Coordination and the Office of Rural Health (ORH) will report on the Department's current efforts on rural health.

I look forward to hearing your testimony on both panels. And now I would recognize Mr. Stearns for an opening statement.

[The prepared statement of Chairman Michaud appears on p. 26.]

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Thank you, Mr. Chairman.

I ask unanimous consent for my colleague, Congressman Henry Brown, who is the Subcommittee Ranking Member, his opening statement be made part of the record.

Mr. MICHAUD. Without objection, so ordered.

[The prepared statement of Congressman Brown appears on p. 40.]

Mr. STEARNS. Okay. I am here today on Mr. Brown's behalf. I am pleased to be here this morning for our Health Subcommittee hearing on ensuring that our veterans living in rural areas are receiving the quality health care they certainly deserve.

Today's hearing affords us the chance to examine how the Department of Veterans Affairs is spending some of the funds allocated to them in the fiscal year 2009 Appropriations Act.

Specifically, we are focusing on funds that were marked to help further the VA's rural health initiative in areas such as mobile health clinics and telemedicine.

My colleagues, we are all aware of the health care gaps that exist for veterans that reside in the rural areas. We know that almost 40 percent of veterans enrolled in VA health care live in rural or highly rural areas and that 44 percent of our veterans returning from Iraq and Afghanistan also reside in these rural areas.

Veterans living in rural America are statistically shown to have lower quality of life scores and are more likely to suffer from treatable diseases. Clearly this is an issue we must address and monitor very closely.

I applaud the VA's current outreach efforts to recruit and retain more health care providers to serve in rural areas and to pursue innovative health care methods such as telemedicine. We are moving in the right direction, but we must stay the course and VA must fulfill the goals it has set.

I welcome our panel of witnesses and look forward to hearing more about how VA has and intends to further distribute the funds allocated to them under the fiscal year 2009 Appropriations Act so

that we can truly, truly begin closing the health care gap for our Nation's rural veterans.

Also, on behalf of Mr. Brown, my colleague, I would like to extend a special welcome to one of our witnesses on the first panel, Dr. Graham Adams. He serves as the Chief Executive Officer and provides overall supervision and direction for the South Carolina Office of Rural Health.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Stearns appears on p. 26.]

Mr. MICHAUD. Thank you very much, Mr. Stearns.

I will apologize up front. I do have to leave for another meeting shortly, so I want to apologize up front. We will start the first panel.

On the first panel, we have Joy Ilem who represents the Disabled American Veterans (DAV), as well Dr. Graham Adams who is the Chief Executive Officer (CEO) of the South Carolina Office of Rural Health.

Once again, I want to thank both of you for coming here this morning. I look forward to hearing your testimony as well as working with you as we move forward to do what we have to to make sure that our veterans in rural areas get the adequate health care in the timely fashion that they need.

So without any further ado, Ms. Ilem.

STATEMENTS OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND GRAHAM L. ADAMS, PH.D., EXECUTIVE DIRECTOR, SOUTH CAROLINA OFFICE OF RURAL HEALTH, AND STATE OFFICE COUNCIL CHAIR, NATIONAL RURAL HEALTH ASSOCIATION

STATEMENT OF JOY J. ILEM

Ms. ILEM. Mr. Chairman and Members of the Subcommittee, thank you for inviting DAV to testify today. We value the opportunity to discuss our views on funding and coordination of care for rural veterans.

We recognize that rural health is a difficult national health care issue not isolated to VA. We also appreciate that many sick and disabled veterans in rural areas face multiple challenges in accessing VA health care services, even private services under VA contract or fee basis.

We deeply appreciate the due diligence of this Subcommittee and Congress by enacting legislation, which authorized VA to establish the Office of Rural Health and the resources it has provided to carry out its mission.

It appears VA is reaching across the Department to lay the foundation for improving the delivery and coordination of health care services to rural veterans. And DAV is pleased and congratulates VA on its progress to date.

VA's appointment of rural care consultants in all its Veterans Integrated Service Networks (VISNs), establishment of three rural health resource centers, and a number of new rural outreach clinics harnessing telehealth and other technologies to reduce barriers to care are all positive steps forward.

In VA's 2009 Appropriations Act, Congress approved $250 million to support new and existing rural health care initiatives and $200 million to increase fee-basis services. It appears that VA has distributed $22 million to its VISNs for rural health care improvements with an additional $24 million being used to establish the pilot programs, new outpatient clinics, provide outreach to rural veterans returning from the wars in Iraq and Afghanistan, and activate a number of mobile health clinics, including a fleet of 50 mobile Vet Centers.

We appreciate the Subcommittee's interest in conducting this oversight hearing and we are interested in learning more from VA about the specific instructions issued to the field guiding the use of these new funds for rural care, what monitoring is being conducted related to the use of those funds, and the degree and type of reporting requirements that have been imposed related to the number of veterans served as well as the information on access, quality of care, and workforce issues.

Although VA is off to a good start, we believe it faces a number of challenges. In our testimony, we have offered a series of recommendations we hope the Subcommittee will consider as it continues its work in this important area.

Initially we suggest VA be required to provide more thorough reporting to this Subcommittee to enable meaningful oversight of the use of the funds provided and to properly evaluate the implementation phase of rural health initiatives.

Without this type of oversight, we are concerned that the funds Congress provides may simply be melded into VA's equitable resource allocation system without the means of measuring whether these new funds will be allocated in furtherance of Congress' intent, specifically to enhance health care services and health outcomes for rural and highly rural veterans and particularly our newest generation of war veterans.

Reports to Congress should include standardized and meaningful measures of how VA rural health care capacity has changed with workload changes reported on a quarterly or semi-annual basis and disclosure of other trends that reveal whether the rural health initiatives and funds allocated for them are truly achieving their purposes.

Health workforce shortages and recruitment and retention of health care personnel are also a significant challenge to rural veterans' access to VA care and the quality of that care.

The Institute of Medicine recommended that the Federal Government initiate a comprehensive effort to enhance the supply of health care professionals working in rural areas.

We believe VA's Office of Academic Affiliations in conjunction with ORH should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural locations.

Finally, DAV is concerned about the organizational placement of the Office of Rural Health within Veterans Health Administration's (VHA's) Office of Policy and Planning and recommends it be placed closer to the operational arm of VA management.

We also suggest increasing staffing levels for the office and urge Congress to continue to provide appropriate financial support to en-

sure VA sustains these new activities without diminishing resources for VA's specialized medical programs in accordance with DAV Resolution 177.

In summary, DAV believes VA is working in good faith to improve access and medical services to veterans living in rural areas and we are hopeful that with continued oversight from this Subcommittee, supported by appropriate resources, rural veterans will be better served by VA in the near future.

That concludes my statement and I am happy to answer any questions you or Members may have. Thank you.

[The prepared statement of Ms. Ilem appears on p. 27.]

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

Dr. Adams.

STATEMENT OF GRAHAM L. ADAMS, PH.D.

Dr. ADAMS. Thank you, and I appreciate the opportunity to speak this morning.

I am Graham Adams, CEO of the South Carolina Office of Rural Health, Past President of the National Organization of State Offices of Rural Health, and a Trustee on the Board of the National Rural Health Association, the NRHA.

The NRHA is a national nonprofit organization whose mission is to improve the health of the 62 million Americans who call rural home. The NRHA has long focused efforts on improving the physical and mental health of our rural veterans and I appreciate this opportunity to testify once again.

Since our Nation's founding, rural Americans have always responded when our Nation has gone to war. Simply put, rural Americans serve at rates higher than their proportion of the population. Nineteen percent of the Nation lives in rural areas, yet 44 percent of U.S. military recruits are from rural America.

And sadly, according to a 2006 study, the death rate for rural soldiers is 60 percent higher than the death rate for soldiers from cities and suburbs.

Mr. Chairman, because of this great level of service, it is incumbent upon each of us to do more for our rural veterans.

There is a national misconception that all veterans have easy access to comprehensive care. Unfortunately, this is simply not true. Access to rural veterans can be extremely difficult and access for rural veterans in need of specialized mental or physical care can be daunting.

In brief, because there is a disproportionate number of rural Americans serving in the military, there is also a disproportionate need for veterans' care in rural areas.

Program expansion and resource coordination are critical to improve the care of rural veterans. We must be mindful of long-term costs and needs because the wounded veterans who return today will not need care for just the next few fiscal years. They will need care for the next half century.

The National Rural Health Association supports the five following recommendations.

One, access must be increased by building on current successes. Community-based outreach centers or CBOCs and vet outreach centers open the door for many veterans to obtain primary care

within their home community. The NRHA applauds the success of these programs, but there are simply too few of these centers.

In my State of South Carolina, there are only eleven CBOCs and three vet outreach centers despite the fact that South Carolina is one of the top 20 States in which veterans reside.

Two, access must be increased by collaborating with non-VHA facilities. Because rural VA facilities are too few and far between, many rural veterans simply forego care. If critical preventative care or follow-up treatment is not received, a veteran will undoubtedly become sicker and in need of more costly care. This must change.

The NRHA's goal is not to mandate care to our rural veterans, but to provide them a choice, a local choice.

The NRHA strongly supports "The Rural Veterans Access to Care Act," which was signed into law last October. The Act establishes a 3-year pilot program which will allow some of the most under-served rural veterans the choice to access their care from a local provider. Despite the limitations of this program, it is a strong and important step in the right direction, but more must be done.

Linking the quality of VA services with rural civilian services can vastly improve access to health care for rural veterans. As long as quality standards of care and evidence-based treatment for rural veterans is adhered to, the NRHA strongly supports collaboration with community health centers, critical access hospitals, and other small rural hospitals and rural health clinics.

Three, access must be increased to mental health and brain injury care. Currently it appears that traumatic brain injury or TBI will most likely become the signature wound of the Afghanistan and Iraqi wars. Such wounds require highly specialized care. The current VHA TBI case manager's network is vital, but access to it is extremely limited for rural veterans. Expansion is needed.

Additionally, 85 percent of mental health shortages are in rural America. Vet Centers do offer mental health services, but the services are not consistently available at a local rural level.

Four, care for rural veterans must be better targeted. Returning veterans adjusting to disabilities and the stresses of combat need the security and support of their families in making their transitions back into civilian life.

The Vet Centers do a tremendous job in assisting veterans, but their resources are limited. Additionally, because more women serve in active duty than in any other time in our Nation's history, better targeted care is needed for rural women veterans.

And, five, improvements must continue with the VA Office of Rural Health. The National Rural Health Association calls on Congress and the VA to fully implement the functions of the VA Office of Rural Health.

Efforts to increase service points have not always been embraced by the VA. It is our hope that the Office of Rural Health and the newly formed VA Rural Health Advisory Committee will work to eradicate previous barriers and expand access options for the betterment of our rural veterans.

The NRHA also strongly encourages greater coordination between the rural health coordinators housed in each VISN and State level officials in each State Office of Rural Health.

Mr. Chairman, thank you again for this opportunity. The NRHA's full recommendations can be found in my written testimony. I look forward to working with you and this Committee to improve the rural health care access for millions of veterans who live in rural America, and I ask that my full statement be submitted into the record.

Thank you.

[The prepared statement of Dr. Adams appears on p. 31.]

Mr. TEAGUE [presiding]. Yes. Thank you.

Hearing no questions, it is so ordered.

First, thank you for sharing your concerns about the organizational placement of the Office of Rural Health. You recommend that the office be moved from the VA's Office of Policy and Planning to an operational arm of the VA system.

Please explain how you think moving the Office of Rural Health to an operational arm would improve the planning and coordination capabilities of the Office of Rural Health.

Ms. ILEM. Thank you for the question.

I think that we are concerned that there is a number of bureaucratic levels that the office is required to go through to the implementation phase under probably Mr. Feely's office. Direct access to that office with, and talking to the VISN directors and the local Medical Center directors directly is going to be, I think, critical during the implementation phase of this program.

I think they need to coordinate with Office of Policy and Planning and continue—I mean, there are a number of initiatives that they are starting which, you know, cross throughout the departments. At the same time, we would like to see the office have that direct access to make sure that these things get implemented in a very expeditious manner.

Mr. TEAGUE. Okay. Also, as you know, the VA received $250 million in the 2009 appropriation. What are your views of the types of services and programs that the VA should support with this funding and do you agree with how the VA has spent it so far?

Ms. ILEM. Just in reviewing very briefly this morning, the VA's testimony, I have not had a chance to look at it thoroughly, but it appears that they have a number of programs that have been initiated, many of them just at the very beginning stages, trying to establish many of these clinics, probably working with their coordinators in each of the VISNs and a variety of other functions.

So I think that they have a tall task ahead of them in terms of the things that they have scheduled to do.

So I think that they need to just continue to keep working on the programs that they have set forth as indicated in their testimony and I think many of those are the right direction. It is just a tall order and it seems like a lot of things are just at the very beginning stages.

Mr. TEAGUE. Dr. Adams, in your testimony, you highlighted the need for rural providers to be trained because of the unique needs of rural, minority, and female veterans.

I'm from a large rural district in New Mexico and we have a lot of the same needs that you were discussing.

I was just wondering if you might be able to expand a little bit on this and tell us a little more about the needs.

Dr. ADAMS. Yes, sir. So often in a physician or a provider's medical training, they receive excellent clinical training, but they do not have the other cultural competency trainings that are so key when you work with disadvantaged populations, be it women, minorities, others. And I think especially when working with these populations, you do need to have special sensitivity to those issues.

I also think that in States and regions that have a high minority population, where possible, the providers serving those populations need to be reflective. So trying to achieve greater diversity in ethnicity and race among those providers that are providing care would be a good thing and could be accomplished through contracting or cooperative arrangements with other non-VHA facilities such as community health centers, rural health clinics, and critical access hospitals.

Mr. TEAGUE. I would just like to say that, coming from the 2nd District of New Mexico, which is bigger than the State of Pennsylvania, and has almost 200,000 veterans, I am encouraged to hear how you are addressing similar concerns across the country.

Mr. Rodriguez from Texas.

Mr. RODRIGUEZ. Thank you very much. First of all, thank you, Mr. Chairman.

Let me point out that my district is one of the largest in the Nation. I have 785 miles along the Mexican border. I have two major cities, but within my district, I do not have any VA clinics or facilities.

We have had a serious problem with the ones that the VA has contracted out in the past who are not willing to work with the VA now because of the fact that they had not gotten paid the way they should.

And now they have gotten some new contracts, but one of them came, and this is probably not to this panel, but to the other, is that there is some other contractor in between that I guess is getting 15 percent from the top before the other person even gets paid, which does not make any sense whatsoever.

And I still have not seen any results in my district in terms of the efforts of some of the pilot programs and trying to get some mobile units out there. That has not happened.

I have a large number of veterans in my district. It has extremely rural areas where people have to go a long ways. A straight shot on I–10 is 550 miles between one side of the district and the other. And the major facilities are in San Antonio and El Paso, but my district is in between.

I have problems with the contracting that has gone on with some of the local providers. In one case, they actually stopped providing services because the VA was not timely in reimbursing them. They just said, "look, I have had enough, I am not going to deal with this."

And the other, we had two groups, two community-based outpatient clinics that they used to work with that are unwilling to work with them now because of past experiences with them.

I just wanted to see if you might comment as to how do we get past some of the things that have happened in the past and how do we make sure that they deliver in the future.

Dr. ADAMS. I believe that creating incentives, financial and other, for VA facilities, be it CBOCs and vet outreach centers, to coordinate and to work with non-VHA facilities will go a long way to creating those partnerships.

And in some cases, veterans are being seen in these facilities already. And the non-VHA facilities that I mentioned, rural health clinics, community health centers, and critical access hospitals, these are all fully qualified, fully staffed facilities that are providing care at the local community, all of which receive some kind of enhanced arrangement from Medicare to provide services, but unfortunately not for veterans.

So if that linkage could be put in place, I think that you will see care increased dramatically and there will certainly be things that have to be worked out, but you have folks that are in the field right now that are willing to see veterans if only a mechanism existed to do so.

Mr. RODRIGUEZ. That mechanism that you are referring to, would that require any form of additional legislation or is that something that is already in place that we could just require them to do?

Dr. ADAMS. I cannot speak exactly as to what authority the VA has. But if the authority would allow and if the intent were there, there are partners on the provider side that are more than willing to see these veterans as long as they are reimbursed fairly and they are in these communities. There is no sense in reinventing the wheel, building another facility, investing additional taxpayer dollars when you have points of access already there.

Mr. RODRIGUEZ. Thank you very much.

Thank you, Mr. Chairman.

Mr. TEAGUE. Next I need to apologize to the gentleman from Kansas. I am sorry. This was my first time to Chair this Subcommittee and I guess it is showing in going out of order here. I would like to present, at this time, Congressman Moran from Kansas.

Mr. MORAN. Because you are new to the Committee, you do not know how offended I am, how difficult I am to get along with.

Mr. Chairman, I am delighted to be here and I am happy to be able to visit with these witnesses at your leisure, at your convenience.

I thank Mr. Michaud and this Subcommittee for having this hearing. The pilot program is a piece of legislation that I have worked on really since I came to Congress and I am delighted that Mr. Michaud has indicated a willingness to have a hearing.

My staff met with folks from the VA and others yesterday for the beginning implementation conversation and we are generally pleased that the VA is paying a lot of attention to this topic. And I think it is important for all of us to stay on point to make sure that it is implemented in a way that demonstrates the value of this pilot program.

Dr. Adams, in the testimony of the Disabled American Veterans, in Ms. Ilem's testimony, she indicated concerns about veterans who may seek health care for convenience with a private provider, that

they may not receive the protections of the VA system, patient safety and other protections that are indicated in the VA system.

Do you have any concerns about how a veteran would be treated in the private system with their hometown doctor and hospital as compared to being treated more directly in the VA system with a VA provider? And if you do have those concerns, do you have suggestions of what it is that we ought to be paying attention to in order to make sure those concerns are addressed? Dr. Adams.

Dr. ADAMS. Thank you.

I do not have concerns. Certainly the VA with the system that they have, they provide excellent care in those facilities. The problem is there just are not enough of those facilities.

So if we can create linkages where there is reasonable requirements for electronic medical records (EMRs) for quality of care, then there is no reason that those veterans cannot receive high quality care in non-VA facilities.

All these facilities meet every quality requirement of the Federal Government that is put upon them. So these are highly trained folks doing the work that they need to do and they do not currently have to abide by all the VA rules. But as long as there were reasonable, and I stress reasonable, requirements in place, I do not know why those partnerships could not exist.

Mr. MORAN. In my early days in Congress, our outpatient clinic was staffed by a physician in her private practice. She ultimately left the system and no longer provided services to veterans through her clinic as an outpatient clinic of the VA.

The concern, the criticism, and the difficulty was related to medical records, to technology, and the inability to connect in getting answers from the VA and, in our case, in Wichita.

At least my sense is that much of that has been resolved. Am I missing something or are we headed—the VA seems to be probably one of the better utilizers of technology in the entire medical delivery system.

Dr. ADAMS. I think that is correct. The VA has an excellent electronic medical record system. All the dollars that are contained within the American Recovery and Reinvestment Act (ARRA) are going to allow even more facilities in rural communities, non-VHA facilities that do not have EMR now, that do not have electronic medical records now, to have that in place.

So I think that the ability for information to be exchanged in a Health Insurance Portability and Accountability Act (HIPAA) compliant, safe way is going to be less and less of an issue once all of these facilities have some form of electronic medical records.

Mr. MORAN. Has anyone in the VA's Office of Rural Health ever contacted you? Do they reach out to people in your position to seek advice and suggestions?

Dr. ADAMS. I do have to say the Office of Rural Health has been very supportive and very helpful with entities like the National Rural Health Association. I think from a staff perspective, they have done a great job of creating good will and seeing where those partnerships could exist.

I get the sense it might be a little bit higher up the food chain, if you will, within the VA that some of this resistance occurs.

And from my perspective at a State level, each of the VISNs has, I believe it is called a rural health coordinator. I do not know who that person is. I have never been contacted by that person. I have tried to go on the VA Web site and identify that person. I cannot do that.

So I would strongly urge for those rural health coordinators, if that is the correct term, that are located within each VISN to be more proactive reaching out to the State level rural health officials in each State.

Mr. MORAN. I will try to ask Ms. Hawthorne a similar kind of question when she is our witness.

There is a Rural Veterans Advisory Committee commissioned now and I want to hear about how it is interacting with the VA and what difference it is making.

My time has expired. I thank the Chairman for his indulgence and appreciate your consideration.

Mr. TEAGUE. Well, once again, I would like to apologize to Congressman Moran and I appreciate his patience with me in my learning process here.

And next is the Congressman from California, Jerry McNerney. Do you have a question, please, sir?

Mr. MCNERNEY. Thank you, Mr. Chairman.

First of all, I would like to thank the witnesses for coming forth today.

Mrs. Ilem, is that correct?

Ms. ILEM. Ilem.

Mr. MCNERNEY. Ms. Ilem. You suggested more oversight by the Committee and I think that is probably a good idea. But I was wondering if you had—and you also mentioned standardized reporting.

Do you have specific recommendations or specific ideas for standardizing the interchange between the Committee and the witnesses or the reporting entities?

Ms. ILEM. I think VA would be able to do that fairly easily. I think if there is a request from the Committee to do that, I am sure they would be willing to provide that.

And I think the main thing would be not just a data dump, but something that you could really read and be able to make a true assessment to see, is capacity improving, what are the workloads, what are they doing.

In briefly looking at their testimony, I think they have a number of reporting requirements that they are requiring from the field. And if they can tally up that information in a very sensible way that would be easy for the Committee to review, I think would just be just another opportunity to really have the oversight that is needed.

Mr. MCNERNEY. Okay. Well, thank you.

Any ongoing suggestions you have on standardizing that would be appreciated by the Committee.

Ms. ILEM. Sure.

Mr. MCNERNEY. You also mentioned more physicians as one of the major problems. Do you see that as the major problem or are there other related problems to the shortage of physicians in rural areas?

Ms. ILEM. I think that is one of the issues. I mean, there are so many factors involved in rural health care issues that the Nation is grappling with in general, including VA.

I think that is just obviously one of the keys to have the willingness for qualified people to be in the rural areas and available to these veterans, but I think it is one of many things that are necessary.

Mr. MCNERNEY. Thank you.

Dr. Adams, I want to say I have both rural and suburban areas in my district and I appreciate your mentioning disproportionate share of active-duty members and veterans from rural areas.

I was just at a funeral in a town of mine, about a 60,000-person town, and it is their eighth fatality in the War on Terror. So they certainly are paying their share or more than their share.

And I also appreciate your suggestion to let non-VA organizations partner up with VA organizations to provide the best possible care to our servicemembers.

I would like to see, speaking of standardized, I would like to see a standardized approach to that so that we can move forward aggressively and provide those services in a way that would benefit everyone.

One of the questions I have is, do you see the telenet being helpful in filling the gap between rural and urban service capabilities?

Dr. ADAMS. I think telemedicine, telehealth is a great tool to provide some services in more isolated rural communities. Specifically things like telepsychiatry, it can be fairly effective with.

I think that while telemedicine and things like a mobile clinic are great steps in the right direction, they do not nearly provide the continuity of care that a full-time provider or a facility would in those rural communities.

And, again, we have a very robust network throughout the country of folks that are already in place to serve the underserved and to serve vulnerable populations. And I think we all could agree rural veterans are a vulnerable population.

So providing linkages with those folks, I think, again will increase access to care dramatically. Telemedicine is a wonderful thing and I think it can be used in conjunction with some additional agreements in place at the local level.

Mr. MCNERNEY. Thank you.

Ms. Ilem, do you have any comments on telemedicine?

Ms. ILEM. We agree telemedicine is another great opportunity to be used in the arsenal of ideas looking at all of these issues that can help to improve services in those communities.

Mr. MCNERNEY. Thank you.

I am going to yield back, Mr. Chairman.

Mr. TEAGUE. Thank you, Congressman McNerney. I appreciate those comments.

At this time, I would like to call on the lady from Illinois, Congresswoman Deborah Halvorson.

Mrs. HALVORSON. Thank you, Mr. Chairman.

And I would like to start with Dr. Adams. In your testimony, you highlighted the need for rural providers to be trained to meet the unique needs of the rural minority and female veterans.

Everywhere and every panel that comes before us, they talk about the need for women veterans and the fact that more and more are coming back and there is going to be a huge need. This is going to really complicate a complicated issue even more.

What do you suggest we do when there is already a need for more rural services and now we are going to need more help with the women population coming back?

Dr. ADAMS. I think that can largely be addressed through increased mental health and behavioral health services. Every veteran that comes back has issues potentially with combat situated problems. And the females who come back often have family burdens. They have children. They have different roles than a male typically plays in our society and they have different expectations when they come home.

So I think a lot around family counseling, marital and other family counseling being available for the family as a whole, not just for the veteran, is key. So often when it was just a male veteran population, they did not have some of those expectations when they returned home. I think you are finding that more and more with returning female veterans.

Mrs. HALVORSON. And if I could ask both of you to comment on this one. So you feel that we should be treating the entire family because I know that there has been some discussion, which has completely caught me off guard, about women who have children while a veteran and how these children are not veterans, but, yet, we have to find a way to take care of them. And there has been a lot of discussion about that.

What are your views on these are veterans, they have served our country, and now we are debating whether to even take care of their children?

Ms. ILEM. I would just start out by saying thank you for the question on women veterans and bringing it up. And I think it is great that Dr. Adams included that in his statement.

This is an issue that VA is working very hard to address right now through their Office of Women's Health Program and the Center for Women Veterans.

VA indicates an increasing number of women veterans returning from war and high rates of use among this Operation Enduring Freedom/Operation Iraqi Freedom population coming to VA with the changing demographic.

I think that it will be really important in the next year for the Office of Rural Health to also reach out to Dr. Patty Hayes' office at VA to really make sure that within the rural health question and initiative that these issues are addressed with respect to women veterans. I think that is great.

Some of the programs that VA has specifically for women veterans are really important in terms of post-deployment issues and some of the things that Dr. Adams has referred to in their post-deployment readjustment. So we want to be able in the rural health communities for those veterans to have that access to VA's unique specialties and providing those types of services or training local people that are seeing them to be able to do that.

And with respect to the child care issues, this has been a longstanding issue in the women's community that this is a barrier, but

we see it not only as a barrier for now just women, there are so many single veterans in general other than just women. Both men and women can have child care issues and primary care responsibilities.

And I think you are referring to the pilot program recommended by Congresswoman Stephanie Herseth Sandlin.

Mrs. HALVORSON. Yes.

Ms. ILEM. We think that when we look at all the research that is put out there, that this is one of the big barriers. So certainly if there is an opportunity to provide, not VA directly providing child care, but providing some sort of chit for them to access child care so that they can attend their appointments, especially if they have post-deployment issues that require extensive mental health sessions. You know, it really would not be appropriate for them to bring their children.

So we just hope that that is a consideration, that the Subcommittee will take up as it looks at that bill further.

Mrs. HALVORSON. Did you have anything to add, Dr. Adams?

Dr. ADAMS. Beyond child care, I do think that the counseling resources should be available to the families as well because so often if the veteran returns home with either psychosocial or severe physical issues, the family are the caretakers and they are the ones that are bearing the burden 99 percent of the time.

So I think resources should be available to them because so often in our rural communities, mental health and behavioral health services are just not available. They are not available for the general population.

And at least in my State, our local community mental health centers will not see veterans. They will not see them because they feel that, first of all, they are overburdened, but, second, they feel like they should be seen at the VA facilities.

So, again, creating a linkage and incentives for that to occur, I think, is vital in providing veterans and their families the services that they need locally.

Mrs. HALVORSON. Thank you.

Mr. TEAGUE. I thank the Congresswoman from Illinois for those questions because they needed to be asked and I thank the witnesses for addressing them.

And now at this time, I would like to recognize the gentleman from Indiana, Congressman Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

In regards to TBI, Dr. Adams, you had mentioned that earlier, and this is for both you and Ms. Ilem, there are approximately four centers throughout the country, polytrauma centers to help with this through the VA system. And if you get in a very rural area, it is hard to get treatment for this.

Would you fully support the opportunity for our vets to receive treatment at either one of our centers in the VA system or to go to a place like the Chicago Rehabilitation Institute where they can go and receive very intensive additional care for this injury?

And there are similar facilities throughout the country. I wanted to find out what you think of expanding the range of places where our vets can go.

Dr. ADAMS. I absolutely think that creating additional access points makes sense. And, yes, we all want the quality of the VA system to be held intact and we want to make sure that the veteran's health information is kept private, but all these things can occur in private settings. And it is of little solace to those that need the care who cannot get it knowing that there are four centers that do this and do it excellent if they cannot get there.

Accessing additional facilities, as you mentioned, that have the expertise, to me makes great sense and it is really just a matter of choice and access, making sure that these veterans get care no matter where it is as long as it is of high quality and it meets reasonable standards.

Ms. ILEM. I would just mention, obviously for the most critical cases that are just coming back, the major polytrauma centers, the way they are going, the VA has established also in each of their VISNs a level two. So it would depend, you know, certainly on the level of the injury and the needs of that veteran. And I know that they have options to outsource that care if necessary and working with the family.

Of course, we want, you know, veterans to have the best care and for those that are really working with these very unique injuries and the polytraumatic injuries they are seeing from the wars in Iraq and Afghanistan. So I do not think, you know, we are opposed to in certain circumstances, you know, making that available.

Certainly the family, there is a lot of family issues, we want the families to be available and to be with them. And we know that many have had to relocate, giving up, you know, jobs and a variety of other things that have made it very difficult or leave one parent at home and not be able to stay in their local area.

So I think those things should be taken under consideration for VA with the unique circumstance of the family.

Mr. DONNELLY. Okay. And, again, this would be for both of you. In terms of listing here is the problem with outsourcing some care for veterans when you have local doctors or local facilities, what do you find the biggest barriers, cost, the technology in the health clinic? What are the kind of things that make it most difficult for rural vets to be able to receive assistance locally as opposed to having to get in a van and travel 3 hours to the VA clinic?

And the VA clinics are extraordinary places, but if you can save yourself a 3-hour trip, it would be a lot better off. What are the kind of things preventing it from happening?

Dr. ADAMS. From my perspective, the largest barrier is that except for in a few isolated pilots, the VA will not pay for care at these local facilities. So——

Mr. DONNELLY. Excuse me. Will not pay at all or at an appropriate level, what you consider an appropriate level?

Dr. ADAMS. Well, to my knowledge, unless a veteran resides in one of these areas where they have a rural pilot, a veteran cannot go to, say, a community health center or just a private doctor, be seen, and have that care reimbursed by the VA.

Mr. DONNELLY. So it is not that the doctor or the clinic itself will not meet a payee number set by the VA, the VA just will not participate?

Ms. ILEM. My understanding is that VA has the option through its fee-basis program to, if there are geographic barriers and a number of certain circumstances, they can authorize fee-basis care based on the individual circumstances of the veteran and location and a variety of other factors. But they do that on an individual basis.

So VA does currently have that authority. The problem we have heard is that through the distribution of the dollars for fee-based programs, they oftentimes are only allotted a certain amount of money for those fee-basis programs.

So they are very judicious in how they allow veterans to use that program. And if there is an opportunity to get them to the nearest clinic, even though it may be several hours away, that is where they want them to go.

But I think looking as part of the establishment of the Office of Rural Health, there was a request to look at the fee-basis program and I know there has been some increased funds in the 2009 appropriation for increasing fee basis. And I would assume that the Office of Rural Health is really looking at the fee-basis issue and to use it appropriately when necessary, especially when you have some very elderly veterans or somebody with TBI that it would be very difficult for them to make extensive trips to and from a facility and a number of trips if required by their medical condition.

Mr. DONNELLY. Okay. Thank you very much.

Thank you, Mr. Chairman.

Mr. TEAGUE. Thank you, Congressman from Indiana. I appreciate that.

And, also, Joy Ilem and Dr. Adams, thank you for your participation. I think that the information and knowledge that we received from you today will be helpful as we make the decisions that we have to make down the road. I really do want to thank you for participating.

Dr. ADAMS. Thank you.

Ms. ILEM. Thank you.

Mr. TEAGUE. Now, at this time, I would like to call panel number two to come to the table. We have Dr. Adam Darkins who is the Chief Consultant, Office of Care Coordination, Veterans Health Administration, U.S. Department of Veterans Affairs, and Kara Hawthorne, Director of the Office of Rural Health, Veterans Health Administration, U.S. Department of Veterans Affairs.

Once again, thank you for being here today and taking a part in this. Dr. Darkins, we will start with you, please.

STATEMENTS OF ADAM DARKINS, M.D., CHIEF CONSULTANT, CARE COORDINATION, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF ADAM DARKINS, M.D.

Dr. DARKINS. Good morning, Mr. Chairman. Thank you for the opportunity to testify before the Committee today.

My testimony covers funding and resource coordination issues associated with the expansion of telehealth programs within the Department of Veterans Affairs or VA and how they help meet the health needs of veterans in rural areas.

Health care delivery in rural areas is a challenge as we have just heard, one that the VA is confronting directly. Telehealth involves the use of information telecommunications technology to increase access to care and reduce travel.

In fiscal year 2008, VA's telehealth programs provided care to over 100,000 veterans in rural areas. These telehealth-based services involve real-time videoconferencing, store-and-forwards telehealth, and home telehealth.

Real-time videoconferencing services in VA known as care coordination and general telehealth provide specialty services to veterans in both VA medical centers and in community-based outpatient clinics.

The main focus of this program is in providing mental health services in rural areas and in 2008 provided services to 20,000 veterans at over 171 sites of care. These services included provision of care to 2,000 returnees from Operations Enduring Freedom and Operation Iraqi Freedom.

Store-and-forwards telehealth, care coordination, store-and-forwards known in VA, involves the acquisition, interpretation, and management of digital imaging screening and assessment purposes of patients.

These services were provided to over 62,000 veterans in rural areas in 2008 and were predominantly to provide care for diabetic eye disease screening and for skin diseases.

To enable veterans with chronic diseases to live independently in their own homes and in local communities, VA provides home telehealth services. In financial year 2008, these services known as care coordination home telehealth services in VA supported 35,000 veteran patients to remain living independently in their own homes. Forty percent of these patients were in rural areas.

VA is very sensitive to the increasing need for services in the home, particularly in rural areas, and is preparing for the future demand by expanding the range of these services it provides as well as other telehealth services.

And I am going to describe briefly some ways in which this is happening in the next year.

Firstly, we are formalizing and implementing a national program using telehealth to help support the 41,096 veterans with amputations who receive care from VA.

Secondly, we are instituting a program to expand the use of telehealth in both home telehealth and in general telehealth to support spinal cord injury and disorder services and to make this renowned specialist care more available, especially in rural areas.

Thirdly, we are completing the necessary work to implement VA's Managing Overweight and/or Obesity for Veterans Everywhere Program known as MOVE. And this is going to be incorporated with home telehealth and will help it expand into rural areas.

Fourthly, we are completing a home telehealth technologies program for supporting veterans challenged by substance abuse issues.

And the last one I would like to focus on is establishing a national telemental health center which will coordinate telemental health services nationally. Its particular emphasis will be on bipolar disorders and on post-traumatic stress disorder and on making those services widely available.

In implementing telehealth solutions to serve veteran patients in rural areas in the ways I have described, collaborations with colleagues within and outside VA is vitally important. We collaborate with mental health, medical surgical services, rehabilitation, prosthetics, spinal cord injury, and spinal disorders amongst many other offices who provide invaluable expertise that ensures VA's telehealth services are appropriate, safe, effective, and cost effective.

Telehealth is a marriage between clinical care and technology and another key ongoing collaboration is that we have with information technology colleagues in order to underpin a robust and sustainable infrastructure to deliver care nationwide.

In financial year 2009, VA is piloting an extension of its preexisting polytrauma telehealth network to create a clinical enterprise videoconferencing network. This will facilitate the extension of polytrauma, post amputation, spinal cord injury care and specialists mental health services to rural areas.

These efforts combined with VA's personal health record, my healthy vet, leverages new technologies to benefit our patients.

VA's Office of Rural Health provides a focus we welcome to address the needs of veteran patients in rural areas and dovetails services into the spectrum of health care provision necessary to support these veterans.

VA has a longstanding relationship with the Joint Working Group on Telehealth, an interagency group. Cross-fertilization of telehealth practices with other Federal partners assists us in developing services, for example, those we deliver to meet the needs of populations such as those in American Indian, Alaska native, and Pacific Islander communities.

VA has three telehealth training centers and has trained over 6,000 staff to ensure workforce is competent using those modalities wherever possible that are virtual.

The safety and efficacy of VA's telehealth programs is substantiated by a national quality management program that reduces utilization and shows high levels of patient satisfaction with the telehealth programs.

Key to the development of telehealth in VA is the energy, expertise, and dedication from various staff from different backgrounds. They are united in their commitment to serve veteran patients.

It is a privilege to work with such colleagues throughout VA and engage in implementing ground-breaking services for those who served our Nation and for whom we are committed to serving, whether they live in rural, highly rural, or urban locations. This remains VA's mission and one we gladly accept.

Mr. Chairman, that concludes my prepared statement. I am pleased to address any questions the Committee may have for me.

[The prepared statement of Dr. Darkins appears on p. 34.]

Mr. TEAGUE. Okay. Thank you.

Next, Kara Hawthorne, please.

STATEMENT OF KARA HAWTHORNE

Ms. HAWTHORNE. Thank you.

Good morning, Committee Members. Thank you for the opportunity to discuss VA's work to enhance the delivery of health care to veterans in rural and highly rural areas.

I would like to request that my written statement be submitted for the record.

VA's Office of Rural Health referred to as the ORH is empowered to coordinate policy efforts across to promote improved health care for rural veterans.

VA has embraced a national strategy of outreach to ensure veterans, regardless of where they live, can access the expertise and experience of one of the best health care systems in the country.

In partnership, Congress and VA can do even more. We appreciate Congress' support and interest in this area and we are happy to report that portions of the $250 million included in this year's appropriation have already been distributed to the field to support new and existing projects.

Specifically, the ORH has allocated $24 million to sustain fiscal year 2008 programs and projects, including the rural health resource centers, mobile health care clinics, outreach clinics, the VISN Rural Consultant Program, and mental health and long-term care projects.

In December 2008, VA provided almost $22 million to VISNs across the country to improve services for rural veterans. This funding is part of a 2-year program and will focus on projects in line with the ORH strategic vision to increase access and enhance quality, education, and training, information technology use, workforce recruitment and retention, and to strengthen collaboration with our non-VA partners.

VA distributed resources according to the proportion of rural veterans within each VISN. VISNs were provided program guidance and directed to identify programs or projects that would support the ORH vision to enhance care delivery and outreach for veterans in rural areas, and also that they are in line with guidelines provided in Public Law 110–329 to increase the number of access points, to accelerate telemedicine deployment, to explore collaborations with non-VA partners, and to fund innovative pilot projects.

The Office of Rural Health instructed VISNs to include funding, validation, and reporting with a breakdown by target to facilitate distribution and tracking, as well as execution and evaluation plans. VISNs are required to report their accomplishments based on these factors to us quarterly.

In February 2009, the ORH distributed guidance to the VISNs and program offices concerning allocation of the remaining funds as early as May to enhance rural health care programs.

A cross-sectional group of VA program offices came together to develop a process and a method to allocate the additional funds.

Together we developed a request for proposal. VISNs and program offices were each eligible to apply for this funding. And, again, we focus on the ORH's six key areas, access, quality, technology, workforce, education and training, and collaboration strategies.

We also required proposals include an evaluation component with specific measures to explain how the proposed work will increase access and the quality of care to our rural veterans.

ORH, along with the other program offices in the panel and other relevant program directors across VA, will be reviewing these proposals in early April. Proposals that recommend new technologies or those that sought to extend current enterprise programs needed to justify how these alternative solutions would be interoperable and embody the essential clinical, technology, and business processes to ensure compatibility with existing programs.

Affected program offices will be involved in the review of these applications to ensure that continuity and consistency within the program areas.

VA's ORH during its short existence has produced a number of programs that are actively improving the delivery and coordination of health care services to rural veterans. Some examples include expanding the existing home-based primary care and the medical foster home programs into rural VA facilities, developing the Geri Scholars Program to support geriatric providers in rural areas, supporting expansion of community-based supports for veterans with severe mental illness, opening ten new rural outreach clinics, and also establishing the mobile health care pilot in 24 predominantly rural counties.

The VA's Office of Rural Health is reaching across the Department to coordinate and support programs aimed at increasing access for veterans in rural and highly rural communities.

And thank you once again for your support to appear today and I am prepared to address any additional questions that you may have.

[The prepared statement of Ms. Hawthorne appears on p. 36.]

Mr. TEAGUE. I do have some questions, but due to the fact that we are fixing to go vote, I will submit my questions in writing and defer to the Congressman from Kansas, sir.

Mr. MORAN. Mr. Chairman, thank you very much. You have more than overcome your slight earlier in the morning.

Thank you both for being here.

One of the things that seems so clear to me as we have finally begun the process of increasing the funding for veterans' health care is that the challenge we now face within the VA system is hiring and retaining health care professionals.

So as we add additional resources that make health care perhaps more accessible and higher quality, what is the VA able to do, what do you need from Congress in regard to the employment of people who perform health care services?

There is a shortage, generally. My hospitals, my communities all struggle to hire necessary health care professionals, from physical therapists to psychologists to psychiatrists to nurses.

My question is and my guess is and certainly my experience is that this is a more difficult challenge in rural communities than it is in urban or suburban settings, and is there a concerted effort at the VA to overcome the health care professional shortage, particularly in rural areas, but just generally?

Ms. HAWTHORNE. Thank you for your question.

You are correct. It is a national problem getting rural providers and the VA is addressing this. We have begun some initiatives to help recruit providers in the rural areas. We are linking in with non-VA entities to help advertise to entice them to come to VA.

Let me tell you specifically about one exciting new initiative that we are undertaking with the Office of Academic Affiliations.

We are expanding the rural residency for physicians into more rural facilities. So what we are doing is we are able to now provide supportive services so that the physicians can practice in rural areas because what we have learned is that providers who do their residencies in rural areas are more likely to stay and work in rural areas. So that is one of the examples.

The other one, as I mentioned in my oral testimony, is the Geri Scholars Program. Finding specialists that concentrate on geriatric services is difficult in urban and rural areas. So we are providing some extra training to the gerontologists about our rural veterans and I am hoping that they will disseminate that information among their peers in the rural communities where they practice.

Mr. MORAN. Is the VA capable of compensating health care providers in a way that we are not at a disadvantage to the private sector?

Ms. HAWTHORNE. I am not able to answer that question directly, but I can take it back and get a more thorough answer for you.

[The VA subsequently provided the following information:]

> Yes, with the flexibilities VHA has and the addition, several years ago, of market pay for physicians we can be competitive. However, salaries alone don't do this. It is the flexibility and use of incentives that makes VHA successful in remaining competitive.

Mr. MORAN. Please do. I thank you for that. And if so, is there a request to Congress that we do something about how we allocate the resources, the increased resources in a way that actually allows the VA to hire more providers?

Dr. DARKINS. Could I just——

Mr. MORAN. Absolutely, Doctor.

Dr. DARKINS. Certainly salary is one of the factors in terms of recruitment and retention of staff. Equally well, my understanding is, preferentially people from different disciplines are working within VA because the culture is very attractive. There is the training, which my colleague just commented on, VA provides substantial training for all health care professionals.

We are also finding, certainly in the area that I work in, telehealth, the benefits from our ability to link some of these rural practitioners into their specialist colleagues and the educational aspects that go with this. To be able to link practitioners directly into training and keep them up-to-date helps prevent that isolation.

So the cost is certainly something. These other factors really, I think, make VA a place where people are very proud to work in terms of the services they are now delivering.

Mr. MORAN. That is, you know, a very accurate description. Communities that have only one physician find it very difficult to retain that physician. You want colleagues. Doctors do not want to be on call 7 days a week, 24 hours a day. There is a collaboration and just a professional necessity of having colleagues in your presence.

The comment by our earlier panelist about not being able to find out who the—apparently each VISN has a rural coordinator and, yet, unable to find out who that person is. Do we have those rural coordinators in every VISN? Are they accessible? What are they doing? What is the status of that program?

Ms. HAWTHORNE. Sure. Yes, sir. We do have a VISN rural consultant in each VISN and this was actually something that the Committee had foresight to put into the Public Law that established the Office of Rural Health.

Some of the VISNs have full-time positions and some of them are not full time, but part of their responsibility is not only to facilitate information exchange between the fields and the VACO Central Office of Rural Health, but also to collaborate with the community, with community partners.

So they are seeking out potential collaborations for direct care, for education and training, and building those relationships.

I will look into your specific VISN and find out who that VISN coordinator is and make sure that they are in touch with the State Office of Rural Health and actually urge all of our VISN rural consultants to reach out to the State Offices of Rural Health.

Mr. MORAN. Thank you for that.

And point out that a couple of instances over a long period of time, we have tried, I have been involved in efforts, this Committee has been involved in efforts, to encourage the VA to employ the services of certain health care providers, chiropractic care, physical therapy. It always seems like there is a push to get the VA to accept certain segments of the medical profession.

And I just would remind you that in both those instances, physical therapy, chiropractic care, that in rural America, those professionals are very important. They fill a real need. And I would encourage your efforts on behalf of rural health care to recognize this, not to be narrow in the way that we define who can be a provider.

I think there is some reluctance to pursue the opportunities that I see there with a wide array of services that are more available in rural America in certain subcategories of professionals than there are just—than sometimes what we look for.

Let me finally, and, again, my time has expired, the Chairman has been very kind, but let me just thank you, Ms. Hawthorne, for your meeting with my staff.

Implementation of the legislation that we have been talking about is a high priority of this Committee. Many Members come from rural areas. It is a high priority with me.

You were very gracious and it appears to me that you are very interested in seeing that this occur in a timely and appropriate fashion and I am very grateful for your attitude and approach and look forward to working with you.

Thank you, Mr. Chairman.

Mr. TEAGUE. Thank you, sir, for those very pertinent questions and appropriate issues that needed to be addressed.

At this time, I would like to ask the Congressman from California, Mr. McNerney, if he has some questions.

Mr. MCNERNEY. Well, I do, Mr. Chairman. Thank you for giving me the gavel here.

And I want to follow-up a little bit on some of the questions by my colleague from Kansas. I certainly recognize the shortage, critical shortage of health care professionals in rural areas. And it is not just for VA services. It is a general problem. So we need to look at how to entice physicians, health care professionals of all kinds to come into rural areas.

One of the problems we are facing in California is that our prisons are severely overcrowded resulting in poor health care for prisoners. And now they are suggesting, the courts are about to mandate that we open up health care facilities in our area that will pay far more than the VA can and that will draw physicians further away from VA use and applications to prison. And that is very controversial. I am sure you can imagine. So it is an area that we need to look at and maybe address at this level.

One of the things that struck me about your testimony, Dr. Darkins, was the sort of difference in tone about telehealth from the prior panel. They certainly acknowledged the need for, the value of telenet, but your testimony was a little bit farther than that. It was not just the value, but how it could be used in several areas, vets with amputations, vets with spinal cord injuries, weight problems, post-traumatic stress and so on.

One of the things I am concerned about with telenet is the lack of personal touch. I mean, you have a screen in front of you and you can see the physician.

How effective is that in terms of reaching a veteran with these sorts of problems as opposed to having someone that can actually touch their hands and look them straight in the eye? You know, how much difference is there in terms of the effectiveness of the treatment if we go that way because it is clear to me that telehealth is a very effective tool? We are not going to be able to get all the physicians we need no matter how hard we try. So how effective is this treatment?

Dr. DARKINS. Thank you very much.

In terms of the VA's use of telemedicine, let me just say it is not a panacea to be able to provide all services. Absolutely it has to fit into a spectrum of care in which it is there with face-to-face services as well. So it is part of a spectrum of services.

VA's experience makes it a nationwide leader if not in certain areas, an international leader. There are certain benefits the VA has to make sure happens and develop very large networks. VA has had an ongoing commitment from leadership toward telehealth. It has been seen as a way to deliver specialist services, particularly out into rural communities.

Secondly, we do not have barriers from State licensure which allow us to develop large networks and to put these enterprise services into place. So it is very much the scale at which it is being done in VA that is so important. I think VA's experience is much higher than elsewhere because we have really an integrated health care system and are doing telehealth on an enterprise level.

In terms of your specifics, that has been something of enormous importance as we have taken telehealth forwards to be able to be quite clear that this is the right care for patients, it is what they want.

What we find is that telehealth services are really seen across the board by patients as being really directly equivalent in many cases to delivering face to face. We find sometimes people prefer to have face to face, but if you take into consideration the travel, sometimes the inconvenience, we are finding that people say they really enjoy the telehealth services.

It is not enough to be able to say anecdotally. We have good evidence from surveys we have done. Our home telehealth patients show an 86 percent satisfaction score with these services. They help them live independently in their own homes. We have 37,000 patients currently who otherwise might be in nursing homes if it were not for these services.

Mr. MCNERNEY. What sort of equipment is needed for home telehealth that a person might not ordinarily have?

Dr. DARKINS. Well, we are very sensitive to the fact that we are dealing with an aging population and may not be the most technology savvy. So we use simple technologies, which are push button.

The current connectivity is largely through telephone land lines, simple to use and communicate backward and forwards. And we are seeing a 20-percent reduction of utilization, so reducing hospital visits, and reducing hospital admissions using these technologies. They are really helping people with chronic disease to be able to stay living independently in their own homes and communities.

Mr. MCNERNEY. Do they need like a big screen TV or, I mean, what physical equipment do they need in the house?

Dr. DARKINS. They are small, little, unobtrusive boxes. There are three different ways in which this is generally done.

One way is to do videoconferencing into the home so somebody can directly see that provider. It means they get much more of that face-to-face contact. Obviously a physical examination cannot be done.

Mr. MCNERNEY. Right.

Dr. DARKINS. Second is to be able to monitor people's vital signs, pulse, weight, blood pressure, temperature. It is possible, thereby, to be able to remotely care for conditions like heart failure. Very simply, if somebody puts on weight and gets symptomatic, it is possible to intervene early and prevent hospital admission.

And the third area really is to be able to use what are known as disease management dialogs, to ask the kind of questions of a patient each day that they might be asked of their provider if they came into a clinic.

So we are finding this is really targeting care. We can expedite admission of people to hospital or referral to clinics based on this personal care each day which takes place from a VA provider back in the VA Medical Center.

Mr. MCNERNEY. Thanks.

If the Chairman will indulge me one more question, what do we need to do here to make sure that the VA can provide these sort of home-based services, make them available? Do we need to provide equipment or people, service people to come in and install, or what do we need to do here?

Dr. DARKINS. Well, I would say in this area at the moment, VA is very much on the leading edge of being able to take this forward. These are emerging technologies that have been used elsewhere but not as widely in the VA.

Patients are very accepting. Patients show high scores of satisfaction. We are working with the vendors that provide the technologies to standardize the systems, which is very important to be able to standardize the data, and thereby, data exchange.

There is not an issue in terms of our use of equipment or having equipment to be able to do this. I think our main issues as we go forward are really just those human being issues. You touched on earlier is it as good to be able to be using telehealth technologies as face to face.

So paradoxically we find a lot of the work is actually on relationships because in the end, it comes down to relationships. So I think the things I would say is one limiting factor is being absolutely sure we have a robust information technology backbone. We are working very hard with our information technology colleagues and the outside vendors to ensure that they are in place.

And the second is relationships, helping veteran patients to be accepting, which they are, of this technology, but also a provider population for whom this is a new way of delivering care as well. So those are really our main challenges are those human challenges rather than the technology.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. TEAGUE. Thank you, Congressman McNerney from California, for that.

Dr. Darkins and Kara Hawthorne, I want to thank you again for coming and testifying before our Subcommittee and thank you for the input that you have had. There will be some other questions submitted in writing.

And with that, that concludes the hearing this morning. Thank you.

[Whereupon, at 11:27 a.m., the Subcommittee was adjourned.]

APPENDIX

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

The Subcommittee on Health will now come to order. I thank everyone for attending this hearing. The purpose of today's hearing is to provide oversight of the VA's rural health funding spending and resource coordination. The hearing will explore whether resources are used efficiently to narrow the health disparities of veterans living in rural areas.

In general, we know that Americans living in rural areas tend to be in poorer health and are more likely to live below the poverty level compared to the rest of the country. This is magnified by the shortage of health professionals. In fact, while a quarter of the U.S. population lives in rural areas, only 10 percent of physicians practice in rural areas.

Focusing on the rural veteran population, we know that among all VA health care users, 40 percent of nearly 2 million veterans reside in rural areas. This includes nearly 80,000 veterans who live in highly rural areas. And according to the VA Health Services Research and Development Office, rural veterans have worse physical and mental health related to quality of life scores compared to their urban counterparts.

I commend the VA for their efforts to improve rural health. This includes building new CBOCs, Rural Outreach Clinics, and Vet Centers in rural and highly rural areas. It also includes pilot programs such as the traveling nurse corps, and the mobile health care pilot which places four mobile clinics in 24 predominantly rural counties in Colorado, Nebraska, Wyoming, Maine, Washington, and West Virginia. I also applaud the advances made in telehealth through the numerous pilot programs which have been implemented to date.

To help the VA's efforts, the Appropriations Committee provided $250 million in September of 2008 to establish and implement a new rural health outreach and delivery initiative. Through today's hearing, we seek a better understanding of how the VA has allocated and plans to allocate the $250 million. The hearing will also address concerns about the lack of coordination and the duplicative efforts by the various offices in the VA that deal with rural health.

Today, the Disabled American Veterans will share their thoughts on VA's progress in improving rural health. We will also hear from the South Carolina Office of Rural Health about local challenges and recommendations for closing the rural health gap. Finally, the VA's Office of Care Coordination and the Office of Rural Health will report on the Department's current efforts on rural health. I look forward to hearing their informative testimonies.

Prepared Statement of Hon. Cliff Stearns

Thank you, Mr. Chairman.

I'm pleased to be here this morning for our Health Subcommittee's hearing on ensuring our veterans living in rural areas are receiving the quality health care they deserve.

Today's hearing affords us the chance to examine how the Department of Veterans Affairs is spending some of the funds allocated to them in the FY2009 Appropriations Act. Specifically, we are focusing on funds that were marked to help further the VA's rural health initiatives in areas such as mobile health clinics and telemedicine.

We are all well aware of the health care gaps that exist for veterans residing in rural areas—we know that almost 40 percent of veterans enrolled in VA health care live in rural or highly rural areas, and that 44 percent of our veterans returning from Iraq and Afghanistan also reside in rural areas. Veterans (and people in general) living in rural America are statistically shown to have lower quality of life

scores and are more likely to suffer from treatable diseases. Clearly, this is an issue we must be addressing and monitoring closely.

I applaud the VA's current outreach efforts to recruit and retain more health care providers to serve in rural areas and to pursue innovative health care methods such as telemedicine. We are moving in the right direction, but we must stay the course and the VA must fulfill the goals it has set.

I welcome our panel of witnesses and look forward to hearing more about how the VA has and intends to further distribute the funds allocated to them under the FY09 appropriation so that we can truly begin closing the health care gap for our Nation's rural veterans.

Prepared Statement of Joy J. Ilem
Assistant National Legislative Director,
Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this oversight hearing of the Subcommittee. We value the opportunity to discuss our views on funding and resource coordination as related to health care gaps for veterans residing in rural and highly rural areas. This is an issue of significant importance to many DAV members and veterans in general.

Approximately 40 percent of veterans enrolled for Department of Veterans Affairs (VA) health care are classified by VA as rural or highly rural. Additionally, 44 percent of current active duty military servicemembers, who will be tomorrow's veterans, list rural communities as their homes of record. Research shows that when compared with their urban and suburban counterparts, veterans who live in a rural setting have worse health-related quality-of-life scores; are poorer and have higher disease burdens; worse health outcomes; and are less likely to have alternative health coverage. Such findings anticipate greater health care demands and thus greater health care costs from rural veteran populations.

Over the past several years through authorizing legislation and additional appropriations Congress has attempted to address unmet health care needs of veterans who make their homes in rural and remote areas. With nearly half of those currently serving in the military residing from rural, remote and frontier areas, access to VA health care and other veterans services for them is perhaps VA's most perplexing challenge. We recognize that rural health is a difficult *national* health care issue and is not isolated to VA's environment. We also appreciate that many service-connected disabled veterans living in rural areas face multiple challenges in accessing VA health care services, or even private services under VA contract or fee basis. Shortage of health care providers, long travel distances, weather conditions, geography and financial barriers all negatively impact access and care coordination for many rural veterans, both the service-connected and nonservice-connected.

Section 212 of Public Law 109–461 authorized VA to establish the Veterans Health Administration (VHA) Office of Rural Health (ORH). We deeply appreciate the due diligence of this Subcommittee and Congress as a whole in exerting strong support for rural veterans by enacting this public law.

As required by the Act, the function of the ORH is to coordinate policy efforts across VHA to promote improved health care for rural veterans; conduct, coordinate, promote and disseminate research related to issues affecting veterans living in rural areas; designate in each Veterans Integrated Service Network (VISN) rural consultants who are responsible for consulting on and coordinating the discharge of ORH programs and activities in their respective VISNs for veterans who reside in rural areas; and, to carry out other duties as directed by the Under Secretary for Health. In the Act, VA also was required to do an assessment of its fee-basis health care program for rural veterans to identify mechanisms for expanding the program and the feasibility and advisability of implementing such mechanisms. There were also a number of reports to Congress required including submission of a plan to improve access and quality of care for enrolled veterans in rural areas; measures for meeting the long term care and mental health needs of veterans residing in rural areas; and, a report on the status of identified and opened community-based outpatient clinics (CBOCs) and access points identified from the May 2004 decision document associated with the Capital Asset Realignment for Enhanced Services (CARES) plan. Finally, the Act required VA to conduct an extensive outreach program to identify and provide information about VA health care services to veterans of Operations Iraqi and Enduring Freedom (OIF/OEF) who live in rural communities for the purpose

of enrolling these veterans into the VA health care system prior to the expiration of their statutory eligibility period (generally, 5 years following the date of military discharge or completion of deployments).

In addition to establishing the ORH, in 2008 VA created a 13-member VA Rural Health Advisory Committee to advise the Secretary on issues affecting rural veterans. This panel includes physicians from rural areas, disabled veterans, and experts from government, academia and the non-profit sectors. We applaud former VA Secretary Peake for having responded to our recommendation in the Fiscal Year (FY) 2009 *Independent Budget* (IB) to use VA's authority to form such a Committee. Recently, this new Committee held its second scheduled meeting. We hold high expectations that the Rural Veterans Advisory Committee will be a strong voice of support for many of the ideas we have expressed in previous testimony before Congress, and joined by our colleagues from AMVETS, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States, in the IB.

We are pleased and congratulate VA on its progress to date in establishing the necessary framework to begin to improve services for rural veterans. It appears that ORH is reaching across the Department to coordinate and support programs aimed at increasing access for veterans in rural and highly rural communities. We note, however, that the ORH has an ambitious agenda but only a minimal staff and limited resources. The ORH is still a relatively new function within VA Central Office and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals of Congress for rural health improvements, we are concerned about the organizational placement of ORH within the VHA Office of Policy and Planning rather than being closer to the operational arm of the VA system. Having to traverse the multiple layers of VHA's bureaucratic structure could frustrate, delay or even prevent initiatives established by this office. We believe rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VA Central Office, with staff augmentation commensurate with its stated goals and plans.

We understand that VA has developed a number of strategies to improve access to health care services for veterans living in rural and remote areas. To begin, VA appointed rural care designees in all its VISNs to serve as points of contact in liaison with ORH. While we appreciate that VHA designated the liaison positions within the VISNs, we expressed concern that they serve these purposes only on a part-time basis. We are pleased that VA is conducting a pilot program in eight VISNs to determine if the rural coordinator function is apropos of a part-time or a full-time position.

VA reported that its approach to improving services in rural areas includes leveraging existing resources in communities nationwide to raise VA's presence through outreach clinics, fee-basis, contracting, and use of mobile clinics. Additionally, VA testified it is actively addressing the shortage of health care providers through recruitment and retention efforts; and harnessing telehealth and other technologies to reduce barriers to care. Also, in September 2008 VA announced plans to establish new rural outreach clinics in Houston County, Georgia, Juneau County, Alaska, and Wasco County, Oregon. VA plans to open six additional outreach clinics by August 2009 in Winnemucca, Nevada, Yreka, California, Utuado, Puerto Rico, Lagrange, Texas, Montezuma Creek, Utah, and Manistique, Michigan.

VA also reported that it has conducted other forms of outreach and developed relationships with the Department of Health and Human Services (HHS) (including the Office of Rural Health Policy and the Indian Health Service), and other agencies and academic institutions committed to serving rural areas to further assess and develop potential strategic partnerships. Likewise, VA testified it is working to address the needs of veterans from OIF/OEF by coordinating services with the HHS' Health Resources and Services Administration community health centers, and that these initiatives include a training partnership, technical assistance to community health centers and a seamless referral process from community health centers to VA sources of specialized care.

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

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IB veterans service organizations believe that these veterans, too, should have access to specialized services offered by VA's Readjustment Counseling Service, through its Vet Centers. In that regard we are pleased to acknowledge that VA

plans to roll out a fleet of 50 mobile Vet Centers this year to provide access to returning veterans and outreach at demobilization sites on military bases, and at National Guard and Reserve units nationally.

The issue of rural health is an extremely complex one and we agree with VA that there is not a "one-size-fits-all" solution to this problem. To make real improvements in access to the quality and coordination of care for rural veterans, we believe that Congress must provide continued oversight, and VA must be given sufficient resources to meet its many missions, including improvements in rural health care.

In regard to funding for rural health, VA acknowledged in 2008 that it had allocated almost $22 million to VISNs to improve services for rural veterans. VA noted this funding is part of a two-year program and would focus on projects including new technology, recruitment and retention, and close cooperation with other organizations at the federal, state and local levels. These funds are being used to sustain current programs, establish pilot programs and establish new outpatient clinics. VA distributed resources according to the fraction of enrolled veterans living in rural areas within each VISN. It is DAV's understanding that VISNs with less than three percent of their patients in rural areas received $250,000, those with between three and six percent received $1 million, and those with six percent or more received $1.5 million.

The ORH has testified VA allocated another $24 million to sustain these programs and projects into 2009, including the Rural Health Resource Centers, mobile clinics, outreach clinics, VISN rural consultants, mental health and long-term care projects, and rural home-based primary care, and has convened a workgroup of VISN and Central Office program offices to plan for the allocation of the remaining funds. In February 2009, ORH distributed guidance to VISNs and program offices concerning allocation of the remaining funds as early as May to enhance rural health care programs.

Concurrently, Public Law 110–329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, approved on September 30, 2008, included $250 million for VA to establish and implement a new rural health outreach and delivery initiative. Congress intended these funds to build upon the successes of the ORH by enabling VA to expand initiatives such as telemedicine and mobile clinics, and to open new clinics in underserved and rural areas. Notably, the bill also includes $200 million for fee-basis services.

Health workforce shortages and recruitment and retention of health care personnel are also a key challenge to rural veterans' access to VA care and to the quality of that care. The Institute of Medicine of the National Academy of Sciences report "Quality through Collaboration: The Future of Rural Health" (2004) recommended that the Federal Government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deep and long-term commitment to health profession education seems to be an appropriate foundation for improving these situations in rural VA facilities as well as in the private sector. VA's unique relationships with health profession schools should be put to work in aiding rural VA facilities with their human resources needs, and in particular for physicians, nurses, technicians, technologists and other direct providers of care. The VHA Office of Academic Affiliations, in conjunction with ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. While VA maintains it is moving in this general direction with its pilot program in a traveling nurse corps, VA's pilot program in establishing a "nursing academy," initially in four sites and expanding eventually to 12; its well-founded Education Debt Reduction Program and Employee Incentive Scholarship Program; and, its reformed physician pay system as authorized by Public Law 108–445, none of these programs was established as a rural health initiative, so it is difficult for DAV to envision how they would lend themselves to specifically solving VA's rural human resources problems. We do not see them as specific initiatives aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

The DAV has a standing resolution from its membership, Resolution No. 177, fully supporting the right of rural veterans to be served by VA, but insists that Congress provide sufficient resources for VA to improve health care services for veterans living in rural and remote areas. We thank VA and this Subcommittee for supporting this specific-purpose funding for rural care without jeopardizing other VA health care programs. Furthermore, we appreciate the Subcommittee's interest in conducting this oversight hearing to learn more from VA about the specific instructions issued to field facilities guiding the use of these new funds, what Central Office monitoring is being provided over the use of those funds, and the degree and type of reporting requirements that have been imposed. Such information would serve everyone's interest in ascertaining how many additional veterans received

care at VA's expense that otherwise would not have received care were it not for the new resources made available for rural veterans, as well as gathering data on how their health outcomes have been affected as a measure of the quality of that care.

VA's previous studies of rural needs identified the need for 156 priority CBOCs and a number of other new sites of care nationwide. A March 30, 2007, report submitted to Congress also required by Public Law 109–461, indicates 12 CBOCs had been opened, 12 were targeted for opening in FY 2007, and five would open in FY 2008. In June 2008, VA announced plans to activate 44 additional CBOCs in 21 states during FY 2009. Of the over 750 CBOCs VA operates, 353 CBOCs are doing real-time video conferencing (predominantly tele-mental health), while 130 CBOCs are transmitting tele-retinal imaging for evaluation by specialists in VA medical centers. Such services greatly enhance patient care, extend specialties into rural and highly rural locations, and drastically cut down on long-distance travel by veterans. VA directly staffs 540 clinics, and the remainder of these CBOCs are managed by contractors. At least 333 of VA's CBOCs are located in rural or highly rural areas as defined by VA. In addition, VA is expanding its capability to serve rural veterans by establishing rural outreach clinics. Currently 12 VA outreach clinics are operational, and more are planned. These are major investments by VA and we appreciate both VA and Congress for supporting this level of extension of VA services into more and more communities.

While we applaud the VHA for improving veterans' access to quality care and its intention to spread primary and limited specialty care access for veterans to more areas, enabling additional veterans access to a convenient VA primary care resource, DAV urges that the business plan guiding these decisions generally first emphasize the option of VA-operated and staffed facilities. When geographic or financial conditions warrant (e.g., highly rural, scarceness, remoteness, etc.), we do not oppose the award of contracts for CBOC operations or leased facilities, but as a contributor to the IB for FY 2010 we do not support the general notion that VA should rely heavily or primarily on contract CBOC providers to provide care to rural veterans.

We understand and appreciate those advocates on this Subcommittee and in Congress in general who have been successful in enacting authority for VA to increase health care contracting in rural areas through a new multi-VISN pilot program enacted in Public Law 110–387. However, in light of the escalating costs of health care in the private sector, to its credit VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected and nonservice-connected veterans might seek care in the private sector as a matter of personal convenience, they may well lose the safeguards built into the VA system by its patient safety program, prevention measures, evidence-based treatments, national formulary, electronic health record, and bar code medication administration (BCMA), among other protections. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, ones that are generally not available in private sector systems or among individual practitioners or group practices (especially in rural areas), would equate to diminished oversight and coordination of care, lack of continuity of care, and ultimately may result in lower quality of care for those who need quality the most.

For these reasons, we urge Congress and VA's ORH to closely monitor and oversee the development of the new rural pilot demonstration project from Public Law 110–387, especially to protect against any erosion or diminution of VA's specialized medical programs and to ensure participating rural and highly rural veterans receive health care quality that is comparable to that available within the VA health care system. We are pleased that the ORH reported it is coordinating with the Office of Mental Health Services to implement this pilot program. We ask VA, in implementing this demonstration project, to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state or other Federal agencies, as VA has previously claimed it would be doing) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health profession academic affiliates. We recommend the principles outlined in the Contract Care Coordination section of the FY 2010 IB be used to guide VA's approaches in this demonstration, and that it be closely monitored by VA's Rural Veterans Advisory Committee, with results reported regularly to Congress.

We also recommend that VA be required to provide more thorough reporting to this Subcommittee to enable meaningful oversight of the use of the funds provided and the implementation of the authorizing legislation that serves as a foundation to this work.

We urge the Subcommittee to consider legislation strengthening recurring reporting on VA rural health as a general matter. We are concerned that funds Congress provided to VA to address shortages of access in rural areas will simply be dropped into the VA "Veterans Equitable Resource Allocation" (VERA) system, absent means of measuring whether these new funds will be obligated in furtherance of Congress's intent—to enhance care for rural and highly rural veterans, with an emphasis on outreach to the newest generation of war veterans who served in the National Guard and hail from rural areas. Reports to Congress should include standardized and meaningful measures of how VA rural health care capacity or "virtual capacity" has changed; VA should provide recorded workload changes on a quarterly or semi-annual basis, and disclose other trends that reveal whether the rural health initiatives and funds allocated for them are achieving their designed purposes.

In closing, DAV believes that while VA may be working in good faith to address its shortcomings in rural areas, it clearly still faces major challenges and hurdles. In the long term its methods and plans may offer rural and highly rural veterans better opportunities to obtain quality care to meet their specialized health care needs. However, we caution about the trend toward privatization, vouchering and contracting out VA health care for rural veterans on a broad scale. As VA's ORH develops its policies and initiatives, DAV cannot stress enough the importance of communication and collaboration between this office, other VA program offices and field facilities, and other Federal, State or local organizations, to reach out and provide VA benefits and services to veterans residing in rural and highly rural areas. As noted above, we are concerned that the current staffing level assigned to ORH will be insufficient to effectively carry out its mission. Moreover, DAV believes ORH's position in VHA's organizational structure may hamper its ability to properly implement, guide and oversee VA's rural health initiative. Also, Congress should monitor VA's funding allocation to ensure rural health needs do not interfere with other VA medical obligations. Finally, we are hopeful with continued oversight from this Subcommittee and, with these principles in mind; rural veterans will be better served by VA in the future.

Mr. Chairman, this concludes my statement. I would be happy to address questions from you or other Members of the Subcommittee.

Prepared Statement of Graham L. Adams, Ph.D.,
Executive Director, South Carolina Office of Rural Health, and
State Office Council Chair, National Rural Health Association

I am Graham Adams, CEO of the South Carolina Office of Rural Health, a Past-President of the National Organization of State Offices of Rural Health and a trustee on the Board of the National Rural Health Association. The NRHA provides leadership on the issues that affect the health of the 62 million Americans who call rural home and has long focused efforts on improving the physical and mental health of our rural veterans. I appreciate the opportunity to speak before you today to discuss this very important issue.

Since our Nation's founding, rural Americans have always responded when our Nation has gone to war. Whether motivated by their values, patriotism, or economic concerns, the picture has not changed much in 230 years. Simply put, rural Americans serve at rates higher than their proportion of the population. Though only 19 percent of the Nation lives in rural areas, 44 percent of U.S. Military recruits are from rural America. And, sadly, according to a 2006 study of the Carsey Institute, the death rate for rural soldiers is 60 percent higher than the death rate for those soldiers from cities and suburbs. Given this great commitment to service on behalf of rural communities, we need to do more to closely examine the health care barriers that face rural veterans. Developing solutions specific to rural veterans and their unique needs must be a priority.

There is a national misconception that all veterans have access to comprehensive care. Unfortunately, this is simply not true. Access to the most basic primary care is often difficult in rural America. Access for rural veterans can be daunting. Combat veterans returning to their rural homes in need of specialized care due to war injuries (both physical and mental) likely will find access to that care extremely limited. What this means, is that because there is a disproportionate number of rural

Americans serving in the military, there is a disproportionate need for veteran's care in rural areas.

Veterans that live in rural communities face great challenges when trying to receive care. Lack of an adequate number of Community Based Outpatient Clinics (CBOCs), Outreach Health Centers or other approved sources of care make it difficult for rural veterans to receive timely, appropriate care. According to the VA website, my home state of South Carolina only has 11 CBOCs, and 3 Vet Outreach Centers. This is especially concerning given that South Carolina is one of the top twenty states in which veterans reside. Scarcity of mental health and family counseling services is also a problem for rural veterans in need of these services.

The NRHA believes that both program expansion and resource coordination is critical to improve the care of our rural veterans and makes the following recommendations:

1. Increase Access by Building on Current Successes

Community Based Outreach Centers (CBOCs) open the door for many veterans to obtain primary care services within their home communities. Additionally, Outreach Health Centers meet the needs of many rural veterans. NRHA applauds the success of these programs and supports their expansion.

2. Increase Access by Collaborating with Non-VHA Facilities

Approximately 20 percent of veterans who enroll to receive health care through the VHA live in rural communities. With an ever-growing number of veterans returning home to their rural communities after military service, these rural health care systems must be prepared to meet their needs. While CBOCs and Veteran Outreach Centers provide essential points of access, there are not enough of these facilities in rural communities. Furthermore, CBOCs do not provide a full range of care and the low volume of veterans in some communities may never be able to support one of these centers. Simply put, more providers are needed to serve the increasing number of rural veterans. Collaboration with existing rural health care facilities provides an effective and timely solution to this problem.

Linking the quality of VA services with rural civilian services can vastly improve access to health care for rural veterans. Our goal is not to mandate care to our veterans, but to provide them a choice, a local choice. As long as quality standards of care and evidence-based medicine guide treatment for rural veterans, the NRHA supports collaboration with:

- *Federally Qualified Community Health Centers (FQHCs)*. These centers serve millions of rural Americans and provide community-oriented, primary and preventive health care. More importantly, FQHCs are located where rural veterans live. A limited number of collaborations between the VHA and Community Health Centers already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas. These successful models should be expanded to reach all of rural America.
- *Critical Access Hospitals and other small rural hospitals*. These facilities provide comprehensive and essential services to rural communities and are specific to rural states. If these facilities are linked with VHA services and models of quality, access to care would be greatly enhanced for thousands of rural veterans.
- *Rural Health Clinics*. These clinics serve populations in rural, medically underserved areas and comprise a vital piece of the safety-net system. In many rural and frontier communities, RHCs are the only source of primary care available. Furthermore, many RHCs are more than willing to see these rural veterans if only a mechanism existed to do so.

The above rural health facilities are the cornerstone of primary and preventive quality health care in rural America. Each is required to meet Federal requirements for quality, provider credentialing and the use of health information technology. Current collaborations with the VHA in Wisconsin, Missouri and Utah are strong examples of success. Expanding the levels of collaboration will vastly increase access to care in a cost-effective manner.

The NRHA is pleased that the Rural Veterans Access to Care Act was signed into law last October. This act establishes a 3-year pilot program in several rural regions of the country to allow the most underserved rural veterans to take advantage of existing quality rural health providers, such as Critical Access Hospitals, community health centers and rural health clinics. The pilot project is relatively small and requirements to qualify are rigid—a veteran must live at least 60 miles from a VA primary care facility like an outpatient clinic, 120 miles from a VA hospital or 240 miles from a VA specialized-care facility when seeking that care. Despite these de-

fects, this legislation is a strong and important step in the right direction, but so much more must be done.

3. Increase Access to Mental Health and Brain Injury Care

Currently, it appears that Traumatic Brain Injury (TBI) will most likely become the signature wound of the Afghanistan and Iraqi wars. Such wounds require highly specialized care. The current VHA TBI Case Managers Network is vital, but access to it is extremely limited for rural veterans—expansion is needed.

Additionally, mental health needs of combat veterans deserve special attention and advocacy as well. Access to mental health services is a problem in many small rural communities. In fact, 85 percent of all mental health shortages are found in rural America. A lack of qualified mental health professionals, shortage of psychiatric hospital beds and the negative stigma of mental illness, often result in many rural residents not getting the care they so desperately need. These problems are exacerbated for veterans who live in rural communities.

Although Vet Centers provide mental health services, they are not consistently available at the local, rural level. More resources are needed in order to contract with local mental health providers, hire additional mental health providers and/or contract with Critical Access Hospitals (CAHs) and other small rural hospitals.

4. Target Care to Rural Veterans

A. ***Needs of the Rural Family***. Rural veterans have an especially strong bond with their families. Returning veterans adjusting to disabilities and the stresses of combat need the security and support of their families in making their transitions back into civilian life. The Vet Centers do a tremendous job in assisting veterans, but their resources are limited. The NRHA supports increases in funding for counseling services for veterans' and their families.

B. ***Needs of Rural Women Veterans***. More women serve in active duty than at any other time in our Nation's history. And more women are wounded or are war casualties than ever before in our Nation's history.

Targeted and culturally competent care for today's women veterans is needed. Rural providers should also be trained to meet the unique needs of rural, minority, and female veterans.

5. Improving Office of Rural Veterans

The NRHA calls on Congress and the VA to fully implement the functions of the newly created Office of Rural Veterans to develop and support an on-going mechanism to study and articulate the needs of rural veterans and their families.

Additionally, efforts to increase service points for rural veterans have, in large part, not been fully supported by the VA Administration itself. The VA has not consistently supported attempts to collaborate with rural health. It is my hope that with a new Administration and the newly formed VA Rural Health Advisory Committee, previous barriers will be eradicated and the Office of Rural Veterans will lead the way in expanding access options for rural veterans. Furthermore, the NRHA strongly encourages greater coordination between the Rural Health Coordinators housed in each VISN and state-level rural health officials in their region. Specifically, quarterly meetings with State Office of Rural Health and State Rural Health Association officials would be prudent.

6. Explore ways to coordinate benefits for dual eligible veterans

As the veteran population ages, a growing number of veterans are eligible for both VHA health benefits and Medicare. The combination of two partial benefits packages should ensure the best possible care for our veterans, but the copayments and Medicare Part D requirements may not be affordable for many veterans. Coordination of benefits would allow veterans to utilize the different resources offered to them effectively to receive high quality care close to home.

7. Increase research on defining the rural veteran population

Without good research about the rural veteran population, we cannot possibly expect to ensure their good health. Epidemiological studies are needed to identify the locations and populations of veterans in various rural areas of the country. These studies must provide information about race, gender, place of residence, health care needs, service-related health issues and service utilization. Only about 39 percent of veterans are enrolled in VA health care benefits; quality research would provide information about how to best serve the veteran population who are currently not enrolled. The NRHA would encourage the VA to collaborate with the six Federal Office of Rural Health Policy/HRSA-funded Rural Health Research Centers to explore this research.

Conclusion

While many opportunities for improvement exist in providing care to veterans in rural communities, the VA is to be commended for the excellent service provided in many of its facilities. However, we must never forget that many veterans forgo care entirely because of access difficulties to VA facilities. Providing health care in rural communities requires unique solutions, whether it is to veterans and their families or the general population. Adopting some of the strategies referenced in this written testimony would aid in addressing these rural needs.

Additionally, we must all be mindful of long-term needs and costs of our sailors and soldiers. The wounded veterans who return today won't need care for just the next few fiscal years, they will need care for the next half century.

Thank you again for this opportunity. The NRHA looks forward to working with you and this Committee to improve rural health care access for the millions of veterans who live in rural America.

Prepared Statement of Adam Darkins, M.D.
Chief Consultant, Care Coordination,
Office of Patient Care Services, Veterans Health Administration,
U.S. Department of Veterans Affairs

Good morning, Mr. Chairman. Thank you for the opportunity to testify before the Committee about addressing the health care needs of Veterans in rural areas. This initiative recognizes our continuing commitment to provide services to Veterans no matter where they live. My testimony today covers issues associated with funding and resource coordination with respect to how the Department of Veterans Affairs (VA) is implementing telehealth programs at the enterprise level to meet the needs of Veterans in rural areas.

Health care delivery in rural areas challenges all health care systems, including VA, but we are not discouraged by this challenge, and we are confronting it directly. Telehealth, which involves the use of information and telecommunications technologies to deliver services in situations where the patient and the provider are geographically separated from one another, offers one solution to this challenge. Telehealth provides health care to underserved rural areas and involves 35 clinical specialties in VA. In Fiscal Year (FY) 2008, VA's enterprise telehealth programs provided care to over 100,000 Veterans in rural and highly rural areas. These telehealth-based services involve real-time video conferencing, store-and-forwards telehealth and home telehealth.

VA provided real-time video-conferencing, also known as Care Coordination/General Telehealth (CCGT), to 32,000 Veterans in rural areas and 2,000 in highly rural areas in FY 2008. Of these, 1,900 Veterans from rural areas served in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) and 112 OEF/OIF Veterans live in highly rural areas. The majority of CCGT services were for mental health conditions. The responsiveness and availability of mental health care services for our clients is a priority. In FY 2008, 19,000 Veterans received tele-mental health services in rural areas and 1,500 in highly rural areas. CCGT services were available to Veterans at 171 sites in rural or highly rural areas.

Store-and-forwards telehealth, known as Care Coordination/Store-and-Forwards (CCSF), involves the acquisition and interpretation of clinical images for screening, assessment, diagnosis and management. These services were provided to 61,776 Veterans in rural areas and 2,911 in highly rural areas during FY 2008. CCSF services were predominantly delivered to screen diabetic eye disease (tele-retinal imaging) and prevent avoidable blindness in Veterans, 50,908 of whom were in rural areas and 2,536 in highly rural areas. Of the 219 sites at which tele-retinal screening took place in FY 2008, 54 of these sites were in rural or highly rural clinics. The remainder of CCSF activity mainly covered tele-dermatology.

To help Veterans continue living independently in their own homes and local communities, VA provides home telehealth services, known as Care Coordination/Home Telehealth (CCHT). CCHT services cover a range of chronic conditions including diabetes, chronic heart failure, hypertension and depression. In FY 2008, over 35,000 Veterans received home telehealth-based care. More than 16,000 Veterans received these services for non-institutional care. VA recognizes we treat an older population, one that will have increasing need of home-based primary care, and we are preparing now for future demand. Currently, 37,000 Veterans receive CCGT for non-institutional care, chronic care management, acute care management and health promotion or disease prevention. Thirty-eight percent of these patients in VA are

in rural areas and 2 percent are in highly rural areas. All together, between 30 and 50 percent of telehealth activity in VA supports Veterans in rural and highly rural areas, depending upon the area of telehealth. Data from the first quarter of FY 2009 show ongoing growth in all areas of telehealth with commensurate growth in rural and highly rural areas.

VA is undertaking a range of initiatives in FY 2009 that are targeted at sustaining this growth of telehealth services and expanding access in rural and highly rural areas. These initiatives focus on the clinical, technology and business processes that are underpinning the safe, effective and cost-effective implementation of telehealth in VA to support Veteran care. For example, Care Coordination Services (CCS) is collaborating with the Office of Rehabilitation Services to formalize the clinical processes necessary to use telehealth to support the 41,096 Veterans with amputations receiving care from VA. Telehealth enhances access to care in rural areas as close to Veterans' homes and local communities as possible, if the Veteran wishes to use the services. CCS is also working with our colleagues in the Spinal Cord Injury and Disorder Service to implement CCGT services to make specialist care more widely available, including in rural areas. We have recently completed the necessary work to implement VA's Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) program within CCHT programs. This development will expand the reach of this successful and groundbreaking program for weight management to Veterans in rural and highly rural areas. We anticipate making a program for supporting Veterans with substance abuse issues via home telehealth available during FY 2009.

CSS is collaborating with the Office of Mental Health Services to establish a national Tele-mental Health Center. This center will coordinate tele-mental health services nationally with an emphasis on making specialist mental health services, such as those for post-traumatic stress disorder and bipolar disorder, available in rural areas. CSS is also proposing an innovative approach for consideration by our colleagues in VA's Office of Rural Health to directly fund VISNs in support of enterprise-wide telehealth programs to expand their reach into rural areas and to increase the number of Veterans served. CSS is working with VA's Medical/Surgical Service to further extend tele-retinal imaging. CSS is seeking funding from the Office of Rural Health to support five additional sites in rural areas. We are currently implementing a pilot program we hope to expand nationally for tele-dermatology in five Veterans Integrated Service Networks (VISNs) in 35 sites, 20 of which are in rural areas.

VA is known for its significant work in creating and institutionalizing an award winning electronic medical record that has propelled VA into the 21st century. VA is very fortunate to have a workforce of clinicians who are so receptive to new technology and who readily embraced the use of VA's electronic health record (EHR). The EHR underpins all that we do in telehealth in VA. With telehealth, as with the implementation of the EHR, it is necessary to ensure clinicians and patients are educated and accepting of a new approach to health care. VA has three training centers for telehealth located in Boston, MA; Salt Lake City, UT; and Lake City, FL. These centers have trained over 6,000 staff to. ensure we have a workforce competent in telehealth and to develop and sustain these services. Always cognizant of the issues involved in training staff in rural areas, our training centers have partnered with VA's Employee Education System to use virtual training modalities wherever possible, including bi-monthly national satellite broadcasts that can be viewed remotely, an annual virtual national meeting, and web-based courses that cover our enterprise telehealth applications.

Telehealth technologies are constantly developing as new functionalities become available. VA is working in this evolving environment to improve usability of the technologies for both patients and clinicians. VA has developed robust interoperable national IT platforms to support the commercial-off-the-shelf (COTS) telehealth devices that interface with patients. In FY 2009, VA is piloting an extension of its preexisting Polytrauma Telehealth Network to create a clinical enterprise videoconferencing network (CEVN). The CEVN will facilitate the extension of polytrauma, post-amputation, spinal cord injury care and specialist mental health care to rural areas. These efforts, combined with My Health*e*Vet, which offers Veterans access to their personal health record any time, anywhere, leverage new technologies to benefit our clients.

VA is also extending its enterprise telehealth programs to American Indian/Alaskan Native and Pacific Islander communities. VA currently operates seven such programs, with four more awaiting connectivity and 11 in deployment for 15 Tribes in four VISNs. VA is one of several agencies working to improve care in these areas through telehealth. We have maintained a longstanding relationship with other Fed-

eral partners through the Joint Working Group on Telemedicine, which is an excellent forum for sharing practices and concepts for expanding care.

In order to substantiate the safety and efficacy of care delivery through its enterprise telehealth networks, we have introduced quality management programs for CCHT, CCGT and CCSF. In FY 2009, these quality management programs are being combined for all three areas of telehealth to create a single assessment process in which the policies and procedures of telehealth programs are assessed biannually in each VISN. In addition, VA collects routine outcomes data for program management purposes. These systems allow us to quantify, validate and monitor the benefits of these approaches to clinical care. The data indicate VHA's enterprise telehealth programs are associated with substantial reductions in hospital admissions (more than 20 percent reductions compared to non-telehealth users) and high levels of patient satisfaction (mean scores above 85 percent).

Many areas of telehealth are still emerging technologies that we are committed to mastering. Our focus will always remain on the needs of Veterans. VA's strategy has been to adopt a systematic enterprise approach with the aim of providing the right care in the right place at the right time to Veterans in rural, highly rural and urban settings. This approach of developing VA's telehealth network has resulted in sustained growth. By remaining client-centric, we provide dynamic, flexible, and responsive specialist care to underserved areas. Key to the development of telehealth in VA is the energy, expertise and dedication of staff from various backgrounds who resolve the ongoing clinical, technology and business issues that arise. Given the commitment of VA to serving the needs of Veterans and meeting the challenges of those requiring care in rural and highly rural areas, the development of telehealth is not solely a technical exercise; we are driven to deliver caring, compassionate and appropriate care in the least restrictive and most accessible manner possible.

In drawing to a close, I would like to acknowledge the challenges of providing health care services in rural areas, particularly with respect to meeting specialist care. Telehealth is part of a spectrum of services that includes obligate needs for in-person provision of ambulatory care and clinical procedures. It is a privilege to work with colleagues throughout VA and engage in implementing telehealth to provide groundbreaking services to those who have served our Nation and to whom we are committed to serving, whether they live in rural, highly rural or urban locations where access to care presents a challenge for them. This remains VA's mission and it is one we gladly accept.

Mr. Chairman, this concludes my prepared statement. I am pleased to address any questions the Committee may have.

Prepared Statement of Kara Hawthorne,
Director, Office of Rural Health,
Veterans Health Administration, U.S. Department of Veterans Affairs

Good morning, Mr. Chairman. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA's) work to enhance the delivery of health care to Veterans in rural and highly rural areas. VA continues our commitment to provide service to Veterans in remote geographic areas, and we look forward to working with the Committee to better promote services and care.

VA's Office of Rural Health (ORH) was authorized in December 2006 by § 212 of Public Law 109–461 and is empowered to coordinate policy efforts across VHA to promote improved health care for rural Veterans. Development of this office started in early April 2007, and a Director was named in October 2007. As the Secretary has said, rural health is a difficult national health care issue, but one that we will meet directly, with an eye toward becoming the leader in this field. Veterans and others who reside in rural areas face a number of challenges associated with obtaining health care. VA has embraced a national strategy of outreach to ensure Veterans, regardless of where they live, can access the expertise and experience of one of the best health care systems in the country. In partnership, Congress and VA can do even more. We appreciate Congress' support and interest in this area, and we are happy to report portions of the $250 million included in this year's appropriation have already been distributed to the field to support new and existing projects.

ORH has allocated $24 million to sustain Fiscal Year 2008 programs and projects, including the Rural Health Resource Centers, Mobile Clinics, Outreach Clinics, VISN Rural Consultants, mental health and long-term care projects, and rural homebased primary care. ORH worked with representatives throughout VA and the Veterans Health Administration (VHA), including VISN Directors, Program Chiefs,

the Office of General Counsel, the Office of Information Technology, VHA's Chief Business Office, and the VHA Chief Financial Office, to develop strategy, guidance and measures for allocating the remaining funds. ORH has adopted an inclusive approach that reaches across business lines throughout the organization.

In December 2008, VA provided almost $22 million to VISNs across the country to improve services for rural Veterans. This funding is part of a 2-year program and will focus on projects including new technologies, recruitment and retention, and close cooperation with other organizations at the Federal, State and local levels. VA will use funds to sustain current programs, initiate pilot programs and establish new outpatient clinics. VA distributed resources according to the proportion of Veterans living in rural areas within each VISN; VISNs with less than three percent of their patients in rural areas received $250,000, those with between three and six percent received $1 million, and those with six percent or more received $1.5 million.

VISNs were directed to identify programs or projects that would develop innovative strategies, care delivery models, educational initiatives, technology uses and other approaches to enhance health care service delivery and outreach for rural Veterans. ORH provided examples, including programs or projects that: a) assess and anticipate the current and future health care needs of rural Veterans; b) address solutions that may be adapted for use by, or have value for, all VA facilities; c) emphasize collaborations with other VHA facilities, as well as public and private entities; or d) programs that would meet the legislative requirements of the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (Public Law 110–329) or the Veterans' Mental Health and Other Care Improvements Act of 2008 (PL 110–387). ORH instructed VISNs to include funding validation and reporting with a breakdown by target (e.g., medical administration, medical services, medical facilities, information technology, etc.) to facilitate distribution and tracking. VISNs are required to report their accomplishments based upon this funding quarterly. This report must include a description of the program, the purpose and objectives, and supporting documentation (including the demographics of the service area, the execution plan and the evaluation plan). ORH supplied evaluative criteria to VISNs, including how objectives compare to legislative requirements, how significant the potential and likely impacts of the program are for rural Veterans, whether there is programmatic relevance and adherence to the award's intent, and whether the budget is appropriate for the proposal. These measures allow us to validate the benefits of our services to Veterans.

In February 2009, ORH distributed guidance to VISNs and Program Offices concerning allocation of the remaining funds as early as May to enhance rural health care programs. Both program offices and VISNs were eligible to apply for this funding, which would support programs in six key areas of focus, including access, quality, technology, workforce, education and training, and collaboration strategies. Projects could include leveraging existing, proven initiatives, such as increasing access points in rural and highly rural areas (i.e., establishing outreach clinics in areas not meeting VA's drive time standards, or developing mobile clinics), structured initiatives to expand feebasis care, developing collaborations with Federal and non-Federal partners, accelerating telemedicine deployment or funding innovative pilot programs. ORH, along with the program review panel consisting of relevant program directors across VA, will be reviewing these proposals in early April 2009 by considering their capacity for meeting legislative requirements, their relevance for rural and highly rural populations, their ability to assess and anticipate current and future health care needs of rural Veterans, their potential for adaptation or use by all VA facilities, their collaborations with other VHA facilities, the evidence-base to support the program, their clear articulation of potential impacts, and their definition of Veterans' needs being addressed. Proposals that recommended new technologies or those that sought to extend current enterprise programs needed to justify how these alternative solutions will be interoperable and embody the essential clinical, technology and business processes to ensure compatibility with existing programs. Affected program offices will be involved in the review of these applications to ensure continuity and consistency within the program area.

Proposals must include a clearly defined purpose and objectives, implementation strategies (including Veteran populations affected, service area demographics, and collaborators), specific program evaluation measures (including cost, quality, access, outcomes, policy effectiveness, and other criteria, such as measures established by VA's Office of Quality and Performance) and budget justifications. ORH will review proposals based on the following criteria: the program's objectives, feasibility, innovation, budget, personnel, service area environment, evaluation, and the recommendations of relevant program offices. All programs receiving funding will be required to submit either monthly or quarterly reports that assess the number of

Veterans served, the funded amounts for all initiatives, program evaluation measures, and additional evaluation measures as defined by ORH. ORH will notify award recipients by May and begin disbursing funds at that time.

At the start of this Fiscal Year, VA opened three Rural Health Resource Centers: one in White River Junction, Vermont; another in Iowa City, Iowa; and the last in Salt Lake City, Utah. These centers develop special practices and products for use by facilities and networks across the country. Each Resource Center is identifying disparities in health care for rural Veterans within their regions. These Centers essentially serve as field-based clinical laboratories capable of experimenting with new outreach and care models. They also serve a crucial function in enhancing academic affiliations with nursing and medical schools and support direct outreach to Veterans.

As an example of the work the Centers are doing, the Eastern Rural Health Resource Center in White River Junction hosted a conference with nearly 100 participants on March 13–14 titled, "New Horizons in Human Health: Bringing Leading-Edge Medicine to Rural Communities." This conference was a collaborative effort between the Togus VA Medical Center, Eastern Maine Health Care, the Maine Institute for Human Geriatrics and Health, and the University of New England. The Resource Centers are also working with ORH to develop an evaluation methodology for the Maine Mobile Health Care Clinic to answer questions about the effectiveness of mobile clinics and their impact on Veteran enrollment and use. The Central Region's Rural Health Resource Center is conducting a telephone-based survey designed to assess structural and functional capabilities of community-based outpatient clinics (CBOCs) in urban and rural settings. Finally, the Western Region has hired a Native Consultant to help the Center examine the current health care policies for rural American Indian/Alaskan Native and rural Native Hawaiian Veterans. The report produced for each population will discuss next steps for policy development and prioritize recommendations for further work.

VA's ORH, during its short existence, has produced a number of programs that are actively improving the delivery and coordination of health care services to rural Veterans. VA is actively expanding the existing Home-Based Primary Care and Medical Foster Home programs (part of VA's Community Residential Care Program) into rural VA facilities with startup funding for Fiscal Year 2008 and partial funding for Fiscal Year 2009. Home-Based Primary Care provides comprehensive, interdisciplinary care to Veterans with chronic, complex diseases that worsen over time. This is a cost effective program for providing primary care services in the home, including palliative care, rehabilitation, disease management and coordination of care. Home-Based Primary Care can reduce Veteran travel time, which can avoid exacerbating chronic conditions.

ORH has also helped develop the "Geri" scholars program, in collaboration with VHA's Office of Geriatrics and Extended Care, to target VA geriatric providers in rural areas and provide them with an intensive course in geriatric medicine and a tailored training program on providing geriatric medicine in rural VA clinics with curricula and supportive activities based on a needs assessment of each participant. Currently, there is a severe shortage of VA physicians with training or certification in geriatric medicine, and VA currently lacks training for primary care clinicians in key aspects of geriatrics and extended care to older Veterans living in rural areas. This new training program consists of intensive didactic training in core issues related to the health care needs of older patients, mentoring curricula to support a model quality improvement process at each participating rural CBOC, and web-based education for interdisciplinary health care teams at CBOCs. Graduates of this program will disseminate this work within their home facility.

ORH is supporting expansion of the Mental Health Care Intensive Care Management-Rural Access Network for Growth Enhancement (MHICM–Range) Initiative to provide community-based support for Veterans with severe mental illness. VA has been adding mental health staff to CBOCs, enhancing our capacity to provide telemental health services and using referrals to Community Mental Health Services and other providers to increase access to mental health care in rural areas. ORH collaborated with the South Central Mental Illness Research, Education and Clinical Center in VISN 16 to fund four research studies investigating clinical policies or programs that improve access, quality and outcomes of mental health and substance abuse treatment services for rural and underserved Veterans.

VA has also taken the lead in opening new rural health care facilities, such as Rural Outreach Clinics. Last September, VA announced the opening of ten new Rural Outreach Clinics this Fiscal Year; four of these are currently operational, including sites in Houlton, ME; Perry, GA; Juneau, AK; and The Dalles, OR. VA utilizes Rural Outreach Clinics to offer services on a part-time basis, usually a few days a week, in rural and highly rural areas where there is insufficient demand for

full-time services or it is otherwise not feasible to establish a full-time CBOC. Rural Outreach Clinics offer primary care, mental health services, and specialty referrals. Each Rural Outreach Clinic is part of a VA network and meets VA's quality standards. Veterans use Rural Outreach Clinics as an access point for referrals to larger VA facilities for specialized needs.

VA recently announced a Mobile Health Care Pilot Project in VISNs 1, 4, 19, and 20. The vans associated with this program will be concentrated in 24 predominately rural counties, where patients would otherwise travel long distances for care. VA is focusing on counties in Colorado, Maine, Nebraska, Washington, West Virginia and Wyoming. This pilot will collaborate with local communities in areas our mobile vans visit to promote continuity of care for Veterans. It will also allow us to expand our telemedicine satellite technology resources and is part of a larger group of mobile assets. ORH is developing evaluation methodologies and measures to determine the effectiveness of this program and to identify areas for improvement.

Vet Centers also provide services and points of access to Veterans in rural communities. Vet Centers welcome home Veterans with honor by providing quality readjustment counseling in supportive, non-clinical environments. By the end of FY 2009, VA will have 271 Vet Centers and 1,526 employees to address the needs of Veterans; any county in the country with more than 50,000 Veterans will have services available through a Vet Center. A fleet of 50 Mobile Vet Centers are also being put into service this year and will provide access to returning Veterans and outreach to demobilization military bases, National Guard and Reserve locations nationally.

Recruiting providers in rural areas is a challenge for VA as well as the civilian community. ORH is working with VHA's Office of Academic Affiliations to develop a program expanding health profession training in rural VA facilities. The Rural Health Training Initiative selection process will be implemented this spring, with trainees scheduled to matriculate at rural health care access points beginning July 1, 2010.

VA is expanding the use of Internet-based venues for health care related job postings in addition to recruiting from the VA job board (VA Careers), which links to USAJobs.gov, and other job boards. The VHA Healthcare Retention & Recruitment Office is hiring recruiters who will concentrate on recruitment of health care providers for rural areas and as well as establishing a national contracts with search firms that target physician recruitment. This Office is developing other collaborative relationships with organizations focused on rural recruitment such as the National Rural Recruitment & Retention Network (www.3Rnet.org), increasing training courses specifically for practices related to rural recruitment issues, and hiring recruiters whose primary aim will be recruitment of physicians.

Similarly, VA has conducted outreach and developed relationships with the Department of Health and Human Services (including its Office of Rural Health Policy and the Indian Health Service), other agencies and academic institutions committed to serving rural areas. VA has also reached out through ORH to government and nongovernmental organizations, including the National Rural Health Association, the National Organization of State Offices of Rural Health, the National Institute of Mental Health Office of Rural Mental Health, the National Cooperative Health Networks, the Rural Health Information Technology Coalition, the Rural Assistance Center, the Rural Health Resource Center, the Georgia Health Policy Center, various rural health research centers, and other organizations to further assess and develop potential strategic partnerships. ORH is working in close collaboration with the Department of Health and Human Services to address the needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans to coordinate services with the Department of Health and Human Services' Health Resources and Services Administration Community Health Centers. These initiatives include a training partnership, technical assistance to Community Health Centers, and a seamless referral process from Community Health Centers to VA medical centers.

Importantly, VA is conducting "in-reach" within VA to identify needs and services relevant for rural Veterans. ORH works closely with the following offices and groups within the Veterans Health Administration (VHA): the Office of Mental Health Services, the Office of Care Coordination, the Office of Geriatrics and Extended Care, the Readjustment Counseling Service, the VHA Business Office, the VHA Finance Office, the Office of Academic Affiliations, the Healthcare Recruitment and Retention Office, the Office of Health Information, the National Center for Patient Safety, the Office of Public Health and Environmental Hazards, the Office of Quality and Performance, the Office of Research and Development, the Employee Education System, and the Office of Operations and Management. ORH also works closely with the Department's Office of Policy and Planning, Office of Information and Technology and Office of General Counsel.

Last year, Congress passed Public Law 110–387, the Veterans' Mental Health and Other Care Improvements Act of 2008. Section 107 of Public Law 110–387 directs VA to conduct a pilot program in at least three VISNs to evaluate the feasibility and advisability of providing OEF/OIF Veterans with peer outreach and support services, readjustment counseling services, and other mental health services through arrangements with, among others, community mental health centers. VA's Office of Mental Health Services and ORH are in the process of implementing this pilot program. The pilot will be conducted in a number of stages evaluating:

- the identification of rural areas that are beyond the reach of VA's mental health services for Veterans but have other mental health providers capable of providing high quality services;
- the willingness and capability of these entities for providing outreach and treatment services for returning Veterans;
- the feasibility of developing performance based contracts with these entities that meet the requirement of Section 107; and
- the use of services and the outcomes of care provided through these contracts.

Section 403 of the law requires VA to conduct a pilot program that would provide non-VA care for highly rural enrolled Veterans in five VISNs. VA is working to implement this pilot while resolving two questions. First, VA must develop a regulation to define the "hardship provision" in Section 403(b)(2)(B). Second, we must reconcile how VA has traditionally defined "highly rural" (based on Census data as discussed above) and how the statute defines it. VA's next steps involve identifying qualifying communities, identifying local providers willing and able to participate, and beginning with acquisition and exchanges of medical information as well as addressing pharmacy benefits and performance criteria for contracts and care. However, it is important to note VA already has the authority to contract with the most appropriate provider when VA is unable to provide necessary services. During FY 2008 VA expended $248 million for inpatient and outpatient services, including long term and home health care, purchased by contract in rural areas. An additional $1.04 billion was expended on a fee-for-service basis in rural areas for Veteran health care.

Mr. Chairman, VA's Office of Rural Health is reaching across the Department to coordinate and support programs aimed at increasing access for Veterans in rural and highly rural communities. We work closely with the Office of Care Coordination and our colleague, Dr. Darkins, in this regard. Thank you once again for the opportunity to discuss VA's continuing efforts for rural Veterans. We are prepared to address any additional questions you might have.

Statement of Hon. Henry E. Brown, Jr.,
Ranking Republican Member,
Subcommittee on Health

Thank you Mr. Chairman.

I appreciate your holding this hearing to take a close look at how the Office of Rural Health is working and being funded.

Congress took a significant step in 2006 when we created a new Office of Rural Health within VA to address the unique needs of veterans living in rural areas. And, I appreciate your holding this hearing to take a close look at how this new office is working and being funded.

It is important that new and emerging technologies are being considered to help effectively bridge the distance gap. The expanded use of telehealth, while not a cure-all, can alleviate some of the distance-based challenges in the areas of primary care, mental health and even long-term or home-based care. I expect that our VA witnesses will provide us with details on what is currently being accomplished in this area and what we can anticipate in the future.

Equally important to the use of new technologies, we must also expand partnerships with the local health care community to provide care closer to the veteran's home. Last year, the Rural Veterans Access to Care Act, legislation sponsored by my good friend and colleague, Jerry Moran, was enacted into law as a pilot program in Public Law 110–387. Although this hearing is not focused on this important measure, Chairman Michaud has assured me that we will have a future hearing dedicated to the implementation of the law later in the year.

In closing, I would like to extend a special welcome to one of our witnesses on the first panel, Dr. Graham Adams. He serves as the CEO and provides overall supervision and direction for the South Carolina Office of Rural Health. Dr. Adams

has consistently worked collaboratively with clinicians, administrators, educations, legislators, community and civic leaders and state and Federal agencies to improve access to quality health care in rural communities.

I am looking forward to listening to and learning from his experiences and that of all of our witnesses.

And, with that, Mr. Chairman, I yield back.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
March 30, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20240

Dear Secretary Shinseki:

Thank you for the testimony of Dr. Adam Darkins, Chief Consultant to the Office of Care Coordination, Veterans Health Administration, and Ms. Kara Hawthorne, Director of the Office of Rural Health, Veterans Health Administration, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Oversight Hearing on "Closing the Health Gap of Veterans in Rural Areas: Discussion of Funding and Resource Coordination" that took place on March 19, 2009.

Please provide answers to the following questions by May 11, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. To date, the VA has awarded about $46 million of the $250 million appropriated for the rural health initiative. Why did the VA choose to phase the grant award instead of fully allocating the $250 million up front?
2. Of the $46 million awarded to date, $22 million was awarded to the VISNs based on the number of rural veterans living in the VISN. The VISN awards ranged from as little as $250,000 to $2.5 million. How did the VA determine the size of the grant award? Is $250,000 sufficient funding for the VISNs to accomplish what you outlined in your testimony?
3. The VA will require the VISNs to submit a quarterly report to track the funding use and to report on their accomplishments. When is the next quarterly report due? Will this information be provided in the required quarterly report to the Appropriations Committee on the uses of $250 million?
4. Of the $46 million awarded to date, $24 million went to sustain FY 2008 Office of Rural Health programs and projects. Please submit for the record the funding amounts associated with the programs that received this money.
5. To allocate the remaining funds from the appropriated $250 million, the VA has set up a program review panel consisting of relevant program directors across the VA. Please identify the panel members.
6. Please also walk us through the timeline for awarding funding. Please explain how the VA will determine its success or shortcomings in meeting the original intent of the appropriated funding or establish and implement a rural health outreach and delivery initiative.
7. How will the VA ensure that local VISNs and program offices leverage this funding to help close the rural health gap?
8. How does the Office of Rural Health ensure that its efforts do not duplicate that of other offices in the VA, such as the Office of Care Coordination?
9. In your testimony, you highlighted the outreach and the "in-reach" the Office of Rural Health has conducted. Please expand on this and explain the specific nature of the collaboration and coordination that has resulted from these relationships.

In addition, please answer the following questions for Representative Ciro Rodriguez.

1. Your testimony reported that VISNs with less than 3 percent rural veterans received $250,000, VISNs with 3 to 6 percent received $1 million, and VISNs with more than 6 percent received $1.5 million to sustain current programs, initiate pilot programs, and establish new outpatient clinics. Please provide any details available on how much VISN 17 and VISN 18 received and what specific programs in those VISNs are to receive portions of these allocated funds.
2. What were the recommendations for enhancing rural veteran access to health care resulting from the March 13–14 conference in White River Junction entitled "New Horizons in Human Health: Bringing Leading Edge Medicine to Rural Communities"? Which recommendations are being considered for Department-wide implementation?

3. Are there any plans to open a Rural Outreach Clinic in Texas District 23 (VISNs 17 and 18), such as the ones mentioned in your written testimony?
4. Why was VISN 18 not selected for the Mobile Health Care Pilot Project mentioned in your testimony?
5. To what degree has the VA considered or used mobile surgery units and screening units, such as those provided by Mobile Medical International, for operational/surgical, ambulatory, or medical screening in remote rural areas? Are these types of units being considered for use in VISN 18?
6. Based on your statements about the section 403 Pilot Program, when do you expect these issues to be resolved and the pilot program actually implemented?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by May 11, 2008.

Sincerely,

MICHAEL H. MICHAUD
Chairman

CW/jb

Prepared Questions for the Record
Hon. Michael Michaud,
Chairman, Subcommittee on Health,
House Committee on Veterans' Affairs
Closing the Health Gap of Veterans in Rural Areas:
Discussion of Funding and Resource Coordination
March 19, 2009

Question 1: To date, VA has awarded about $46 million of the $250 million appropriated for the rural health initiative. Why did VA choose to phase the grant award instead of fully allocating the $250 million up front?

Response: The Department of Veterans Affairs (VA) chose to disburse funds from the $250 million included in this year's budget appropriation in phases to ensure the funds were allocated properly to achieve the greatest possible advances in reducing the health care gap for rural Veterans. VA recognized there were immediate needs in rural and highly rural areas across the country and provided initial seed money (approximately $22 million) with specific guidelines on allocation to Veterans Integrated Service Networks (VISN) to support their rural health programs in compliance with Public Law (P.L.) 110–329, *the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009*.

On March 19, 2009, VA testified that $24 million of the $250 million allocated to VA for a rural health initiative in P.L. 110–329 was being used to support continuing programs from fiscal year (FY) 2008 into FY 2009. VA has since decided to fund these programs out of the Office of Rural Health's (ORH) base budget. Consequently, of the $250 million included in this year's appropriations bill, VA has only allocated approximately $22 million. The remaining funds will be used to support programs proposed by program offices and VISNs; these proposals have been reviewed for merit and feasibility by a panel and have been approved by Veterans Health Administration (VHA) leadership. ORH has informed the recipients of these funds and disbursements are underway.

As rural solutions are market driven, VA wanted to provide VISNs and program offices more planning time and the opportunity to compete for the remaining funds to support their initiatives that resolve local health issues and hold promise for regional or national adoption. These proposals would support programs in six key areas of focus including access, quality, technology, workforce, education and training, and collaboration strategies.

Additionally, projects could include leveraging existing proven initiatives (such as increasing access points in rural and highly rural areas by establishing outreach clinics in areas not meeting VA's drive time guidelines or deploying mobile clinics); structuring initiatives to expand fee-basis care; developing collaborations with Federal and non-Federal partners, accelerating telemedicine deployment, or funding innovative pilot programs.

Question 2: Of the $46 million awarded to date, $22 million was awarded to the VISNs based on the number of rural Veterans living in the VISN. The VISN awards ranged from as little as $250,000 to $2.5 million. How did VA determine the size

of the grant award? Is $250,000 sufficient funding for the VISNs to accomplish what you outlined in your testimony?

Response: ORH worked with the Deputy Under Secretary for Health for Operations and Management to ensure the unique interests of rural Veterans were considered. In December 2008, VA provided $21.75 million directly to VISNs to help them immediately implement programs to improve services for rural Veterans. This funding is part of a 2-year program focusing on initiatives such as new technologies, provider recruitment and retention incentives, and cooperation with other organizations at the Federal, State and local levels. Facilities are using these funds to sustain current programs, initiate pilot programs, and establish new outpatient clinics.

VA distributed the initial resources according to the proportion of Veterans living in rural and highly rural areas within each VISN: VISNs with less than 3 percent of their patients in rural areas received $250,000; those with between three and 6 percent received $1 million; and those with 6 percent or more received $1.5 million. VISNs were directed to identify programs that could develop innovative strategies, care delivery models, educational initiatives, technology uses and other approaches to enhance health care service delivery and outreach for rural Veterans in compliance with P.L. 110–329.

For the three VISN's that received $250,000, the initial seed money was adequate based on their unique rural health needs. If more funds are required, those VISNs can apply for additional funds under the February 2009 ORH Funds Distribution Program Guidance.

Question 3: VA will require the VISNs to submit a quarterly report to track the funding use and to report on their accomplishments. When is the next quarterly report due? Will this information be provided in the required quarterly report to the Appropriations Committees on the uses of $250 million?

Response: Senate Appropriations Report No. 110–428, which accompanied the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2009, directed VA to report quarterly to the House and Senate Committees on Appropriations on new rural health initiatives implemented as a result of the funding. The current report is nearing final clearance through VA leadership and VA expects to furnish it by May 30, 2009. This report will contain additional information on the VISN funding allocations.

Question 4: Of the $46 million awarded to date, $24 million went to sustain FY 2008 Office of Rural Health programs and projects. Please submit for the record the funding amounts associated with the programs that received this money.

Response: ORH, in conjunction with VHA program offices, supported a range of initiatives in FY 2008, and VA has allocated funds to sustain those programs in FY 2009 out of ORH's base budget. VA originally testified that a portion of the $250 million included in P.L. 110–329 would be used to fund these efforts. The chart below provides specific amounts for each initiative.

ORH Funded Initiatives	FY 2009 Funding
Veterans Rural Health Resource Centers	$6,600,000
VISN Rural Consultants	$1,200,000
Veterans Rural Health Advisory Committee	$300,000
Rural Outreach Clinics	$3,600,000
Rural Mobile Health Care Clinics	$2,100,000
Home Based Primary Care Rural Expansion	$1,500,000
Medical Foster Home Expansion	$600,000
Geri Scholars Program	$500,000
Idea Award Funding	$2,000,000
Contract Support	$5,000,000
Veterans Sessions Educational Sessions	$600,000
TOTAL FUNDING	$24,000,000

Question 5: To allocate the remaining funds from the appropriated $250 million, VA has set up a program review panel consisting of relevant program directors across VA. Please identify the panel members. Please also walk us through the timeline for awarding funding.

Response: ORH requested that both VISNs and program offices submit proposals to fund additional initiatives to support rural and highly rural Veterans within their areas of operations. The deadline for proposals was March 20, 2009. A panel with representatives from program offices across VA is reviewing proposals for compliance with P.L. 110–329 and prioritizing them based on merit and feasibility. ORH presented its final selection to VHA leadership on April 14, 2009, and submitted selected proposals to the appropriate program offices for review and concurrence to ensure the project(s) were consistent with the program office mission and plans. Based on the overwhelming response from the VISNs and program offices, ORH projects the remaining funds will be fully allocated during the third quarter of FY 2009.

The ORH P.L. 110–329 Review Panel membership includes rural health resource center directors, VISN rural consultants, key program office representatives, senior VA staff professionals (including chief officers, deputy chief officers, network directors, and deputy directors), and other subject matter experts.

Question 6: Please explain how VA will determine its success or shortcomings in meeting the original intent of the appropriated funding or establish and implement a rural health outreach and delivery initiative.

Response: A key requirement of the ORH funding guidance is that project objectives must be consistent with ORH's mission and that they adhere to the legislative requirements of P.L. 110–329. In addition to the stated primary requirements, ORH will evaluate project development and execution through review of the periodic project reports.

All programs receiving funding will be required to submit quarterly reports that assess the number of Veterans served, key program indicators, and additional evaluation measures as defined by ORH. Specifically, all funded projects are required to adhere to the reporting requirements detailed below:

a. Quarterly reports that present a summary of issues and accomplishments, the numbers of Veterans served, funded amounts for all initiatives, and program evaluation measures (specific to each project) as proposed in each project proposal using a standard format;
b. A final report that summarizes the entire period of performance, due at the end of the performance period;
c. Stated deliverable(s) from proposal; and
d. Additional reports, which may be required as stipulated during award negotiations.

Question 7: How will VA ensure that local VISNs and program offices leverage this funding to help close the health care gap?

Response: ORH is working with VISNs and program offices to identify projects and programs that will develop innovative strategies and care delivery models to enhance health care delivery and outreach to rural Veterans. VISN and program office initiatives are expected to support projects in six key areas of focus: access, quality, technology, workforce, education and training, and collaboration strategies. To support their efforts ORH has supplied evaluative criteria to VISNs, including how objectives compare to legislative requirements, how significant the potential and likely impacts of the program are for rural Veterans, whether there is programmatic relevance and adherence to the award's intent, and whether the budget is appropriate for the proposal. Additionally, each project is required to submit a list of measures that they will be monitoring to determine program effectiveness.

Question 8: How does the Office of Rural Health ensure that its efforts do not duplicate that of other offices in VA, such as the Office of Care Coordination?

Response: ORH is conducting ongoing "in-reach" within VA to identify needs and services relevant for rural Veterans. Soon after ORH was created, VA conducted an assessment to determine the most challenged areas in terms of drive time access. ORH also spent time developing and building a robust infrastructure to continue to learn about rural Veterans and how best to serve this population through the development and execution of pilot projects, promotion of rural health issues through education, training and information dissemination, engagement in VISN level strategic planning, and relationship building with community partners.

ORH also immediately began collaborating with, and learning from, the already established VHA program offices and VA staff. ORH sought to learn what services were already provided and to use the input and guidance to assist ORH in identifying necessary actions and how best to deploy ORH funds. ORH recognized there were successful programs already in place and did not want to use resources to duplicate services.

ORH continues working with offices and groups across VA to ensure efforts are unique and consistent with program offices' goals and missions.

Question 9: In your testimony, you highlighted the outreach and the "in-reach" the Office of Rural Health has conducted. Please expand on this and explain the specific nature of the collaboration and coordination that has resulted from these relationships.

Response: ORH has collaborated with other offices within VA to identify current or emerging solutions for rural Veterans. For example, by working with the Deputy Under Secretary for Health for Operations and Management, ORH was able to fund 10 additional rural outreach clinics, while cooperation with the Readjustment Counseling Service helped deploy 4 mobile health clinics in rural areas. ORH's work with the Office of Patient Care Services resulted in plans to expand telehealth, geriatrics and extended care initiatives, and mental health initiatives. Specifically, VA is actively expanding the existing home-based primary care and medical foster home programs into rural VA facilities with start-up funding for FY 2008 and partial funding for FY 2009. ORH has also helped develop the Geri Scholars program, in collaboration with the VHA Office of Geriatrics and Extended Care, to target VA geriatric providers in rural areas. ORH is also supporting expansion of the *Mental Health Care Intensive Care Management-Rural Access Network for Growth Enhancement* initiative to provide community-based support for Veterans with severe mental illness. VA has added mental health providers to community based outpatient clinics (CBOC), enhancing capacity to provide tele-mental health services and using referrals to community mental health services and other providers to increase access to mental health care in rural areas.

Recognizing rural communities have limited capital for health information technology investment, the likelihood for rapid changes in technology, and the absence of national technical standards pose additional challenges; ORH has worked closely with the VHA Chief Information Office to expand My Health*e*Vet, which offers Veterans access to their personal health record any time, any where. ORH is also investing in health information exchanges and regional health information organizations that have been created in many localities to test the electronic exchange of protected health information, and VA is establishing connections with these successful networks.

Most importantly, ORH has used the expertise and guidance of representatives throughout VA—including VISN directors, chief officers of different programs, the Office of General Counsel, the Office of Information Technology, VHA's Chief Business Office, and VHA's Chief Financial Office—to develop strategies, guidance, and measures for allocating ORH's appropriated funds. This inclusive approach reaches across business lines throughout the organization.

Hon. Ciro Rodriguez

Question 1: Your testimony reported that VISNs with less than three percent rural Veterans received $250,000, VISNs with three to six percent received $1 million, and VISNs with more than six percent received $1.5 million to sustain current programs, initiate pilot programs, and establish new outpatient clinics. Please provide any details available on how much VISN 17 and VISN 18 received and what specific programs in those VISNs are to receive portions of these allocated funds.

Response: VISN 17 received $1 million in initial funding. Of this, $333,334 has been obligated to three initiatives. The first is the expansion of home health services. This initiative will expand services using existing contracts with home health agencies and includes the Southern Oklahoma counties of Bryan and Choctaw and the Northern Texas counties of Cooke, Delta, Fannin, Grayson, Hopkins, Hunt, Lamar and Red River. The second initiative expands telemedicine access for mental health compensation and pension (C&P) exams for rural Veterans in the Central Texas Veteran Health Care System. This project will install additional telemedicine equipment for C&P exams at the CBOC in Brownwood and Palestine, TX. The third initiative expands contract nursing home care to rural Veterans who do not have access to VA nursing homes and will cover a service area of 15 rural counties through contracts with 20 non-VA nursing homes. VISN 18 received $1 million in funding to be used to support fee-basis programs that provide care to rural and highly rural Veterans who are eligible for fee-basis care. These programs will strive to decrease the drive time for rural and highly rural Veterans.

Question 2: What were the recommendations for enhancing rural Veteran access to health care resulting from the March 13–14 conference in White River Junction entitled, "New Horizons in Human Health: Bringing Leading Edge Medicine to Rural Communities"? Which recommendations are being considered for Department-wide implementation?

Response: The following recommendations were discussed at the *New Horizons in Human Health: Bringing Leading Edge Medicine to Rural Communities* meeting and are being considered for broader implementation:

- Considering the use of existing medical resources in remote locations rather than attempting to build new VA facilities in these areas;
- Expanding telehealth presence in rural areas to overcome transportation barriers;
- Integrating VA rural health efforts with other Federal rural initiatives (such as partnering with federally qualified health centers and rural health centers);
- Reducing VA administrative barriers to private sector partnership (for example, contracting regulations); and
- Making VA more of a two-way player when it comes to sharing medical information across systems.

Question 3: Are there any plans to open a Rural Outreach Clinic in Texas District 23 (VISNs 17 and 18), such as the ones you mentioned in your written testimony?

Response: VHA has not developed plans to open a Rural Outreach Clinic in Texas District 23. However, VISN 17 awarded a contract to LifeLine Mobile for a mobile clinic, based out of Laredo and McAllen, TX which will visit designated cities every other week. The mobile clinic will provide primary care, mental health care, immunizations and education services to Veterans living in Texas in Rio Grande City (Starr County), Roma (Starr County), Zapata (Zapata County), Falfurrias (Brooks County), Hebbronville (Jim Hogg County), and Port Isabel (Cameron County). Veterans living in the southern end of District 23 including the counties of Kinney, Maverick, Uvalde, Medina, Zavala, Dimmit and Bexar are proximate to the contract awarded for the LifeLine Mobile Clinic, and may have opportunities to use these services. South Texas Veterans Health Care System (VAHCS) has done a market analysis of the 11 counties they support and the West Texas VAHCS (VISN 18) continues to review care services support opportunities within its area of Congressional District 23.

Question 4: Why was VISN 18 not selected for the Mobile Health Care Pilot Project mentioned in your testimony?

Response: In FY 2008, a mobile fleet strategic plan workgroup was established to assess VHA assets and to develop ORH pilot project initiatives. ORH worked in collaboration with the workgroup to draft a request for proposals to initiate a rural mobile health care clinic pilot project to enhance the delivery of care for Veterans in rural areas. ORH received applications from VISNs 1, 4, 10, 17, 18, 19, 20, and 21 requesting funds for both purchases and operations. The process was competitive and an interdisciplinary team scored and ranked applications. The application proc-

ess focused on three critical issues: the geographic area to be served, the projected impact, and operational plans. The application rating criteria covered five areas:

- Improving access to services in rural area;
- Soundness of operational plan;
- Collaborations with community and other partners;
- Use of telemedicine;
- Innovation and program uniqueness; and
- Veteran population.

The four-member review panel recommended VISNs 19, 1, and 4, in rank order, to receive funding for purchase and operations. Based on this competitive process, VISN 18 did not rank high enough relative to the other VISN applicants to be considered for funding.

Question 5: To what degree has VA considered or used mobile surgery units and screening units, such as those provided by Mobile Medical International, for operational/surgical ambulatory, or medical screening in remote areas? Are these types of units being considered for use in VISN 18?

Response: Rural health mobile clinics funded by ORH provide primary and mental health care, screening and limited specialty care. They are not designed to provide higher intensity care such as surgical procedures. Currently, VISN 18 is not pursuing such units.

Question 6: Based on your statements about the section 403 Pilot Program, when do you expect these issues to be resolved and the pilot program actually implemented?

Response: Section 403 of Public Law 110–387 requires VA to conduct a pilot program that would provide non-VA care for highly rural enrolled Veterans in five VISNs. VA is working to implement this pilot while resolving two issues: 1) VA must develop a regulation to define the "hardship provision" in Section 403(b)(2)(B); and 2) VA must reconcile how it has traditionally defined "highly rural" and how the statute defines it. VA's next steps involve identifying qualifying communities, identifying local providers willing and able to participate, and beginning with acquisition and exchanges of medical information, as well as addressing pharmacy benefits and performance criteria for contracts and care.

On March 17, 2009, VA met with staff from both the House and Senate Committees on Veterans' Affairs to provide an update on the pilot program. VA and the Committees staffs discussed the hardship provision from (b)(2)(B) and the statute's definition of "highly rural". VA proposed potential approaches to resolve these concerns and we are awaiting guidance from both Committees. In the interim, VA continues to work on this pilot program in accordance with the statute.

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