AN EXAMINATION OF RURAL AND NATIVE AMERICAN VETERAN ACCESS TO CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

WEDNESDAY, AUGUST 27, 2014

Serial No. 113–85

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE
96–128 WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

JEFF MILLER, Florida, *Chairman*

DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida, *Vice-Chairman*
DAVID P. ROE, Tennessee
BILL FLORES, Texas
JEFF DENHAM, California
JON RUNYAN, New Jersey
DAN BENISHEK, Michigan
TIM HUELSKAMP, Kansas
MIKE COFFMAN, Colorado
BRAD R. WENSTRUP, Ohio
PAUL COOK, California
JACKIE WALORSKI, Indiana
DAVID JOLLY, Florida

MICHAEL H. MICHAUD, Maine, *Ranking Minority Member*
CORRINE BROWN, Florida
MARK TAKANO, California
JULIA BROWNLEY, California
DINA TITUS, Nevada
ANN KIRKPATRICK, Arizona
RAUL RUIZ, California
GLORIA NEGRETE McLEOD, California
ANN M. KUSTER, New Hampshire
BETO O'ROURKE, Texas
TIMOTHY J. WALZ, Minnesota

JON TOWERS, *Staff Director*
NANCY DOLAN, *Democratic Staff Director*

SUBCOMMITTEE ON HEALTH

DAN BENISHEK, Michigan, *Chairman*

DAVID P. ROE, Tennessee
JEFF DENHAM, California
TIM HUELSKAMP, Kansas
BRAD R. WENSTRUP, Ohio
JACKIE WALORSKI, Indiana
DAVID JOLLY, Florida

JULIA BROWNLEY, California, *Ranking Member*
CORRINE BROWN, Florida
RAUL RUIZ, California
GLORIA NEGRETE McLEOD, California
ANN M. KUSTER, New Hampshire

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

CONTENTS

Wednesday, August 27, 2014

AN EXAMINATION OF RURAL AND NATIVE AMERICAN VETERAN ACCESS TO CARE

Wednesday, August 27, 2014

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

The subcommittee met, pursuant to notice, at 9:59 a.m., at the Veterans of Foreign Wars Post 2780, 3400 Veterans Drive, Traverse City, Michigan, Hon. Dan Benishek [chairman of the subcommittee] presiding.

Present: Representatives Benishek and Brownley.

OPENING STATEMENT OF DR. DAN BENISHEK, CHAIRMAN

Mr. BENISHEK. Thank you, gentlemen. The subcommittee will come to order. Good morning and thank you all for joining us today. I'm Dr. Dan Benishek, and it's my honor to be both your congressman and the Chairman of the Subcommittee on Health for the Committee on Veterans' Affairs of the United States House of Representatives.

I'm joined here today by Congresswoman Julia Brownley, the ranking member of the Subcommittee on Health, Representative of the 26th District of California. Ranking Member Brownley is a steadfast leader and advocate for our service members and veterans. I am grateful to her for joining us today in Traverse City.

Before I go any further, I would like to ask all of our veterans in the audience today to please stand, if you are able, or raise your hand and be recognized.

[Applause.]

Mr. BENISHEK. Thank you so very much for your service. We are here today for you and to make sure that the care that you and your fellow veterans in Michigan and around the country receive through the Department of Veterans Affairs is timely, accessible, convenient, and high quality.

It is no secret that the VA is in crisis and has fallen far short of providing the care and services that our veterans have earned, deserve and should expect. Just five months ago a committee investigation, along with numerous whistleblower revelations from conscientious employees, exposed widespread corruption and systemic access delays and accountability failures across the VA Health Care System.

As a result of VA's incompetence, thousands of veterans, including some right here in Michigan, were left waiting for weeks, months, and even years to receive the care they needed. I want to

assure you all that my response to the scandal was swift and aggressive.

I was honored to be joined by my colleagues in the House and the Senate from both sides of the aisle in a conference committee that just a few weeks ago created a bipartisan agreement that Congress passed, and the President signed into law, to improve accountability for VA employees, increase access to care for veteran patients, and pave the way for long-term cultural and structural reforms throughout the VA Health Care System.

This law is not perfect, and the problems at VA will not be solved overnight; however, this bill for the first time will allow veterans suffering long waiting times for care the option to be seen by local doctors. This effort is the best chance we've had in years to make fundamental changes to the way VA operates.

Much more needs to be done. And my work will not be complete until all of our veterans receive the care and treatment they've earned and they deserve. The time for excuses is over. The time for action is now.

For 20 years, it is my privilege to serve as a physician at the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan. From that experience I learned firsthand from veteran patients I treated and hard-working care providers I worked with about the many challenges and frustrations they face when attempting to access or provide healthcare throughout our nation's second largest bureaucracy.

Our veterans fought for our freedom. They shouldn't have to fight bureaucrats when they return home. Those challenges and the frustrations are nowhere more apparent than where our Native American and rural veterans are concerned.

During today's hearing we will discuss the issues these veterans face here in our community. We will hear testimony from tribal and local leaders, veterans, and VA employees. Their input, expertise, and advice is critical to informing the work we do in Washington, and I am grateful to each of them for agreeing to speak on the record here today and for all of you in the audience for joining us. Thank you so much for being here.

Before I yield to Ranking Member Brownley, I would like to take a moment to recognize and thank the VFW Post 2780 for allowing us to use their hall this morning and for their assistance in preparing and setting up for the hearing. And, again, for the Honor Guard for their work and contribution, as well. Thank you for having us this morning.

With that, I would like to recognize Ranking Member Brownley for any opening statement she may have.

Ms. BROWNLEY. Thank you, Mr. Chairman. You must not have had your microphone on. Thank you, Mr. Chairman, and thank you for your extraordinary leadership on this committee and the committee as a whole and for continuing to keep the issue of access to quality and timely services provided to our rural veterans and our Native American veterans at the forefront of this subcommittee.

And thank you to all of our witnesses here today for coming and talking with us about the critical issues that have plagued the Department of Veterans Affairs. I hope that with your help and testimony we may find a better way to move forward.

I'd also like to thank all of you in the audience who are here today in support of our veterans. Today's hearing will examine the progress VA has made in serving Native American veterans and rural veterans in Northern Michigan. We will particularly look at the issues of non-VA care, telehealth and transportation services. I am pleased to be here today to support the Chairman and look forward to hearing the testimony of all of the witnesses.

Like Chairman Benishek, I believe caring for our veterans is an ongoing responsibility of our nation. As these brave men and women have sacrificed so much, the country must ensure resources are available and programs in place to address their needs during and after their transition to civilian life.

The difficulty of providing care to rural veterans and Native American veterans is not new and presents some complex problems. Issues such as lack of transportation, lack of access to technology, and VA reluctance to turn to the community to help support our veterans through contracting of care closer to home are ones that this subcommittee has examined many, many times. And, in fact, we have passed legislation to address some of these concerns, but more needs to be done.

While this hearing will focus on access to care in Northern Michigan, I meet regularly with veterans in my home district of Ventura County, California, who face similar challenges regarding the long drive times to get to our regional medical center and the long wait times for appointments.

We all know about the current crisis that has embroiled the VA for months now: Untenable wait times, misleading and manipulation of data, gross mismanagement. I think we can agree that this crisis did not develop overnight and will not be fixed overnight; however, our committee also has a responsibility to assist the VA on the road to recovery.

We want the VA to be viewed as an employer of choice and to be able to attract people who want to serve our veterans. The Department has allocated over 450 million—has allocated over 450 million system-wide to implement the Access to Care Initiative. I look forward to hearing from the VA today just how much of that funding they have received here in VISN 11 and how it has been used to open up access and services to our deserving veterans.

I would also like to hear from the VA what progress is being made in working with the Native American community through the memorandums of understanding that have been signed by VA and the Indian Health Service. I understand that the two agencies are working together, but could increase collaboration and oversight to ensure that Native American veterans have access to quality care closer to where they reside.

I am hopeful that this will be an honest, open discussion on ways to provide the care needed such as more partnering with the public and private sector, increasing the pool of providers, and other creative ways to address the gaps in health treatment and services.

And finally I would be remiss if I did not recognize the dedication of the VA employees who provide quality healthcare to our veterans every day. Thank you for all that you do for our nation's veterans.

And, again, Mr. Chair, I thank you for your extraordinary leadership and being a great mentor to me as a new member of the Committee. I want all of your constituents here to know how—what an important member you are to this Committee, and clearly your leadership specifically on health issues for our veterans. Thank you, Mr. Chair, and I would yield back.

Mr. BENISHEK. Thank you, Ms. Brownley. We are going to begin today's hearing with our first panel of witnesses who are already seated at the witness table. Before I introduce the panelists, I'm just going to gently remind you all how this all works. We have a 5-minute limit on the testimony. We ask you all to stay within that five minutes. The green light says you're good, the yellow light says you've got a minute left, and the red light means you hit the five minutes. So we want to have the opportunity for everyone to testify. And then we will take turns asking questions after you've all testified, and we have five minutes each, so it goes back and forth, we each have an opportunity to do questions. We may go back and forth two times depending how the time goes.

Then we will allow the second panel to come up, and then they will testify, and then we will ask them questions as well. We typically have VA go up last. So thank you for that consideration.

With us on the first panel this morning is Fred Kiogima, the Ogema of the Little Bay Traverse Band of Odawa Indians; Curtis Chambers, a veteran and a community leader in Cheboygan; Carl Archambeau, the Post Commander of the Veterans of Foreign Wars Post 2780 here; Lieutenant Colonel Retired Linda Fletcher of the U.S. Army Nurse Corps and Executive Director of a Matter of Honor; and Chuck Lerchen, a Veteran Service Officer for the Grand Traverse Region.

I am so grateful to each of you for your willingness to be here this morning to speak candidly about the issues of importance to our veterans in our community. I'm honored and privileged to have you here.

With that, we will begin with Ogema Kiogima. Mr. Chairman, you are recognized for five minutes.

STATEMENTS OF FRED KIOGIMA, TRIBAL CHAIRMAN, LITTLE TRAVERSE BAY BAND OF ODAWA INDIANS; CURTIS CHAMBERS, VETERAN; CARL ARCHAMBEAU, COMMANDER, VETERANS OF FOREIGN WARS POST 2780; LINDA FLETCHER LTC (RET.), EXECUTIVE DIRECTOR, A MATTER OF HONOR; CHARLES R. LERCHEN, A.C.V.S.O., DIRECTOR OF VETERANS SERVICES, GRAND TRAVERSE, LEELANAU, AND BENZIE COUNTIES

STATEMENT OF FRED KIOGIMA

Mr. KIOGIMA. Good morning. I am Fred Kiogima, the Tribal Chairman of the Little Traverse Bay Bands of Odawa Indians in Harbor Springs, Michigan, and I respectfully submit this written testimony into the record for the House Committee on Veterans' Affairs hearing on August 27th, 2014.

Mr. BENISHEK. Without objection, so entered.

Mr. KIOGIMA. On behalf of the Little Traverse Bay Bands of Odawa Indians, I would like to thank all those responsible for in-

viting us to provide testimony at this hearing. We are most appreciative to have this opportunity to bring our concerns to light.

To address every concern that is within our purview in our work with the local VA reps at the county, state and federal level would be an enormous task; however, what I will focus on today is a list of issues that are most critical to us at Little Traverse Bay Bands of Odawa Indians.

We do have a Veterans Liaison Office established within our tribe; the coordinator was trained and certified by the VA reps and worked hand in hand with all the levels of the VA system.

And I do thank Jim Alton, the Emmet County Vet Rep, who helped train our tribal liaison.

We do have—we currently have in excess of 145 veterans within our tribe. Identifying all of our vets is an ongoing process. Some of our vets are from World War II, like my father; I'm a retired Gunnery Sergeant from the United States Marine Corps and a veteran of Central America, Desert Storm, Somalia and served in support of Iraqi Freedom. We also have active duty Ogichidaawok "Warriors" that are still deployed.

Paramount to our Zhimaaganishak or veterans is the ability or inability to let them know about all the programming. What's available, what time frames, active, inactive, National Guard, retired.

The second point is different wars are noted for different issues and concerns, and to clarify those, for example, would be the Vietnam—Agent Orange, Desert Storm—trying to get on; the registry, the current war in Iraq and Afghanistan—traumatic brain injury, PTS.

The third one is direct client assistance is a concern for us; i.e., emergency funding for vets in need, homelessness, job training.

Four: Clarifying the difference between peacetime and combat times. It's confusing to many veterans that have served, why the distinction, and what category was the Cold War. It always leads to a conversation of the Cold War was an accepted war, but it's always listed as the Cold War.

There needs to be a better PR effort sent out to the veterans to offset the impact of budget cuts, sequestration, and all the bureaucratic nightmares that are still being encountered on a daily basis.

Six: For many veterans, they still seem to associate VA healthcare as substandard and cumbersome.

Accessing VA care is a continuing journey for many, without a clear roadmap, and the rules and regulations seem to change on a whim.

Number 8, there is always room for better cultural competency at VA clinics and hospitals.

We have been working with our health clinic and the VA to iron out some details on reimbursement. There is such a long trail to walk with the VA to get movement on that, and we are continually and actively pursuing that.

With that being said, we know that also in Alaska with the tribal village clinics out there, the VA does work hand in hand with them. And that is—I was up in Alaska about a month and a half ago, talking to their reps. It's a system that works, tribal and non-tribal access those clinics. And it's a very functional way to work.

Why would a non-tribal veteran have to fly down to Seattle or some other place when they can do it in Alaska at a tribal village clinic. If the stickler is the reimbursement part of it, that is what needs to be fixed. Our veterans need access, whether they're tribal or non-tribal. It's a lot easier to get that if the clinic is right there in that same village.

We are very rural nature here in Michigan. And we know that. But that's one of the things that we definitely need to look at, is working with the tribal clinics and the VA to iron out the reimbursement issues so we're servicing all veterans.

Having had access to the VA Health System for minimal appointments myself, I can understand the frustration caused by the long wait for appointments and the long drive—3-plus hours—to Saginaw for follow-up appointments.

And why I cite that is, I go to get some doctors' appointments done. I try to avoid it, but the system was not working the way it should. It took me, start to finish, about two years. But I'm also one of those that are able to get around by myself.

And my theory is the veterans that do need the help, I feel that they need it more than I do, so they can access that care better than I can. They need those fundings, those issues. I'm a retired Marine, I can get those some other way or I can tap into my tribal clinic to an extent.

In conclusion, we at LTBB have utilized the VA Health Care System to the extent reasonable given drive times, appointment times, and length of ongoing medical conditions. We are appreciative of the VA system, but it is so overrun with bureaucracy, consistently short-funded, and horribly short-staffed. All of these are opportunities for improvement.

This opens the door to actively pursue a consistent approach toward working with tribal clinics to alleviate some of that stress.

Chi Megwetch.

Semper Fi.

Fred Kiogima, Little Traverse Bay Bands Tribal Chairman.

[THE PREPARED STATEMENT OF FRED KIOGIMA APPEARS IN THE APPENDIX]

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

Mr. Chambers, you are recognized for five minutes.

STATEMENT OF CURTIS CHAMBERS

Mr. CHAMBERS. Thank you, Congressman. Thank you, Congressman Brownley, for being here today and holding this meeting.

My name is Curtis Chambers. I am honored to appear before you today. I am equally honored to be seated with these great leaders here beside me today. I'm an Ottawa Indian and a Navy veteran. My father was a Navy veteran, and two of my sons are Navy veterans. We are all honored to serve this Great Nation as members of the greatest Navy this world's ever seen.

And I would like to speak with you today about the need for transportation services, telehealth, and non-VA care. My son had planned to be here with me today, but he's on his way to Saginaw right now to have a consulting appointment for an end procedure he's going to have next week. He's going to travel twice in two weeks here.

I have had the unfortunate opportunity to deal with our present system and to regale you with the failings would take you more time than we have allotted today. Such as the 18-month waiting time for an existing problem that one of my sons had, or medical records being lost not once, not twice, but three and four times and much more.

I would prefer, however, to focus on the positive and possible fixes to the problems today. One: Non-VA healthcare. I don't understand why we can't just use our present doctors and send the bills to the VA.

And then Number 2, some of our health concerns and questions—preferably like my son's going through today—could be done via Skype or some other sort of technology?

Mr. BENISHEK. Telemedicine.

Mr. CHAMBERS. Yes, exactly. And then when it comes to travel problems and expenses, those would all be drastically reduced just by doing that. Certainly in the cases of my son and other people in Cheboygan.

In my experience, the actual care a veteran receives is outstanding. The hospitals that my son has gone to, the care has been wonderful. Just caring, loving people. But the paperwork and the bureaucracy are mind-numbing. And when you add this to our Native cultures, you have a rural nightmare accessing VA care.

I believe the percentage of able-bodied men in Indian Country who serve in the military is about 30 percent. That's higher than any other nationality and probably due to our warrior societies. We have hundreds, maybe thousands, of widows who probably qualify for pensions. There are hundreds of young vets not accessing any healthcare just because of the bureaucracy and the problems associated with that.

According to the VA website, there are veterans homes and veterans trust funds available. I'd like to see more of an open dialogue between the VA and various societies in Indian Country. Perhaps we could have talking circles with vets and others associated with tribes and the VA itself.

Mr. Chairman, I'm just a stump-jumping half-breed from Northern Michigan, and I realize that the devil is in the details. But it seems to me that in this Great Nation, and it is truly a Great Nation, that by working together, we can supply the veterans of the greatest military on earth, the greatest healthcare on earth. And they deserve no less. I thank you for your time. And thank you again for holding this hearing. We appreciate it.

[THE PREPARED STATEMENT OF CURTIS CHAMBERS APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Curt. And thanks a lot for staying within the time. Perfect.

Let's see, who do we have? Oh, Commander Archambeau. You're up next. You have five minutes.

STATEMENT OF CARL ARCHAMBEAU

Commander Archambeau. Yes. Thank you for having me here today. First of all, I am a U.S. Marine, retired, and CW—combat veteran of U.S. Marine Corps, retired CW–4 of the United States Army.

First of all, thank you for the testimony of the subcommittee on this health program. First of all, I would like to say that the Veterans Affairs Clinic in our area is doing an exceptional job for the veterans considering the space and equipment, personnel that they have to work with.

Also, we have a Disabled American Veterans, DAV, transportation system in place to get some of our veterans to Saginaw, Ann Arbor or Detroit for hospital appointments, and that's a great thing to have that in our area.

Having said that, the distances that we have to travel to get to the VA hospitals for an appointment are a problem. It is an all-day event to travel to and from the hospitals, plus waiting time at the hospitals, making it a hardship to our elderly veterans.

After traveling the distance, like it's two and a half hours to three hours to Saginaw, and we start out like around 3:30 in the morning to gather these gentlemen up, or ladies, and to get them down there. Plus Ann Arbor is another hour and a half. And Detroit's another two, two and a half hours from there, which is really a hardship on our elderly veterans.

By the time they get home, they are—if they were really ill, they're going to be a lot worse.

So Traverse City is more than 40 miles from the VA hospital. And I feel that the veterans should be allowed to use local doctors and hospitals for any medical needs that the local VA clinic cannot provide versus transporting these distances.

The VA hospital in Saginaw is an old building. It needs to be redone. A new hospital in Gaylord area would better serve our veterans in Northern Michigan and Upper Peninsula area versus having them travel long distances. And that's basically all I have. And I appreciate you having me here.

[THE PREPARED STATEMENT OF CARL ARCHAMBEAU APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Commander. Appreciate your testimony.

Lieutenant Colonel FLETCHER. You are recognized for five minutes. Hit the button.

STATEMENT OF LINDA FLETCHER

Lieutenant Colonel FLETCHER. Can you hear me now?

Mr. BENISHEK. Yes, I've got you now.

Lieutenant Colonel FLETCHER. Well, I thank you, Chairman Benishek, for the opportunity to address this group today. I hope to provide an interesting perspective for the topics at hand. The recent events surrounding the VA have been very disturbing, to say the least, but it was Winston Churchill who said, "Never fail to take advantage of a crisis." And that is what we have in the VA system today.

Now is the time for problem identification, for opening to the consideration of conventional and unconventional ideas, and the formulation of bold steps to institute carefully conjured solutions.

Abraham Lincoln eloquently captured the mission of this organization, which he created in 1865, with these words: "To care for him who shall have borne the battle and for his widow and his orphan."

The structure and configuration of what we currently know as the Department of Veterans Affairs has changed through the centuries and our many wars, but the promise and the intent have not wavered, and the mission statement has remained the same.

This nation has lately been generous with funding for our veterans: The FY 2014 budget is $152.7 billion. Approximately 40 percent of that budget, or 61.1 billion, is directly related to the provision of healthcare. And due to the recent findings regarding administrative issues, an additional 16 billion is being added.

There can be little doubt that America wants to take care of its veterans and we are willing to pay whatever it takes to do so. Unfortunately, sometimes pumping in money to patch a sag in the ceiling isn't the answer. Sometimes we have to start by fixing deeper foundational issues.

I am in hopes that reformation of the VA system will begin with a review of the original mission statement so we can proceed to evaluate our existing organization in accordance with that guiding light.

According to *VA.gov*, the VA is currently the largest healthcare system in the nation. In 2012, the VA provided healthcare for approximately 5.9 million Americans. That's 2 percent of our entire population.

Interestingly, of that group, some 1.6 million, or 26 percent, qualify for care which the VA categorizes as not associated with war related illness or injury. In view of these numbers, perhaps the answer to the situation facing us is not what seems to be the foregone conclusion that we need to super-size the VA; perhaps we need to consider streamlining the system in accordance with the mission statement by targeting care—by targeting care only for war related illness or injury.

A restructuring that focuses specifically on that population would decrease the workload by 26 percent and provide a more focused approach to care for the remaining group.

The care required by that smaller group could be provided in the local civilian sector by having the VA assume all costs associated with insurance provided by the Health Care Act. This mechanism may also be—might also be considered as an option for our many veterans located in rural areas where accessibility to VA facilities is geographically challenging. Perhaps we should consider allowing these veterans the option to receive equivalent local care funded by the VA through the HCA.

From an administrative perspective, I would also like to recommend the VA revise their practice of hiring from within. The intellectual and cultural inbreeding that results from selection from the same pool chokes the breath of new ideas, perspectives and leadership that comes from selecting from a diverse assortment of potential employees.

Lastly, care to veterans is restricted by more than just geography. There are some existing concepts emerging and/or reemerging regarding different psychotherapeutic techniques which target the resolution of cause, not just the current objective of mitigation of symptoms.

Additionally, there's a wide variety of treatment methodologies from acupuncture to Zen meditation available in the alternative

medicine communities that target stress reduction, a major component of PTSD care. In view of our less-than-successful results in managing PTSD to date, we need to explore, not restrict, new possibilities in theory and treatment.

I'm well aware that this is a superficial and limited overview of a very complex situation. I hope that some of these thoughts will be helpful as this nation struggles to provide better care for those who give—gave us so much. And let me—let it be remembered that the VA may be stumbling, but with our help it can resume its revered and important position in our nation. They have a long and honorable history, and they can regain their glory with our support which includes constructive, not destructive, criticism.

We are in crisis, and it presents the chance to take great strides in an abbreviated length of time. Let's take Winston Churchill's advice and not fail to take advantage of this opportunity to advance our systems for the good of our veterans. Thank you.

[THE PREPARED STATEMENT OF LINDA FLETCHER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Lieutenant Colonel Fletcher.

Mr. Lerchen, you are recognized for five minutes.

STATEMENT OF CHARLES LERCHEN

Mr. LERCHEN. Thank you, Mr. Chairman.

Good morning. My name is Chuck Lerchen. I am a Veterans Services Officer and Director of Veterans Affairs for a 3-county area here in Northern Michigan. I would like to thank you for bringing the field committee together to gather information concerning the challenges confronted by veterans in rural areas in accessing and obtaining their healthcare needs.

Speaking from the perspective of a local official who interacts with veterans daily, I believe I'll be able to provide you with some valuable insight as to the real world challenges rural veterans encounter after enrolling and choosing the VA to provide them with their healthcare services.

What's become clear today and everybody knows is the VA is an agency in crisis. Both the Veterans Benefits Administration and the Veterans Health Administration struggle daily to accomplish their mission to our nation's veterans. Their congressional mandates routinely go unheeded.

Billions of dollars continue to be thrown at these problems with little or no quantifiable results. And the biggest problem is that lack of accountability.

The largest obstacle confronting the VA right now is the culture of the VA itself. Health care provision to the significant number of rural veterans is just another victim of this corrosive and obstinate culture. So while the VA and Congress continue to grapple with the core problems within the agency, the veteran continues to grapple with the effect it has on him or her.

It is unreasonable to think that the VA can provide every veteran in the country easy access to every kind of healthcare they need in their own backyard. Since it was introduced over 20 years ago, the clinic model for rural areas created by the VA has been a tremendous success. The need for rural veterans to have to travel

great distances for primary care has been markedly reduced; however, the question now becomes, is how do we provide the specialty services a veteran needs while still addressing that need for the unreasonable travel and appointment times necessary to receive it.

The answer to this question may lie in the authorization for rural veterans to receive certain care at non-VA providers. The VA has long held tightly to the notion that they and they alone will be the provider of all tertiary care. If your primary care provider at a clinic orders an MRI, the VA will do it, even if it means a 10-hour drive in the middle of a Northern Michigan winter and you're eighty-eight years old. The VA will still provide that service to you. This is the mindset of the VA, and it needs to be changed.

The metropolitan VA medical centers have all the business they can handle. This is very clear. If the VA cannot provide the needed tertiary care to the rural veteran, then contract it out to the community. The military does this all the time. Our local Coast Guard Air Station is a good example of that. They do not fly their members down to Cleveland where a clinic or a hospital is. They are authorized to receive it in the community. Why can't the VA do this?

The rural veteran clogs the wait list for these services unnecessarily. Equity and good conscience must come into play. None of us would find it acceptable to be required to drive 5 hours one way to receive a needed medical service. Nor would we find it acceptable if our aging parent was required to make such trips.

So, just as it is unreasonable to expect the VA to be able to provide all of these services to our rural veterans, it is likewise unreasonable to expect the veteran to endure the hardships currently required to receive their needed medical care.

The rural veteran has entrusted their health and well being to the VA system. We are supposed to treat their ailments, not create more in doing so.

We are beginning to see some progress in addressing these lingering deficiencies. VA's move to improve the method for identifying urban, rural and highly rural veterans by adopting a method used by other leading federal agencies is a major step in the right direction.

It is also a step in the right direction in breaking down the core problem within the VA. The malignant culture that has existed in the VA for far too long must now be replaced with a culture of altruism and service to our nation's veterans.

This concludes my testimony. Thank you for the opportunity to address your committee today.

[THE PREPARED STATEMENT OF CHARLES LERCHEN APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Lerchen. I truly appreciate your efforts and your testimony here today.

We've heard some of the issues that you've talked about here today. And I'll yield myself five minutes to ask a few questions. The issues that you all brought up, many of us have heard them before in this committee and also from veterans groups around the country and around the district.

It's the same problems that come up over and over again. It's been very frustrating to me to hear the people from the VA say, "yes, well, we understand and we're working on it." And yet, at

times thirty years will go by and nothing changes, even though we get the answer, "We're working on it." So they are not working very effectively on it.

Let me just ask a couple of questions that we've thought of here. In VISN 11, which includes all Michigan except for the UP, they were awarded $8 million in Fiscal Year 2014 to increase access to care for rural veterans. Anyone seen any new programs or initiatives put into place? To improve access to care this year? Anyone can answer that question. They got an extra 8 million bucks. Has anything happened that you've seen as a change in care in this year?

[No response.]

Mr. BENISHEK. Mr. Kiogima, have you seen anything new?

Mr. KIOGIMA. I have not seen anything new. And, like I say, the intent of how the—my Tribal Nation would like to see more local care.

Mr. BENISHEK. That's not happening. Mr. Chambers, have you seen any change?

Mr. CHAMBERS. No, sir. My son is still driving to Saginaw for consulting problems.

Mr. BENISHEK. Not even for the procedure, just to get the——

Mr. CHAMBERS. Just to talk about setting up the procedure.

Mr. BENISHEK. Right, right.

Commander Archambeau.

Commander ARCHAMBEAU. I agree with the other two gentlemen. I haven't seen anything.

Mr. BENISHEK. Lieutenant Colonel Fletcher.

Lieutenant Colonel FLETCHER. Yes, sir, I have.

Mr. BENISHEK. What have you seen?

Lieutenant Colonel FLETCHER. I've had the distinct pleasure and opportunity to be able to address a lot of different groups with regard to post traumatic stress disorder in the Traverse area. And, I'm not a counselor. I guess I'm really more of an epidemiologist than anything.

And when I talk to groups, I bring up things that are important and—and sometimes they are destabilizing to people who have PTSD. I frequently have people who come to me after the talks in tears and needing counseling.

So I went to the VA and I said, I need somebody here. Somebody here to support me with counseling so that I can say: "Here's the VA, they're right here in the community, and they want to help you." That has happened. I have that support now. And I'm very appreciative of it, as are the people who are falling apart after I talk. So I think that's a step in the direction—the right direction. And I think it's representative of something that we probably need to target, and that is the confluence of the efforts of the VA and the community. We need to work together. Not in the—not within the halls of the VA, but in the community itself.

Mr. BENISHEK. Thank you. Mr. Lerchen, do you have an answer to that question? Have you seen anything new in the last year as a result of this $8 million that the VISN got?

Mr. LERCHEN. We have been informed—keeping in mind that they don't talk to us very much, whether at the medical center level or the VISN level, so nothing formal has been related to us.

I do hear back from the veterans that there has been maybe a slight increase in authorizations to receive some local care. But nothing formal, nothing official, nothing that we've been asked to participate in any way, shape or form. So I can't answer your question.

Mr. BENISHEK. Quickly, I have a few more seconds left. Do any of you have any examples of what you think could be changed in the way that we take care of rural veterans other than, getting people to local clinics? Is there something else that VA should be doing as far as any of you think?

Voice. I have just recently had four procedures at the Ann Arbor VA. I've had to make 12 trips, some days they were 18-hour days. One trip was to have a preop examination. I had just had my complete physical about a week or so with my primary care here in Traverse City.

But I had to go to Ann Arbor and have my heart listened to and have an EKG because they said that they could not accept what was done here in Traverse City. Again, surprisingly, the EKG came up abnormal. I asked the—and I'm an RN, and I asked the nurse practitioner what is—what is going on with this EKG? "Oh," she says, "I get that reading all the time. It's an old machine." So I had to make a 12-hour trip to go down and have my heart and lungs listened to, have an EKG that wasn't—wasn't good, and I had just had the care done here in Traverse City a week or so before. So there needs to be some consistency across the board. It's all the same.

Mr. BENISHEK. Right.

Voice. It was wasteful. Totally wasteful.

Mr. BENISHEK. Thank you. I'm out of time. I'm going to yield five minutes to Congresswoman Brownley from California for her questions.

Ms. BROWNLEY. Thank you. Thank you, Mr. Chairman. So, I wanted to ask a few questions around our service to veterans who are Native Americans. And it was in your testimony, Mr. Chairman, you talked about knowing the programs—I think Mr. Chambers here talked about a—how did you describe it—a talking circle with tribes and the VA.

What form of communication is happening now so that your veterans are well aware of all of the services that are available to them?

Mr. KIOGIMA. Okay. Speaking for my tribe, we had initiated a Veterans Liaison Office, which we staffed as I came into office last year. It's has a more administrative approach to it.

We also transcend, the non-tribal and the tribal lands. We work hand in hand with the Emmet County Veterans person, point of contact, and he helped us get trained up all the way through the VA system.

But that in itself, we don't have a traditional approach as per se. Those are something that tribal nations, tribal people are kind of reluctant to do unless it's just strictly tribal. Because that's what—one of the uphill struggles we have with the Native veterans are there—it is not that they are afraid. It's just the way we're raised. You don't go out and seek help and bring it to attention that you

have a problem. And that's across the board. But it's more so on Native—in Indian Country.

I think if you talk to any of the veteran reps in this room, they will tell you almost all veterans are that way. They almost have to be falling apart before they raise their hand and say, "Help me." That old mantra of no pain/no gain kind of kicks us in the butt when we're in the military, and it catches up to us years later.

But just in itself in the Indian Country, that's one of the biggest problems we have, is the outreach. And we're scattered into very rural areas. And then after that, it just kind of rolls into a big ball of not having access to get to the VA clinic, which is—up in the UP, it's over in the Congressman's area; down here, it's in Saginaw. There is a lack of funding all the way across the board with transportation issues. But ——

Ms. BROWNLEY. So do you think if there were talking circles and the VA came, would—would your folks also come? Or is it—or is it something that you're going to gather for one purpose, and a VA person or someone who can, communicate to your folks be there? So I guess when you're talking about some of the cultural issues, about not speaking up and needing help or asking for help ——

Mr. KIOGIMA. When we say a talking circle, it's more along—I guess here it would be called group therapy or something else. But it's not to exclude anybody, but it's almost like the veterans have their own world to be in. Even within that circle of veterans, for some reason we've built up a wall between combat veterans and noncombat. I don't know where that came from because to me we're all the same. But even when we get in our talking circle, that seems to be a wall there. And it shouldn't be there.

But a talking circle, in and of itself, on a cultural level, is for the tribal people. But that's not to negate anybody could come to a talking circle because a warrior is a warrior. Ogichidaawok is Ogichidaawok, whether they're tribal or not, and it's a healing circle.

But having somebody from the VA staff to sit in on one would probably be most appreciative so you could actually see some of the things that are going on and some of the concerns. Because that's where you get the vocalness is within those circles, where they feel safe within that circle, because they are talking back and forth with other veterans, people who have experienced the same thing.

Ms. BROWNLEY. So it's not an issue, tribal and non-tribal? Together, it's fine.

Mr. KIOGIMA. Yes.

Ms. BROWNLEY. Okay. Very good. And Commander, you talked about the transportation system here. And I think you were saying that you thought the transportation system was relatively successful and relatively positive. Is there something—can you describe the transportation system?

Commander Archambeau. Basically we have—I believe it's two vans that we utilize, and we basically transport the patients. We pick them up at their homes or wherever they need to be picked up at, and then we deliver them to—usually Grayling. And from Grayling, then they are transported down from a bus that comes out of Grayling, and then they have to ride this bus down there.

But there is times that we'll actually transport them also all the way down to their appointments. Depends on how many we have. And I'm not really up on that as much as I should be due to the fact that's—the coalition basically—I mean, the DAV people handle that a lot, but I do drive for them.

But I guess it's a good system. It works. But the thing is that they—we start out like 3:30 in the morning, and they don't get back till sometimes till 8:30 at night, and that's a long time for a veteran to be sitting around.

Plus once they get to the hospital, if they would get priority as soon as they hit the hospital. Instead of the people in the local area that could drive to the hospital to be taken care of, these veterans, when they come in, should be taken care of immediately so they could turn them around and try to get them home in their earlier part of the day versus going into the evening.

And then they don't get to eat properly. Because the food isn't, given to them while they're there, if I am not mistaken. And, so the veterans have to fend for themselves while they're there. So it's a hardship on elderly veterans.

Voice. The VA doesn't pay for it. It's mostly volunteer organizations and local people in communities that pony up the money to pay for the vans, the fuel, the maintenance. And the drivers are 99 percent volunteers. And these are guys that go above and beyond all the time to make sure these guys get to their appointments.

The VA has not contributed a dime of money that I'm aware of to anything in Manistee County as far as transportation of veterans to appointments. It's all been volunteer and people in the local area donating money to pay for it.

Commander Archambeau. That's true what he's saying, is like we have a fund going now, trying to make money to raise X amount of dollars so we could get a new DAV van. And that's being done by the local people donating that $15,000. Then the rest of the funds are coming in—I don't know where they're coming from, but—I'm not up on that myself. But what he's saying is true. The local people are supplying that money for that DAV van. And I cannot believe that the DAV—I mean, the VA can't support that cost.

Mr. LERCHEN. Ms. Brownley? For clarity, I'm sorry.

Ms. BROWNLEY. Yes.

Mr. LERCHEN. Just to be sure we're accurate here, I ran that program locally for about 17 years. I have now turned it over to another coordinator.

But the VA does participate with that program. It's a collaboration between the national DAV and the VA and Ford Motor Company. It's been going on for quite some time.

Essentially the DAV chapters in the state and national organization raise the funds to buy vehicles; 100, 140 of them annually nation-wide. At reduced rates from the Ford Motor Company.

They then donate those vehicles to the VA. The VA accepts ownership of those. The VA pays all of the expenses associated with gas and oil and maintenance, feeding the drivers, all of that. So it's a collaborative effort between the VA and the DAV, and then—which filters down to the local—the coordinators. Those are all volunteers.

It's still not a perfect system. But I did want to make sure that—to stand corrected—the VA participates actively with that program nation-wide.

Ms. BROWNLEY. So if we were going to improve upon it, would more vans improve upon it? Or——

Mr. LERCHEN. We're asking volunteers—where we live, we're asking a volunteer, typically a retired person themselves, who may be looking for a volunteer gig—instead of working the information desk at the local hospital for a couple hours, we're asking them to get up at 3:00 o'clock in the morning, in the middle of February, travel on interstate and rural roads for 5 hours one way, with a van load of veterans needing appointments, wait at the hospital for 5 and 6 hours, and turn around and drive it all back.

It's hard to get volunteers willing to do that. And then the VA, you know—because of liability reasons, the VA owning the van and accepting all the liability associated with that, they have to pass a physical. The VA has to clear them to drive the vehicle. So it becomes a logistical problem. It's hard to get and maintain drivers. Up here.

Voice. Background searches, fingerprints.

Mr. LERCHEN. Up here we lose a lot of drivers in the winter. They go down to Florida and Alabama and whatever. So it's a logistical problem. So.

Voice. Can I throw in things?

Ms. BROWNLEY. I yield back, Mr. Chairman. I don't want to go over my time.

Mr. BENISHEK. We're trying to go back and forth a little bit. I want to ask another question on the tribal issue.

According to the statement of VA, they have done extensive outreach to all 13 tribes in Lower Michigan. Would you agree that the VA's outreach to Native American veterans in the Lower Peninsula has been extensive?

Mr. KIOGIMA. You can define 'extensive' probably with four or five e-mails a day, Congressman. There's a difference between outreach and consultation. That's one of the biggest problems that we do have in Indian Country. The determination that they call of outreach is what pops up on my computer.

That is to me a function. It is not an outreach. That is a notification of something. An outreach is literally what we're doing here or at the VA level to have the representatives up here in Northern Michigan occasionally so we can see one-on-one what the problems are and how it's doing. So, no, that would be a negative as far as an outreach—workable outreach program being handled up here.

Mr. BENISHEK. Mr. Chambers.

Mr. CHAMBERS. I'd agree with the Chairman. You could define that in different ways. I would challenge anybody in the VA to show me a list of tribal representatives for each tribe that is connected with the VA. I don't know that there is such a list. I've tried to put one together myself and haven't been able to do so.

Mr. BENISHEK. Okay. Do you have any ideas about how they could improve the outreach? Some of the things you've already said, I guess. I mean, having somebody actually come up here.

Mr. KIOGIMA. To reiterate, that was the intent of our Tribal Liaison Office, was to make direct contact. Because it is a different sce-

nario with the Tribal Nation. The one-on-one should be at a higher level. But the VA reps, that was the intent of our Tribal Liaison Office, was to work hand in hand with the county reps and with the state reps and keep it going. That to me is an open communication and an outreach program. If it is not being done that way, then it's just another blip on the radar.

Good consultation with the VA, whether it's semi-annually, quarterly, from Saginaw or even up at the hospital in Escanaba, somewhere needs to be. Rural America is caught in between up north/Escanaba and Saginaw; everything in between seems to be rural to an extent that's hard to get to the system. So outreach has to be preeminent in how they get out there and talk to the people.

Mr. BENISHEK. Curt.

Mr. CHAMBERS. And also they don't necessarily just have to outreach to the veterans. outreach to the community itself can include just letters in our local bulletins. Newsletters. The widow's fund that we have. There are just so—hundreds of people would be eligible for this if they knew that it existed. But they don't.

These things are on the web site. There's quite a few—you need to search through them. I wouldn't know about them myself except Jason Allen pointed them out to me.

Mr. BENISHEK. Let me ask all of you this question. Is there some type of care for our veterans that you think can only be provided by VA itself? And not provided by the out—by, local community Lieutenant Colonel, do you have any thoughts toward that?

Lieutenant Colonel FLETCHER. I do.

Mr. BENISHEK. These microphones are something, I know.

Lieutenant Colonel FLETCHER. Am I on now?

Mr. BENISHEK. Yes.

Lieutenant Colonel FLETCHER. Well, I really don't think that there is anything special that the VA can offer that can't be done in the community. And—if that's what you're asking me.

Mr. BENISHEK. Yes.

Lieutenant Colonel FLETCHER. And, actually, I don't see any reason why we have to limit healthcare for veterans to the Veterans Administration. I mean, it—when I hear about the transportation issues and everything else, it looks to me like the ancillary—the answer is localize this stuff.

I mean, instead of trying to make a cumbersome transportation system and everything else work, why don't we just authorize a mechanism so that people can get their care on the local economy. I think that mechanism may be available through the HCA. I don't know, I made that up. I have to tell you, I am not an expert on that. But it seems to me that for the first time there may be a fiduciary tool that we could use to, expedite that. So, no, I don't think there's anything that has to happen in the VA.

Mr. BENISHEK. Does anyone else have a different answer than that?

Mr. LERCHEN. Real quickly, and this is my perspective on it, but there's nothing that the VA does that can't be handled locally. I mean, it's healthcare. The culture of veterans being former military members, there is a certain understanding of that at the VA facilities. And that's important.

In my opinion, you have to look back historically. The VA system, is—is needed for this country. During World War II, Korea, Vietnam, the VA was responsible for treating returning casualties. We have to have some—we don't have that right now. Will we ever have that in the future. Hopefully not again.

But if we do, doesn't that system have to be up and running? Don't we need that system to be able to handle that if we ever need that again?

In the meantime, what do we do with it? So I'm—I think it's a bigger question than whether or not it can be handled. It's the need and the national security, whatever you want to call it. Do we need that system? And history has told us, yes, we've needed it in the past. And if we need it in the future, it's hard to get it back up and running again.

So, but, keeping the focus on rural veterans, I think it was in my testimony, where these VA hospitals are that service. The rural veterans, they are already full. Why are we making the rural veterans come in there and further clogging that up, and then we have the incidences like Phoenix. I'm sure they were bringing rural veterans from Arizona in there. So a hybrid answer is probably the answer.

Mr. BENISHEK. Thank you. I'm out of time here. Let's ask Representative Brownley if she has any further questions of the panel.

Ms. BROWNLEY. I wanted to——

Mr. BENISHEK. And then we'll get to the next.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I just wanted to follow up with the Lieutenant Colonel on her testimony around alternative therapies for mental health.

Lieutenant Colonel FLETCHER. Yes.

Ms. BROWNLEY. I'm just curious to know, are there acknowledged alternative therapies for veterans here in this VISN for mental health?

Lieutenant Colonel FLETCHER. If there are, there are very few of them. And the VA in general is reticent to embrace those. I think, across the nation, they are becoming more and more embraced.

But the VA is being very cautious to ensure that appropriate standards are available for each one of those disciplines. And so that's difficult, because these are sometimes ancient practices that don't have those kinds of fundamental disciplines.

The possible answer to that is to have the VA come up with some ideas about what it is that they would require from each one of those different sectors. And instead of them—those providers coming to them with the answers, the VA say: This is what we demand of you. And that way they could access that care.

Ms. BROWNLEY. Well, I've been an advocate for the alternative therapies—as a matter of fact, the hearing that we had in California that the Chairman joined me on was focused on that. So I'm hoping very, very much that the VA will take another step towards that.

Because I think, therapy through telemedicine, talk therapy, one-on-one, group sessions, these are all good. And not one method is going to work for every single veteran. And I know in my district we have equine therapy that works——

Lieutenant Colonel FLETCHER. Yes, we have that here.

Ms. BROWNLEY [continuing]. Very, very well.

Lieutenant Colonel FLETCHER. And we—I think you're—I applaud your efforts in that regard. We need—at this juncture, we need every single tool we can probably gather. We're not in a position to be able to show—to shut the door on any sort of option whatsoever. We just need to explore everything.

Ms. BROWNLEY. Thank you. And, one question for all of you is—that I would like to ask. every time I speak to a veteran, all of the testimony that we've had back in Washington—and believe me we've had hundreds of hours worth—one thing that is always consistent is veterans believe once they're in the system, they're getting good quality healthcare. It's accessing the system is where the problems reside. So in this discussion about using local facilities and local doctors and—I understand the travel time and the elderly, and I'm sure in the wintertime here it's—it must be really onerous. And——

But I guess the question is, if you were going to survey all of your veterans that are serviced here, would they all choose to go to a local doctor versus travel to—to the VA? Understanding that the one thing that I've heard that is true is that the healthcare is of good quality once they're inside the system. So I'm just curious to hear generally what you might think.

Lieutenant Colonel FLETCHER. I don't think you can say 100 percent of the population would go with that.

Ms. BROWNLEY. The majority?

Lieutenant Colonel FLETCHER. Yes, I would certainly expect that.

Voice. I have a comment. I've rode down several times with gentlemen who were receiving radiation therapy. It was a 5-minute radiation therapy treatment, but they would have to go down on Monday, stay through the week, and come home on a Friday. For a 5-minute-a-day treatment that could definitely be rendered here in—within the community. Or closer to their home.

Ms. BROWNLEY. Mr. Chairman, I am going to let you respond to that.

Mr. BENISHEK. Well, I think if you and I are out of questions, I think that will get VA up in the next panel and let them give their testimony and I'll ask them a few questions.

Voice. I thank you all for spending time with us here this morning. I want to tell the audience that we will have time and staff to answer questions and take comments after the hearing. But in view of the time situation, we want to keep the ball rolling.

So please don't think that we don't want to hear what you have to say. But in the format of the hearing, we have to keep moving. So please talk to the staff. We will have staff here staying afterwards that you can speak with. So I appreciate everyone being here and their wish to comment.

The first panel is excused. And then we'll ask the second panel to come up forward.

[Pause.]

Mr. BENISHEK. I would like to welcome the second panel to the table. Joining us today from the Department of Veterans Affairs is Paul Bockelman, the Director of Veterans Integrated Service Network "VISN" 11.

He's accompanied by Peggy Kearns, the Director of the Aleda E. Lutz VA Medical Center in Saginaw; and James Rice, the Director of the Oscar G. Johnson VA Medical Center in my town that I practiced medicine in, Iron Mountain. I want to thank you all for being here today.

Mr. Bockelman, will you please proceed with your testimony.

STATEMENT OF PAUL BOCKELMAN, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK (VISN) 11, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PEGGY KEARNS, DIRECTOR, ALEDA E. LUTZ VA MEDICAL CENTER, VISN 11, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JAMES RICE, DIRECTOR, OSCAR G. JOHNSON VA MEDICAL CENTER, VISN 12, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF PAUL BOCKELMAN

Mr. BOCKELMAN. Good morning, Chairman Benishek and Ranking Member Brownley.

First, I would like to thank the first panelists for their candid conversations. We are all about learning. We are all about looking for opportunities to increase our services to veterans that will improve their experience with us. That is so important to us, so we appreciate their comments.

Thank you for the opportunity to be here at VFW Post 2780 to discuss VA's commitment in providing accessible, high quality, patient-centered care.

Today, we are here to discuss VHA's care for rural veterans and Native American veterans in Northern Michigan and the Upper Peninsula. I am accompanied this morning by Ms. Peggy Kearns, Director of the Saginaw VA, and Mr. Jim Rice, Director of Iron Mountain.

We sincerely appreciate the assistance we have received from our partners at local veteran service organizations, Native American Tribes and key non-profit stakeholder groups. We would not be able to provide the necessary care to our rural and Native American veterans without the support of our partners who are dedicated to ensure our nation's veterans are receiving the services they have earned.

The VA's committed to enhancing the care rural veterans receive. Approximately 43 percent of Michigan's veterans enrolled in the VHA live in rural areas. In Michigan, we have multiple projects and programs in place to increase access to rural areas. These include telehealth; home-based primary care; our mobile prosthetics van, which brings prosthetic services to the CBOCs or the clinics; clinical training opportunities for providers in rural areas; and our program to provide mental health support to veterans living in rural areas.

We also partner with the Escanaba mobile vet center to provide ready access to returning service members during the mobilization events.

Throughout Northern Michigan, we use innovative methods to meet the healthcare needs of veterans in rural areas. One of the

ways we accomplish this is through telehealth technology. Our telehealth program ensures veterans get the right care in the right place at the right time very much an issue with our panelists this morning.

In Fiscal Year 2013, Michigan's telehealth programs conducted roughly 62,400 visits using telehealth modalities.

Transportation is a challenge unique to the highly rural areas we serve. We continue to look for opportunities to expand access to care for rural veterans and we look forward to talking to the folks that spoke earlier about any opportunities they may see for us to expand our transportation system.

For example, our transportation program and network of volunteer drivers—which we so much appreciate—assist veterans in rural communities with their rural transportation needs. Transportation is provided to the Saginaw Medical VA Center as well as Ann Arbor and Detroit. The Iron Mountain Medical Center also has a bus that travels to Milwaukee twice a week.

Veterans have expressed satisfaction and appreciation with the transportation program. I would add we continually are looking for drivers. This is a wonderful volunteer opportunity for them, and it is so much appreciated by the veterans and the employees that enable them to see the veterans, as well.

VHA has done outreach to Native American Tribes in Michigan to build closer relations with tribal governments and promote awareness of VHA services. Our efforts include charting an outreach team to connect with Native American veterans in order to increase awareness of benefits and services, promote VA's high quality of care, receive feedback from veterans, and address access gaps.

Working with local veteran service officers and tribal and community representatives, local outreach teams coordinated and participated in numerous outreach events in Fiscal Years '13 and '14, including over 20 at area Tribal Nations.

Through collaboration, the Iron Mountain VA Medical Center established a satellite, home-based, primary care team located at the Lac Vieux Desert Tribal Health Clinic to provide care to our veterans living in that area.

In addition the Saginaw, Battle Creek and Iron Mountain Medical Centers held the Third Annual Tribal Veterans Representative Training. This training promotes the practice of having a tribal veteran representative in federally recognized tribes throughout Michigan.

VA's goal is to provide care to veterans directly in a VA medical facility; however, when we cannot provide the necessary services at one of our facilities, we are authorized to provide that care through our community providers.

We recognize that in Michigan, travel distance and the number of available providers is a challenge in our efforts to provide non-VA care. VA is committed to providing the high quality care that our veterans have earned and deserve.

We appreciate the opportunity to appear today before you and we appreciate the resources Congress provides VA to care for veterans throughout Northern Michigan and the UP. We are prepared to answer questions you may have for us. Thank you.

[THE PREPARED STATEMENT OF PAUL BOCKELMAN APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Bockelman. I'm going to start and I'm going to yield myself five minutes to ask some questions. I'm going to start with something that Fred talked about when he mentioned the tribal outreach in his testimony. The way he related it, it was basically some e-mails he was getting. I appreciate that they have had this outreach at the Lac Vieux Desert Tribe, but I was hoping maybe we could use this meeting here this morning to encourage you to actually get somebody to talk to Fred on a regular basis rather than an e-mail. Because I think he's feeling as if there's—could be better communication. Don't you think he felt that way?

Mr. BOCKELMAN. Always willing to look for opportunities. We do have some face-to-face. I think the recognition, hearing his testimony that the more face-to-face, the better. For that culture, written communication/oral communication is not as good as face-to-face communication. There's a great nugget for us to take home and work to increase our outreach efforts.

Mr. BENISHEK. I think in our culture, as well——

Mr. BOCKELMAN. Sure.

Mr. BENISHEK [continuing]. That works out well. I mean, we're trying to develop a better relationship with Ms. Kearns here, and I think my office has a good relationship with Mr. Rice. And regular communication tends to help things go. And I was hoping I could get your commitment today to try to make that happen better.

Mr. BOCKELMAN. You do.

Mr. BENISHEK. Good. I have another question about—something that's come up talking to veterans in the district. Is there a registry for people who have been subject to these burn pits that were present in the Gulf War? The people that have been exposed to these burn pits, and they are now starting to report medical conditions related to that? Are you familiar with that?

[No response.]

Mr. BENISHEK. It's similar to Agent Orange, but in the Gulf War they had these burn pits in some of the camps, that people were exposed to ash and chemicals for a long period of time. I am beginning to hear now that those veterans are developing medical illnesses, which they feel as if it's related to the burn pits. Is there anything like that going on, developing a registry of people exposed to these burn pits?

Mr. BOCKELMAN. We will get back to you on the exact nature of the registry. I know there's been a lot of outreach to folks that have been exposed to make sure we understand what kind of symptoms they are having.

Mr. BENISHEK. You are not doing that now, though?

Mr. BOCKELMAN. I need to find out if there is a registry.

Mr. BENISHEK. Okay. All right. Another thing that keeps coming up, too, then, that was mentioned today by Mr. Chambers is the lost records issue. This is something that I hear all the time. I sent my records in not once, not twice, but three times and they are lost. How exactly does that happen? You must have heard this. Have you ever heard this before, I hear it a lot.

Mr. BOCKELMAN. I know within the VA now that we have a well established electronic medical record, we don't have those problems within the agency like we've had in the years gone by.

When we do have records that come in, it is very difficult to keep hands on them. We do want to make sure that we've got that system figured out so that it does get included in the patient's electronic record.

Knowing that we are going to continue to do non-VA care and expanding that in the future, this is critical. One of the concerns we have about expansion of non-VA care is will we lose continuity of care. And we will have to work very diligently to make sure we don't lose that consistency.

As a physician, the concept of knowing what other physicians have provided or think is important is just critical to ensuring we are not going off on the wrong track. So if we have opportunity for——

Mr. BENISHEK. So you don't have an answer for that story, then?

Mr. BOCKELMAN. I don't have an—not for that specific question.

Mr. BENISHEK. I still have a few minutes left. The other thing that I want to talk about is this $8 million that the VISN received for increased access to care for rural veterans. What exactly have you spent that $8 million on this year?

Mr. BOCKELMAN. Within Michigan, Northern Michigan, we have spent 3 and a half million on the CBOCs that are rural up in this area. This was a way for us to get the CBOCs established. This is the third year for several of those, and after three years the funding should be within the regular budget. We've spent the money on the transportation system, several other outreach-specific—and I can get you the exact details on those.

Mr. BENISHEK. That would be great, if you just sent me how you spent 8 million bucks.

Mr. BOCKELMAN. I can do that.

Mr. BENISHEK. The other thing is I know there is a bus that the VA provides in Iron Mountain that transports the guys back and forth to Milwaukee. And Madison, too, I think. I've heard about this transportation issue that these volunteers, they are getting a little bit older, tougher to pass the physical.

What is the long-term plan for continuing decent transportation? Is there anything beyond the volunteers? Is there any other plan that you're trying to implement Because it doesn't seem to me like this is a very good system. Are there buses that you provide similar to the ones in Iron Mountain, here, down below the bridge?

Mr. BOCKELMAN. Yes, we do. And I will have Ms. Kearns describe that. But, again, I just need to say how crucial it is to have the volunteers. They are wonderful. It is amazing to see, on the worst weather days, the volunteer drivers do get the veterans to care. And that is appreciated.

Ms. Kearns, can you describe the transportation within the district.

Ms. KEARNS. Yes, in addition to our volunteer network—which they service about 90 veterans a month that they are transporting back and forth in their vans—we also have a program through the Rural Health Transportation Program that we were given funding for. That is VA employees that drive patients down to Saginaw, De-

troit, and Ann Arbor. And this starts at Gaylord, stops at West Branch, Grayling, Standish, picks people up, takes them down to Saginaw. And then we take them to wherever they need to go, whether they need to go to Detroit or Ann Arbor.

Mr. BENISHEK. This is separate from the volunteers?

Ms. KEARNS. That is separate from the volunteers. That's our bus that goes back and forth, and it's run—it's funded through Rural Health Initiative money and it's VA employees doing that. So we have two programs: The volunteer program and—our own bus, which has serviced about 1,200 veterans in the past year.

Mr. BENISHEK. I see I'm running over time. I am going to allow my colleague, Representative Brownley, to ask questions for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Mr. Bockelman, thanks for your testimony, and I really appreciate your introductory comment saying that you appreciated the candid conversation from the first panel and always looking to learn and to grow. Because I honestly am a firm, firm believer that in order for us to really improve the VA and change culture, we really need to be in a mindset of continuous improvement, always—always trying to improve.

And I also really believe that there's not—one size doesn't fit all. So, we go across the country, in different areas there are different needs, and we're going to have to solve those issues differently. So I appreciate those comments.

And I guess my first question to you—and after all of the crisis that we have had within the VA, I am convinced that communities need to be having ongoing conversations with one another. Just like we're having today. And—but to have a process and a system set up where veterans in the community can talk to you and you can talk to the veterans and have that communication sort of back and forth.

And so I'm just wondering, do you have a system like that, where you are, on an ongoing basis, talking to the veterans in Northern Michigan to make sure that you, as the VISN director, can do absolutely everything possible to sort of meet the individual needs throughout the area?

Mr. BOCKELMAN. A couple things. One, within our VISN 11 organizational structure, our governing structure, we recognized last year at our strategic planning, a year ago, that this is something that we needed to crank up is how do we get more veterans' input? So we've tasked ourselves with getting more veterans as members on our facility level committees.

We value their input. They surely present different things, different perspectives of the same issue, and it always adds value to our discussions. So we've been doing that with great success. And with great eye-opening input from these members. So that's something that we've been doing as an organization as the leaders felt that we needed to do that.

As the new Secretary has identified, we will be holding town halls in all of our facilities over the next couple of weeks to make sure we look for opportunities. Typically the facilities have regular and routine outreach or opportunities to speak to veteran services officers, the congressional delegations. Most of the facilities do that

at least quarterly and most are in conversations with your offices much more frequently than that for all sorts of reasons, and we look for any opportunity to get input from the congressional staff. The veteran service organizations do simple things like suggestion boxes, as well.

One of the things that we've heard this morning that we look forward to helping is some of the discussion on just basic information eligibility. It's always tough to get that message out to everybody. But we can improve on that if that's seen as a real need. We would look forward to reaching out and seeing if we can get that into any local publications. And we would ask for input from the community on what kind of publications would best suit the needs of them to hear more about the VA.

Ms. BROWNLEY. Thank you. I appreciate that. And I think in all of our conversations and hearings that we've had back in Washington—the committee is unanimous on this—is, we want change and we want the VA to be veteran-centric, service-focused. And the veterans are at—are at the core here.

And I think the only way that we will become a veteran-centric, veteran-centered organization is if we are constantly talking to the folks that we serve and knowing what their needs are and—and having a nimble enough organization to be able to bend and flex to meet our veterans' local needs. So I appreciate your comments on that.

And I see that I'm running out of time, so I will yield back.

Mr. BENISHEK. When are the town halls going to be?

Mr. BOCKELMAN. We will get you the exact schedule. Each facility is having one of those.

Ms. Kearns, do you have yours scheduled?

Ms. KEARNS. Ours is September 18th at the Saginaw VA.

Mr. BENISHEK. So on September 18th you are having a town hall at the Saginaw VA. What time is that?

Ms. KEARNS. It's at 5:00 p.m.

Mr. BENISHEK. 5:00 p.m.

Mr. BOCKELMAN. Mr. Rice.

Mr. RICE. Ours is September 24th and 25th.

Mr. BENISHEK. How about here at the CBOC?

Ms. KEARNS. That is something we are going to be planning in the future. We need to find a spot that is kind of central to——

Mr. BENISHEK. Is every CBOC going to have a town hall?

Ms. KEARNS. We hadn't planned on doing it at present. We were trying to have an area in between, so we could have two or three of the CBOCs come to the one spot. But we could end up having them at the CBOC.

Mr. BENISHEK. That's what we're talking about, the difficulty with driving.

Ms. KEARNS. The transportation, yes.

Mr. BENISHEK. Can we use the CBOC as well?

Ms. KEARNS. Yes, if we could get space like—something like this, we could certainly have a town hall in here.

Mr. BENISHEK. I'm sure the communities would just be more than happy to be able to have a town hall meeting. There's a lot of people with questions about—and it would be really helpful, I think. Just think what you learned here today——

Mr. BOCKELMAN. Sure.

Mr. BENISHEK. Mr. Bockelman, just from the testimony we've had my view of the leadership is you've got to be out there, hearing for yourself what's actually going on, because sometimes the leadership gets a different view from the people that work for them than when they actually go out and hear what people have to say.

So I would encourage you and Ms. Kearns also to be participating in this town hall so that you really learn from the front and not just lead the division from the rear. But lead the division from the front and see what people on the ground are actually seeing. So thank you for that.

How are we going to change the culture in your VISN, Mr. Bockelman? I mean, frankly, Ms. Brownley and I have heard testimony—and frankly, had the Secretary tell me that we've increased the waiting list by 40 percent. And then we find out that those numbers have all been fudged. So we members of the committee, we've sort of become very jaded when the VA tells us, "We're doing great. We're really improving." So, I think communication on your part, being out there and being at the front of things, is very, very important. Because, frankly, we've stopped believing most of the things VA says. Because their actions, haven't—you've fouled up from what you're saying. So I would encourage you to really focus on getting out there and doing outreach and that.

I have a couple questions for Mr. Rice. What can we do, Mr. Rice, because you and I have talked in the past about the difficulties in getting providers. And, we've worked at the committee level—the Inspector General has told the VA eight different times over the last 30 years they need a central plan for hiring providers.

And one of the biggest problems we have in Northern Michigan is having each individual VA find enough providers to provide care, continuity of care, so you're not seeing a different doctor every time, as doctors don't stay long.

You and I have talked about the various challenges you've had. How can this system be changed, other than with central planning and more evident recruitment, to make sure that you have the providers you need to provide care?

Mr. RICE. That's a great question. I think one of the things we've been working on lately is really trying to recruit providers that want to live in Northern Michigan. We hired recently 4 new primary care providers that had a background, they grew up in the UP and then left.

One of the things we've also started for other providers is a college program where we hired 15 kids while they're going to school, and the hope is that when they graduate and they want to come back and raise their families they'll think about us. But it gives them the exposure to the VA, so they are familiar with the VA culture.

Personally, we had a vacancy in Sault Ste. Marie for about a year and a half, so I personally outreached to every provider in the Soo area and sent them a personal letter asking them if they would consider coming to work for the VA. So it's a challenge, and we struggle with that every day in Iron Mountain, recruiting.

Mr. BENISHEK. You would agree it would be better if the VA had a central plan to hire physicians nation-wide to get a pipeline of people in the system?

Mr. RICE. Yes.

Mr. BENISHEK. Mr. Bockelman, do you have any more thoughts on that?

Mr. BOCKELMAN. A lot of thought has gone into recruitment and retention. Once they get them——

Mr. BENISHEK. See, the problem is, it's all happening at each individual medical center.

Mr. BOCKELMAN. And I think there's some value to having some local medical center responsibilities for that. The efforts that Mr. Rice has got are going to be a whole lot different than an urban setting, so it's nice to have that opportunity to fine tune the recruitment.

One of the things that came out in the law that was just passed was the ability for us to pay up to $120,000, I think for the amount, for education debt reduction. That will make us much more competitive.

One of the things that Mrs. Kearns has brought in since her arrival a year ago is to actually use some of the recruitment incentive funding that has been available, some tools that just have not been used.

VISN 11 is having in November a recruitment and retention training session. I want to make sure our providers, the leaders that have areas where there are critical shortages, know all the tricks of the trade and all the tools that are available to do them.

We've got to make sure that we get as many available. We recognize not everybody is a good candidate for the VA, but we've got to get folks in the door. We do find once they come to the VA, get a feel for the mission, they do stay. So the recruitment, getting them there, is significant.

Mr. BENISHEK. I'm over time. I'll yield to Ms. Brownley.

Ms. BROWNLEY. Thank you. I wanted to know—you had mentioned in your testimony identifying access gaps, I think is how you termed it. So what are they?

Mr. BOCKELMAN. I think we've talked about the distance. I think if we look at gaps being the limitation to healthcare, is going to be the distance. The winter weather is a serious gap. Can't do much about that.

We have worked hard on the telehealth domain to get that. We've now got the capability to start to go into veterans' homes to do it directly. We're working hard to find providers that are willing to do that. This is new for them, too. That's important.

And some veterans aren't too excited about having a screen in front of them. We recognize that for some it will work and some it won't. But we're expanding those products wherever we can.

And a good example is in Beaver Island, which is an island off the coast here that I think we have 90 permanent residents. And I will share with you a picture of that island in the middle of the winter, and you'll understand how difficult it is to access.

We now have an arrangement with the local, state and rural health facility there to provide primary care for those veterans there so they don't have to travel. They would have to fly to get

to the mainland, and then travel through normal ground methods to get there.

We are also providing telehealth equipment that we'll be able to use to work with the veterans; specifically, for mental health services that that clinic is not able to provide. As we know, much of healthcare is done in primary care, and so if we can avoid them having to come off the island except only for specialty care, which everybody on the island does have to come off to do, that's the kind of efforts we're making. So we're looking for those kind of points.

Ms. BROWNLEY. Thank you. So, before this—before we passed this law that's in place now that hopefully is going to help in terms of access, before the law was passed, VISNs and the VA had the opportunity to use community partners or private practitioners when they couldn't meet wait times and so forth. So in terms—were you utilizing that? Were you utilizing—sending your veterans, at least in this area, to—to community partners and utilizing that before the law was passed?

Mr. BOCKELMAN. Yes. I will pass to Ms. Kearns to discuss the budget. But this is a significant portion of our budget. And just to give you a flavor of what it—the impact it has on Saginaw.

Ms. BROWNLEY. Is using private practice for—is it a significant part of your budget?

Ms. KEARNS. For the—this year—well, of our overall budget, for all nine clinics and the hospital this year we've spent almost $20 million on non-VA care. In this particular——

Ms. BROWNLEY. What percentage is that?

Ms. KEARNS. It's about 17 percent of our budget.

Ms. BROWNLEY. Okay.

Ms. KEARNS. Is being sent out. In this particular district, this year we've spent over $3 million. We've sent out over 2,200 veterans to care in the community.

Ms. BROWNLEY. And do you know their satisfaction levels?

Ms. KEARNS. We—they are happy when we can send them out closer to home. That's the answer.

Ms. BROWNLEY. Do you survey the veterans that you're sending out so you get a sense of the kind of care they're getting and their level of satisfaction?

Ms. KEARNS. We have not surveyed them. That's probably something that can be done. Oftentimes getting the records back and finding those things out—but, yes, we could do that.

Ms. BROWNLEY. And for the local CBOC here that I had the opportunity and pleasure to visit, what's your average wait time for primary care and specialty care at this moment in time?

Ms. KEARNS. Our average wait time for primary care is about 12 days. Specialty care, depends on what the specialty care is, it can be up to 30 days.

Ms. BROWNLEY. But it's not—you don't have—you're not beyond 30 days?

Ms. KEARNS. No, we are not beyond 30 days in most of our areas. There are a few little pockets that could be—like neurosurgery is a difficult one to get anywhere. But in general about 30 days.

Ms. BROWNLEY. I was very impressed with the fact that the—speaking to your RNs this morning, before they got into their cars to travel today, to have in-home care. And so that was very impres-

sive, and it sounds like you're going to look further into—to the degree of, how much more of in-home care we can do.

And I really think in the long term, with telehealth and sort of in-home care, too, that the combination, if we can bring telehealth into the home, in essence, is probably a good—a good, longer-term solution as well. So I'll yield back my time.

Mr. BENISHEK. I just want to touch on one of the things that was brought up in the previous panel again. Mr. Lerchen said that no one of us would find it acceptable to be required to drive 5 hours to receive a needed medical service, nor would we find it acceptable for our aging parent to be required to make such a trip. And Mr. Chambers also mentioned his son, not elderly, but driving apparently for a preop visit for an endoscopy to Saginaw.

This is a pretty huge issue. I'm surprised that there's not more local care being done or why, like, somebody has to travel preop to Saginaw for an endoscopy. I did endoscopy at the VA. They didn't do that. I am not exactly sure what he's getting done.

But this—this 5-hour trip—or 3-and-a-half or whatever it is to Saginaw, that's a pretty big deal for up here. And it's a common theme that you hear. Why aren't we doing more of this care here now? I know that the bill that we did is supposed to make it easier, but it's already been within the realm of VA to make it happen. And don't you think there should be more local care being given here so people don't have to make that drive to Saginaw? What are we doing? Are you doing anything specific now to make that happen easier?

Ms. KEARNS. One of the things that I've done since I've gotten there is ease up who can go out and have care if they're eligible to go out and have care. We've spent almost $4 million more than last year already on non-VA care because we're finding pockets of people that we can send out.

For example, a good example I had was, it was brought to my attention an 88-year-old veteran who they wanted to travel to Ann Arbor. And when it was brought to my attention, I said, "No, he will go local," and we paid for him to go local. So those are the kind of things that, I agree, we need to try to do those things like that.

Mr. BENISHEK. So what is happening to make it be better? Because these are questions I've asked for three years—and, I see that—you say $4 million more this year than last year. And is it going up that fast, then, every year, then? Is it going to continue to improve?

Ms. KEARNS. I would guess with the new law that's been put into place, yes, it will continue to.

Mr. BENISHEK. What about the PC–3 thing? This is something I've spoken to people in DC, about where they are to provide more of a tri-care like network for veterans. Where are you with that?

Mr. Bockelman, do you have any idea where that is at? Because my experience is that—I was concerned, number one, what they were going to pay providers. And, number two is what—how many providers are actually signing up and when will that network be complete?

Mr. BOCKELMAN. This has been a challenge in VISN 11, especially in Michigan where there is not an existing network by this company. They are working hard, they are scrambling to get pro-

viders signed up. We have had some early communication—I would call them start-up problems with recognition of territories. Is this town closer than this town? And they might be sending veterans to the farther-away town than a closer one.

Mr. BENISHEK. It's not very good, it sounds like.

Mr. BOCKELMAN. We are still struggling to get this program up and running.

Mr. BENISHEK. I'm concerned about this piece of legislation that we passed is supposed to be able to give an access card to veterans from this area basically. I mean, people that live more than 40 miles from a VA facility that provide their care.

I mean, how are we going to—I know you probably don't have the answer for that because you're the VISN director and not the big wheel in Washington. But, we're hoping for something to happen fast. So we're not waiting two years to implement something that is supposed to happen right away for the people who are suffering. Do you have any comment on that?

Mr. BOCKELMAN. I know they are working vigorously to get a full understanding of the law to make sure we're able to carry it out as intended. We look forward to the opportunity to expedite the care. Especially with the choice card.

We are concerned about the continuity of care like we discussed. That's always going to be a concern, knowing in the back of our heads as healthcare providers that we don't want to lose that, because that is so critical.

There will be new rules that we will have to learn on how we're going to handle that. We will have the horsepower ready to go as it comes to implementation so that we could do this. There will—I'm recognizing that any new program like this will have some start-up time. We will do whatever we can to expedite that and not be in a position to wait for action.

Mr. BENISHEK. But do you agree that 5 hours is excessive?

Mr. BOCKELMAN. That's a long time. A long time, yes.

Mr. BENISHEK. A long time to be traveling.

Mr. BOCKELMAN. I do.

Mr. BENISHEK. Thank you. I will yield to Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chair. Mr. Bockelman, I wanted to ask, so how much funding did your VISN receive from the Access to Care Initiative? Do you know the number?

Mr. BOCKELMAN. We have about $11 million earmarked for that. 2 million of that came from the Washington component. We drained our reserves to put up the additional 8.8 million approximately.

We're on target to get all this spent in the next 5 weeks. We've been working hard to monitor our progress, to make sure that we got that done. If there comes a time, if we were so lucky as to have funds that weren't spent, we would sure be ready to share those with other parts of the country that have a need that we don't. But to this point——

Ms. BROWNLEY. So what was your criteria for disbursement?

Mr. BOCKELMAN. We went to the facilities and asked them what are their needs. Where do you find delays? Where are you having problems meeting that within house? Come up with a budget and

let's look at it. And we've been adjusting it a little bit more here, a little less there as we do find that.

Ms. BROWNLEY. So what were the needs here?

Mr. BOCKELMAN. Across our network, we had a lot of optometry.

Ms. KEARNS. Audiology

Mr. BOCKELMAN. Audiology was another area.

Ms. BROWNLEY. So how was money going to solve those issues? We talked a little bit about that earlier today, but——

Mr. BOCKELMAN. A couple things. That will help with the backlog to get those done.

Ms. BROWNLEY. Yes.

Mr. BOCKELMAN. I think one of the things—a good example might be optometry, which is—plain optometry is a rather low risk/high volume. That is something that we should be looking at our contract for, because that can be done locally.

We've been doing some work with teleaudiology, which will now enable us to do work at the CBOCs; not just helping veterans adjust hearing aids, but actually able to plug into the computer system that will allow the audiologist back at the main facility. We are rolling that out over the next year.

Ms. BROWNLEY. Very good. And then also I think in your testimony you said that the—your VISN had received $8 million from the Veterans Health Administrative Office——

Mr. BOCKELMAN. Yes.

Ms. BROWNLEY [continuing]. Of Rural Health to support 25 projects and programs to increase access to care for rural veterans. So, can you tell us what the process is to receive that funding? And do you—do you have to provide measurable outcomes at the end of the project?

Mr. BOCKELMAN. Yes, we do. A couple things. One—the nice part about this program is the rural health office keeps a running list of all the successful programs, so we can look to see if there's something that we just hadn't thought of that we can go pick right off the list.

At the same time we do ask the facilities, go and look and see what might work at your facility. What's the deficit there. Maybe we've got something unique. We've got a lot of rural health transportation dollars coming to Saginaw because of the transportation.

So it can come either way. We could look for projects that have been successful or the ground up.

We then have a coordinator, Mr. DeLoof, who does a wonderful job getting these packages put together at the network level, bundled up, making sure that they're sound, making sure that we do have metrics or understanding of what would be a recognition of success. And then they do go forward to Washington where we hope they compete well because there's a lot of folks.

Ms. BROWNLEY. Can you give me some examples of some of the measurable outcomes that you've set in place?

Mr. BOCKELMAN. A good one that we've done lately, in the last couple years, is our prosthetics vans. Recognizing that a veteran might go a long way just to get a brace adjustment or an orthotic shoe adjustment, we now have mobile vans that go out to the CBOCs routinely, on schedule, that allows the veterans to get that work done at the CBOCs.

We have monitored that. We can now show you conclusively: Here is the cost. Here's the gaps. Here's the maintenance for the vehicle versus what we would pay for beneficiated travel to come to the medical center.

Not even counting or trying to put a dollar value to the veteran for not losing a whole day of work. That has saved us money.

And I think it also probably enables the veterans to be more comfortable in their orthosis. If it fits well, and therefore they will wear it more often and have better clinical successes.

Ms. BROWNLEY. Thank you. I yield back.

Mr. BENISHEK. While preparing—I'm going to yield myself five more minutes for questioning. While preparing for the hearing today, my office received a call from a Northern Michigan VA employee who, due to fear of retribution did not want to be identified, but did want to alert me to his concern regarding the alleged use of no call/no show lists at the Saginaw VA Medical Center.

According to this person, some veterans are scheduled for VA appointments without being made aware of the appointment time or the date. When that veteran then misses the appointment, which he or she was never advised of, the veteran is then placed on a no call/no show list, and VA's access number looks better than they really are.

Needless to say this is an allegation from someone. But we are going to be investigating it further.

Is there a no call list for people who have a history of not showing up at their appointments and then they get put on a list of—a no show list?

Ms. KEARNS. Well, when somebody no shows for an appointment, it comes up in the computer when they don't show up. It shows that they're—that they didn't show up for the appointment. So you would be able to track that by no shows, and we do keep track of how many no shows we do, so that we have access for other veterans.

So when somebody doesn't show up, then we can put somebody in that slot to see. If they—if we have somebody available at that point in time. But as far as a list that—I am not aware of any list that we put people's names on other than we can show who no showed for the day. That's part of the computer system that all VAs have.

Mr. BENISHEK. Right, right, right. Is there a—consistent way of reminding people of their appointments?

Ms. KEARNS. Definitely. We make phone calls. We have letters. We have cards. In fact, the comment we get most often is, "Quit calling us, quit telling us I have an appointment." It's a very good system with multiple reminders to people.

I had somebody tell me just recently that they got three reminders about an appointment in the same week. So we do have a system for that, plus a calling system that goes out. So.

Mr. BENISHEK. Right. That's been a complaint elsewhere in the country. Of veterans, not being told when their appointment is, and then the appointment is made for them, but nobody actually spoke to the veteran prior to making the appointment. So that they may have been off to a funeral or—you know what I mean, something like that. So you're saying that that does not occur, then.

Ms. KEARNS. No, no, what I'm saying is we—when somebody has an appointment, we remind them of the appointment. I was talking about reminders.

Mr. BENISHEK. When people's appointment is scheduled, are they usually spoken to, then, when you schedule the appointment?

Ms. KEARNS. Generally, yes. I mean, I would have to have an example of what you're speaking of.

Mr. BENISHEK. We've heard at other testimony that VA would make somebody an appointment without speaking to them, so that they may have had other plans than the appointment. They didn't speak to the veteran when they made the appointment. They just made the appointment and told the veteran when the appointment was later, and the veteran may not have been available at that time. You know what I mean? So you're saying that doesn't happen that way?

Ms. KEARNS. That can happen when a consult is done, and we send out the consult to another facility. They may make the appointment then.

Mr. BENISHEK. They speak to the veteran, then, when they make the appointment?

Ms. KEARNS. I would hope that they speak to the veteran.

Mr. BENISHEK. You don't know that for sure?

Ms. KEARNS. I don't know that for sure when we send out the consult, to another facility.

Mr. BENISHEK. Is that the standard method, then, of actually speaking to the patient when they make an appointment?

Ms. KEARNS. Well, that's what we endeavor to do every day, if we can actually speak with them. I——

Mr. BENISHEK. What I'm trying to get to is the point is that when a veteran is scheduled for an appointment, do they speak to the veteran as they schedule the appointment——

Ms. KEARNS. Yes.

Mr. BENISHEK [continuing]. Or prior to scheduling the appointment, so they know the patient is going to be available that day? Not just: Well, the appointment is going to be on three weeks from Tuesday. Send the letter to the veteran that the appointment is three weeks from Tuesday. Do you understand?

Ms. KEARNS. Generally a follow-up appointment is made, it's made right with the veteran when they're standing in front of us.

Mr. BENISHEK. Right. That's what I want to make sure happens.

Mr. BOCKELMAN. One thing that happened after the access issue became so apparent, I went out and met with the scheduling people at the medical centers. And I know Ms. Kearns and Mr. Rice have done the same thing. To make sure we understood what issues they were facing that we might not know about, we don't know about.

One of the questions is how come these are not filtering up? And I think that's the cultural question that we really need to address.

But one of their toughest parts of their job is getting ahold of veterans for appointments. They might call. No answer. They call a number that's listed, it's not current. All those kinds of things.

They are very reluctant, very reluctant to settle for sending a letter to a patient saying we've been trying to get ahold of you, can't

get ahold of you, now we're going to go ahead and schedule and get this ball rolling, we hope you can make it.

The clerks know that is not ideal. They do not want to do it. They are really anxious to try to capture that appointment information before the veteran leaves in front of them if at all possible.

Mr. BENISHEK. Thank you.

Ms. Brownley.

Ms. BROWNLEY. I just wanted to follow up on the no shows. So it sounds to me like you have a methodology, though, that if you do have a no show, you can fill that slot.

Because we've heard some testimony in Washington that some folks no show, no appointment, the appointment just stands open and is never filled. So, in some places a doctor may see—in a clinic or a CBOC might see two patients. Ten were scheduled, but, because of no shows and other kinds of things, only two were seen.

But—so there were suggestions about different systems, I guess that private practices utilize. And one of them being just a series of open appointments every single day so that if you do have no shows and so forth, you can fill them. And that's what you're doing?

Ms. KEARNS. We have open slots that people can walk in.

Ms. BROWNLEY. So what's your average amount of—what's your average—how many patients does a doctor see in a given day?

Ms. KEARNS. Generally at the clinic here in Traverse City they see about 10 patients a day.

Ms. BROWNLEY. Thank you.

Mr. BENISHEK. I've got a couple more questions. In a statement for the record, the Sault Ste. Marie Tribe of the Chippewa Indians stated that they are seeking an agreement with VA to allow members who are veterans as well as non-Native veterans to receive care at one of the tribal clinics in the 7-county service area that they have. And to receive reimbursement payments from the VA to provide care for those veterans. Without the burden of travel and financial stress created by the long distance between reservations and VA clinics. Would you be supportive of such an arrangement?

Mr. RICE. Actually, my facility has been working with them. We do have—we've already set up one clinic, optometry, because we needed access over in the Manistique area. So the clinic—the tribal clinic in Manistique is now seeing our optometry patients. It's a veteran's choice that's put out on fee.

But we have been working with them for a while to try to get the issue—the issue is treating non-Native Americans at their clinic. So we've been working at that for about 12 months to get that resolved.

Mr. BENISHEK. So are you still working on individual contracts with clinics rather than the PC–3 thing? Because that obviously is a problem, it sounds like.

From what you said, that that's not going as well as it could. So you're still contracting on an individual basis to get care for veterans at local clinics like this?

Mr. RICE. Yes.

Mr. BENISHEK. Can you keep me informed as to how that continues to go.

Mr. RICE. Yes.

Mr. BENISHEK. I want to keep up to speed on that.

Do you have any further questions?

Ms. BROWNLEY. No further questions.

Mr. BENISHEK. Well, I know that we haven't covered all the aspects of VA's problems that we've heard in Washington. I know that in your positions, from where you're at, you can't solve the problems of how the whole management of the system works.

For the audience we passed a pretty major veteran reform bill this past time that, frankly, it's going to come down to implementation. And is VA going to be able to implement the changes that we've made in the law to allow veterans better and easier access to care locally. That's pretty much the gist of the bill.

And the bill also demands reform of VA with outside third party evaluation of the entire management scheme of VA. So, this crisis that's come up has led to a new secretary. It's led to the changes that we made for access for care. And it's made for an evaluations of the system and an ability for management to demand more accountability out of its people.

So hearings like this help develop a communication between our committee and my office to VA staff. I hope that you all learned something from the conversation that we had with the first panel, and that we'll be reaching out to members of the first panel to continue to work with them in a constructive fashion rather than adversarial fashion to improve care for our local veterans.

So I appreciate you all being here today, and I know I'm going to continue to work on it, as will Ms. Brownley.

If you have any closing comments, Ms. Brownley.

Ms. BROWNLEY. Well, I would just say, thank you to everybody who has participated. And I know I don't represent your area, but your concerns here have been expressed is of great interest to me and not only Dr. Benishek, but it's important to the committee.

And I know I can say with great certainty that our—the VA committee back in Washington had many, many meetings around this crisis. And I think it was pretty clear that we identified what the problems were. And this bill is a beginning step. But we know the most important work for us to do at this particular point in time now is to make sure that we provide—the committee provides the oversight and making sure that the execution is taking place and making sure that the accountability and so forth that we all want and believe we need is in place, so that we are improving—and as I said earlier, continuously improving—our services to our veterans, not only here but across the country.

And so this is just, in my mind, a—a beginning, and we've got a long way to go. And I think—and I am not talking about VISN 11 specifically here. I am talking about the VA in general. there's got to be a major, major sort of cultural shift that has to take place. And cultural change is hard. And it's hard work. And I think it's our responsibility to make sure that we move forward with those changes.

And at the end of the day, we want to provide high quality, timely healthcare to our veterans in every single corner of our country. And that's our goal and that's our mission. And what you have provided for us here is helpful to us. And we take that infor-

mation back, and it will be helpful in terms of our next steps. So thank you.

And I—you live in a wonderful, beautiful place. And I've enjoyed my stay here very much. Thank you, Chairman.

Mr. BENISHEK. Once again, I want to thank all the witnesses and the audience members for participating in today's conversation. It's been a pleasure for me to be here and spend the morning with you.

With that, I ask unanimous consent that all members have five legislative days to revise and extend their remarks, and include extraneous materials without objection.

Mr. BENISHEK. So ordered. The hearing is now adjourned.

[Whereupon, at 11:07 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CURTIS P. CHAMBERS

My name is Curtis P. Chambers, I am honored to appear before you today, and I am equally honored to be seated with these great Tribal Leaders. I am an Ottawa Indian and Navy Veteran, my father was a Navy Veteran, and two of my sons are Navy Veterans. We were all honored to serve this great nation as members of the greatest Navy this world has ever seen. I would like to speak with you today about the need for transportation services, telehealth, and non-VA care.

I have had the unfortunate opportunity to deal with our present system and regaling you with the failings would take more time than we have allotted today. Such as an eighteen month waiting period for an existing problem one of my sons had, or travel records being lost not once, not twice, but three and four times . . . and much more. I would however prefer to focus on the positive and possible fixes to the problems facing us today.

1. Non-VA healthcare, why can't we just use our present Doctors and healthcare providers and then send the bill to the VA.

2. Some of our health concerns and questions could probably be answered via skype and some other such device which could be done at various VA Clinics

3. The above ideas will both decrease travel expenses.

I/my experience, the actual care our veterans receive is outstanding however, the paper work and bureaucracy are mind numbing.

Mister Chairman, I am just a stump jumping half breed from Northern Michigan and I realize that the devil is in the details but I'm sure that by working together we can supply the Veterans of the greatest Military on earth the greatest healthcare on earth.

I would like to thank Congressman Benishek and everyone involved in the efforts to improve our present VA care system.

Respectfully,

Curtis P. Chambers

PREPARED STATEMENT OF CARL ARCHAMBEAU

August 25, 2014

Dan Benishek

U.S. House of Representatives
Committee on Veterans Affairs
Subcommittee on Health
Washington DC 20515

Re: Testimony before Subcommittee on Health

First of all, I would like to say that the Veterans Affairs (VA) clinic in our area is doing an exceptional job for the veterans considering the space, equipment and personnel they have to work with. Also, we have a Disabled American Veterans (DAV) transportation system in place to get some of our veterans to Saginaw, Ann Arbor, or Detroit for their hospital appointments.

Having said that, the distances we have to travel to get to a VA hospital for an appointment are a problem. It is an all day event to travel to and from the hospitals plus the waiting time at the hospital making it a hardship on our elderly veterans. Traverse City is more than 40 miles from any VA hospital and veterans should be

allowed to use local doctors and hospitals for any medical needs that the local VA clinic cannot provide.

The VA hospital in Saginaw is in an old building and needs renovation. A new hospital in the Gaylord area would better serve veterans in Northern Michigan and the Upper Peninsula.

Commander, VFW Post 2780

PREPARED STATEMENT OF LINDA L. FLETCHER LTC/ANC (RET)

I thank you, Congressman Benishek, for the opportunity to address this group today. I hope to provide an interesting perspective on the topics at hand.

The recent events surrounding the VA have been very disturbing to say the least. But . . . it was Winston Churchill who said "Never fail to take advantage of a crisis" . . . and that is what we have in the VA system today. Now is the time for problem identification, for opening to the consideration of conventional and unconventional ideas and formulation of bold steps to institute carefully conjured solutions.

Abraham Lincoln eloquently captured the mission of this organization that he created in 1865 with these words . . . "to care for him who shall have borne the battle and for his widow and his orphan". The structure and configuration of what we currently know as The Department of Veterans Affairs has changed through the centuries and our many wars but the promise and the intent have not wavered and the mission statement has remained the same.

This nation has lately been generous with funding for our veterans. The FY 2014 budget is $152.7 billion. Approximately 40% of that budget ($61.1 billion) is directly related to provision of health care. And, due to the recent findings regarding administrative issues, an additional $17 billion is being added. There can be little doubt that America wants to take care of our veterans and we are willing to pay whatever it takes to do so. Unfortunately, sometimes pumping in money to patch a sag in the ceiling isn't the answer. Sometimes we have to start by fixing deeper foundational problems. I am in hopes that reformation of the VA system will begin with a review of the original mission statement so we can proceed to evaluate our existing organization in accordance with that guiding light.

According to *www.va.gov* the VA is currently the largest health care system in the nation. In 2012 the VA provided health care for approximately 5.9 million Americans. . . . 2% of our entire population. Interestingly, of that group some 1.6 million (26%) qualified for care which the VA categorizes as not associated with war related illness or injury.

In view of these numbers perhaps the answer to the situation facing us is not what seems to be the foregone conclusion that we need to supersize the VA. Perhaps we need to consider streamlining the system in accordance with the mission statement by targeting caring only for war related illness or injury. A restructuring that focuses specifically on that population would decrease the workload by 26% and provide a more focused approach to care for the remaining group. The care required by that smaller group could be provided in the local civilian sector by having the VA assume all costs associated with insurance provided by the Health Care Act.

This mechanism might also be considered as an option for our many veterans located in rural areas where accessibility to VA facilities is geographically challenging. Perhaps we should consider allowing these veterans the option to receive equivalent local care funded by the VA through the HCA.

From an administrative perspective I would also like to recommend that the VA revise their practice of hiring from within. The intellectual and cultural inbreeding that results from selection from the same pool chokes the breath of new ideas, perspectives and leadership that comes of selecting from a diverse assortment of potential employees.

Lastly, care to veterans is restricted by more than just geography. There are some exciting concepts emerging and/or re-emerging regarding different psychotherapeutic techniques which target resolution of cause not just the current objective of mitigation of symptoms. Additionally, there is a wide variety of treatment methodologies, from acupuncture to Zen meditation, available in the alternative medicine communities that target stress reduction, a major component of PTSD care. In view of our less than successful results in managing PTSD to date we need to explore, not restrict new possibilities in theory and treatment.

I am well aware that this is a superficial and limited overview of a very complex situation. I hope that some of these thoughts will be helpful as this nation struggles

to provide better care for those who gave so much for us. And let it be remembered that the VA may be stumbling but with our help it can resume it's revered and important position in our nation. They have a long and honorable history and they can regain their glory with our support which includes constructive, not destructive, criticism. We are in crisis and it presents the chance to take great strides in an abbreviated length of time. Let's take Winston Churchill's advice and not fail to take advantage of this opportunity to advance our systems for the good of our veterans.

Thank you and God Bless America

PREPARED STATEMENT OF CHARLES R. LERCHEN,

Good Morning, Mr. Chairman. I would like to thank you for bringing the Field Committee together to gather information concerning the challenges confronted by veterans in rural areas in accessing and obtaining their health care needs. Speaking from the perspective of a local official who interacts daily with veterans, I believe I will be able to provide you with some valuable insight as to the real world challenges rural veterans encounter after enrolling and choosing to have the VA provide them with their healthcare services.

As we all know, the VA is an agency in crisis. Both the Veterans Benefits Administration and the Veterans Health Administration struggle daily to accomplish their missions to our nation's veterans. Their Congressional mandates routinely go unheeded. Billions of dollars continue to be thrown at the problems with little or no quantifiable results; and the biggest problem is the lack of accountability. The largest obstacle confronting the VA right now is the culture of the VA itself. Health care provision to the significant number of rural veterans is just another victim of this corrosive and obstinate culture.

So while the VA and Congress continue to grapple with the core problems within the agency; the veteran continues to grapple with the affect it has on him or her. It is unreasonable to think the VA can provide every veteran in the country easy access to every kind of health care they need in their own back yard. Since it was introduced over 20 years ago, the clinic model for rural areas has been a tremendous success. The need for rural veterans to have to travel great distances for primary care has been markedly reduced. However, the question now becomes is how do we provide the specialty services a veteran needs while still addressing the need for the unreasonable travel and appointment times necessary to receive it? The answer to this question may lie in the authorization for rural veterans to receive certain care at non-VA providers.

The VA has long held tightly to the notion that they and they alone will be the provider of all tertiary care. "If your primary care provider at the clinic orders an MRI—we will do it even if it means a 10 hour drive in the middle of the winter, a six month wait to have it scheduled and OH . . . by the way we don't care if your 88 years old". This is the mind set of the VA and it needs to be changed. The metropolitan VA Medical Centers have all the business they can handle . . . this is clear. If the VA cannot provide the needed tertiary care to the rural veteran than contract it out to the community. The military does this routinely, why can't the VA? The rural veteran clogs the wait lists for these services unnecessarily. Equity and good conscious must come into play. None of us would find it acceptable to be required to drive 5 hours one way to receive a needed medical service; nor would we find it acceptable if our ageing parent was required to make such trips.

So, just as it is unreasonable to expect the VA to be able to provide all of these services to our rural veterans; it is likewise unreasonable to expect the veteran to endure the hardships currently required to receive their needed healthcare. The rural veteran has entrusted their health and well being to the VA system. We are supposed to treat their ailments, not create more in doing so.

We are beginning to see some progress in addressing these lingering deficiencies. VA's move to improve the method for identifying urban, rural and highly rural Veterans by adopting a method used by other leading Federal agencies is a major step in the right direction. It is also a step in the right direction in breaking down the core problem within the VA. The malignant culture of oppugnancy that has existed in the VA for far too long must now be replaced with a culture of altruism and service to our Nations veterans.

This concludes my testimony. Thank you for the opportunity to address the committee today.

PREPARED STATEMENT OF PAUL BOCKELMAN

Good morning, Chairman Benishek, Ranking Member Brownley Thank you for the opportunity to discuss rural healthcare and healthcare specifically for American Indian Veterans within the Veterans Integrated Service Network (VISN) 11. I am accompanied today by Ms. Peggy Kearns, Director of the Aleda E. Lutz VA Medical Center (VAMC) and Mr. James Rice, Director of the Oscar G. Johnson VAMC.

VISN 11 and Aleda E. Lutz VA Medical Center (VAMC) Overview

The employees of VISN 11 proudly provide patient-centered care to the approximately 386,000 Veterans living in portions of Michigan, Ohio, Indiana, and Illinois. VISN 11 consists of 30 Community-Based Outpatient Clinics (CBOC) and healthcare system main campuses located in: Ann Arbor, Battle Creek, Detroit, and Saginaw in Michigan; Indianapolis and Ft. Wayne in Indiana; and Danville in Illinois.

With a budget exceeding $2.1 billion, we are in a position to provide our Nation's heroes with high quality care through traditional and innovative methods. VISN 11 also has a collaborative relationship with the Vet Centers located in Macomb County, Dearborn, Detroit, Escanaba, Grand Rapids, Saginaw, and Traverse City.

The Aleda E. Lutz VAMC, located in Saginaw, Michigan, is accredited by the Joint Commission and consists of the Medical Center with a Community Living Center (CLC) and Annex in Saginaw and CBOCs in Alpena, Bad Axe, Cadillac, Cheboygan County (Mackinaw City), Clare, Gaylord, Grayling, Oscoda, and Traverse City. These facilities provide care to Veterans in the 35 counties of Central and Northern Michigan's Lower Peninsula. On April 21, 2014, the Aleda E. Lutz VAMC was awarded Planetree Bronze Recognition for Meaningful Progress in Patient-Centered Care. The Aleda E. Lutz VAMC is the first healthcare organization in Michigan to be awarded Bronze-level recognition since Planetree first introduced the recognition level in 2012.

The Aleda E. Lutz VAMC provides primary and specialty medical services, ambulatory surgical services, mental health services, inpatient medical care, rehabilitation, dentistry, audiology, optometry, blind rehabilitation, pain management, geriatrics, and extended care.

Expanded mental health programs include: Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) case outreach, Mental Health Intensive Case Management (MHICM), Posttraumatic Stress Disorder (PTSD) Clinical Care, Home-Based Primary Care (HBPC) psychology services, Compensated Work Therapy (CWT), recovery-based programs, suicide prevention, outpatient substance abuse programs, evidenced-based therapies, VA Caregiver Support, and Homeless Veterans Program, including Veterans Justice Outreach.

Focus on Access

No Veteran should have to wait for the care and services that they deserve. We remain committed to ensuring Veterans have access to the highest quality care that they have earned through their service to this country. Patients at the Aleda E. Lutz VAMC can consistently access primary care, specialty, and mental health services within thirty days. Access is monitored daily to assure availability.

The Aleda E. Lutz VAMC has implemented the Accelerating Care Initiative along several different tracks. Approaches to assure timely access include:

1. Increasing the use of Non-VA care;
2. Use of Saturday clinics;
3. Hiring a substitute provider (known as a locum tenens provider) for Primary Care, and;
4. Ongoing recruitment of staff.

There have been reductions in the number of patients waiting both on the Electronic Wait List (EWL) and the New Enrollee Appointment Request (NEAR) list. From May 15, 2014, to August 1, 2014, the Aleda E. Lutz VAMC EWL dropped from 61 to 34. From June 1, 2014 to August 1, 2014 its NEAR list dropped from 110 to 9. .

As part of our commitment to transparency, VA is posting regular data updates showing progress on our efforts to accelerate access to quality healthcare for Veterans who have been waiting for appointments. These access data updates are posted at the middle and end of each month at the following link: *http://www.va.gov/health/access-audit.asp*.

VA Rural Health Care Program—State of Michigan

There are approximately 660,800 Veterans in the state of Michigan, of which an estimated 31 percent or 207,200 live in rural areas. Approximately 227,400 Veterans in Michigan are enrolled in VA, and 43 percent or 97,300 enrolled Veterans live in

rural areas. An estimated 34 percent of all Veterans living in Michigan are enrolled in the VA healthcare system.

In addition to funding allocated to VISN 11 through the Veterans Equitable Resource Allocation (VERA) system for Veterans' healthcare, in Fiscal Year (FY) 2014, VISN 11 received $8 million from the Veterans Health Administration's (VHA) Office of Rural Health to support 25 projects and programs to increase access to care for rural Veterans. The programs specific to Michigan include our Mobile Prosthetics Van, which brings prosthetic services typically found only at the main campus to the CBOCs; clinical training opportunities for providers in rural locations; telehealth; and HBPC which currently serves around 300 Veterans. Since the telehealth and HBPC services are co-located within the community Veterans Service Office, such as the American Legion building, in Ludington, MI, we are able to facilitate Veterans' needs by working closely on Veterans Benefits Administration and claims issues and providing community-based services. This program is made available to Veterans in the Mason, Lake, Newaygo, Mecosta, and Oceana counties by the Battle Creek VAMC Northern Rural Expansion Team.

We continue to look for opportunities to expand our care via telehealth technology. VHA is in the early stages of developing a collaborative effort with community providers to be able to exchange health information. We now have the capability to provide Clinical Video Telehealth (CVT) in the home, which will improve access to care for rural Veterans and mitigate the need for travel to a VHA site of care. We are also establishing additional Mental Health services via telehealth to Veterans at the Patriot House in Gaylord in 2014.

The Battle Creek VAMC has taken the lead on several Veteran outreach projects in the rural areas of Michigan. To address low utilization rates, the Battle Creek VAMC signed a Memorandum of Understanding (MOU) with local Veteran Service Organizations, such as Veterans of Foreign War (VFW) and American Veterans (AMVETS), to allow VA to use their space to deliver care to rural Veterans. Additionally, the facility started delivering care in Veterans' homes. The care provided included access to a nurse practitioner, psychologist, social worker, registered nurse, pharmacist, occupational therapist, registered dietitian and a telehealth clinical technician. The use of home telehealth, as well as utilization of tele-dermatology and tele-retinal services, has been incorporated into this team.

These services enable rural Veterans to access VA care without long drives to one of the Battle Creek CBOCs. The psychologist has initiated some mental health groups in addition to utilizing clinical video telehealth to connect Veterans with other providers at the main medical center. To date, this motivated team of Federal employees has provided VA services and care to over 560 Veterans, with the numbers growing weekly.

Rural Health Outreach Transportation Program

The Aleda E. Lutz VAMC's Rural Health Transportation Program is well developed, averaging nearly 1,200 patients per year, over 80 percent of whom reside in rural communities. Patient satisfaction has increased with this program. Many of the users of the transportation program may not otherwise get to appointments and are repeat customers. Veterans requiring transportation assistance have pick-up sites in Gaylord, Grayling, West Branch, and Standish. Transportation is provided to the Aleda E. Lutz VAMC, as well as the Ann Arbor and Detroit Medical Centers.

Beaver Island Outreach Project

The Aleda E. Lutz VAMC, the VISN 11 Rural Health Consultant, and the VISN 11 Planner have worked with the Beaver Island Rural Health Clinic to bring VA healthcare services to Beaver Island Veterans using non-VA Care authorizations. This partnership enables eligible Veterans to receive primary care, laboratory, and general radiology services from the Beaver Island Rural Health Center instead of traveling to a VA facility. To be eligible for services, Veterans must be enrolled in the VA Health Care System and meet VA eligibility requirements. VA and the Beaver Island Rural Health Clinic held a VA Day on June 13, 2014, to provide information for Beaver Island Veterans on VA healthcare as well as listen for additional opportunities to meet their healthcare needs. As a result of the information collected, we will establish a VA telehealth clinic to provide these Veterans access to VA healthcare. This service will be established by October 1, 2014.

Readjustment Counseling Service

VA's Vet Centers present a unique service environment—a personally engaging setting that goes beyond the medical model—in which Veterans, Servicemembers, and their families receive professional and confidential care in a convenient and safe community location. Vet Centers are community-based counseling centers, within Readjustment Counseling Service (RCS), that provide a wide range of social and

psychological services including professional readjustment counseling to eligible Veterans, Servicemembers, and their families; military sexual trauma counseling; and bereavement counseling for eligible family members who have experienced an Active-Duty Death.

The Saginaw and Traverse City Vet Centers, like those throughout the country, also provide community outreach, education, and coordination of services with community agencies to link Veterans and Servicemembers with other VA and non-VA services. A core value of the Vet Center is to promote access to care by helping those who served and their families overcome barriers that may impede them from using those services. All Vet Centers have scheduled evening and/or weekend hours to help accommodate the schedules of those seeking services.

VISN 11 Telehealth Clinic Expansion in FY 2013

In FY 2013, VISN 11's Telehealth program conducted 109,806 visits using telehealth modalities, reaching 12.4 percent of Veterans in VISN 11 who use the VA system. The Aleda E. Lutz VAMC led VISN 11 in telehealth performance targets. In the past 12 months, this VAMC has achieved a 20 percent increase in virtual visits and 28 percent increase in the number of Veterans using telehealth programs.

Recognizing the Aleda E. Lutz VAMC is not a tertiary healthcare site, VISN 11 is developing virtual capabilities to link Veterans with specialty care found in our tertiary facilities in Ann Arbor and Detroit, including care for substance abuse; and also provide pharmacy clinical video health services to a Veteran's home. Utilizing telehealth for follow-up care helps eliminate travel and ensures Veterans receive the appropriate follow-up consultation. The Aleda E. Lutz VAMC is also working with the National Telemental Health Center to provide mental health services for patients with chronic pain—an area of growing demand and concern.

The Battle Creek VAMC expanded their healthcare reach by placing telehealth equipment at the rural Volunteers of America (VOA) site. Telehealth equipment was purchased for the VOA site in Lansing to provide telehealth services for homeless Veterans. Some of the services for homeless Veterans include, telemental health counseling, substance abuse treatment, and case management. Future services to be provided will be primary care basic visits, diagnostic visits, mental health visits, and mental health case management. We are in the planning stages for a project that will allow for small, county mental health offices to have telehealth equipment to connect with providers located within the Battle Creek VAMC.

Obesity is a significant problem impacting the healthcare of many in the United States. VA has enthusiastically engaged in weight management programs, such as our MOVE!® weight management program. We have and continue to expand these services by adding TeleMOVE!® to our CBOCs. The goal of the TeleMOVE!® Program is to assist with weight management in the comfort and convenience of the Veterans home through a home messaging device. Time spent with our registered dietitians assisting and motivating Veterans has proven to be an effective component—of a Veterans weight loss plan.

FY 2014 Expansion Goals

As we learn about additional opportunities or tools related to telehealth we have been aggressive in investigating them for utilization within VA. We still have opportunities to expand mental health programs in such areas as OEF/OIF/OND case outreach, outpatient substance abuse programs, evidence-based therapies, the VA Caregiver Support Program, telehealth for the homeless Veteran, and the Veterans Justice Outreach. Aleda E. Lutz VAMC is participating in a VA national telespirometry project to provide spirometry testing to patients at the CBOCs. We know that addressing hearing aid deficiencies is a big need for Veterans. We have learned there are components of such care that we can provide virtually through tele-audiology. We will be expanding this program in four additional CBOCs in Michigan.

Homeless Veterans and the Veterans Justice Outreach Programs

Homelessness is not just an urban issue – homeless Veterans are in rural areas too. We provide direct help daily through our homeless staff and programs such as HUD–VASH wherein HUD provides Housing Choice vouchers and VA provides case management services. We also recognize that it is important to create and maintain access points within Veterans Affairs Offices and/or local community partners where the homeless congregate. Our goal is to identify homeless Veterans and introduce them into the continuum of care we have available to serve them. We continue to combat homelessness proactively by working to identify Veterans who are incarcerated or at risk for incarceration and working with the court systems to intercede where possible. Working proactively before an incarcerated Veteran is released has been instrumental in avoiding Veterans instantly becoming homeless. We have Veterans Justice Outreach Coordinators located throughout the state and have strong

relationships with seven Veterans Courts in Michigan. We have experience with utilizing telehealth to link our Veterans and the judges involved with their care and we look forward to expanding this capability where possible.

VISN 11 American Indian/Alaskan Native Veterans Overview

The VA and Indian Health Service (IHS) Memorandum of Understanding was signed in 2010 to increase access and quality of care for American Indian and Alaskan Native Veterans across the Nation. VISN 11 has done extensive outreach to all tribes in Lower Michigan, particularly with the Little Traverse Bay Bands of Odawa, Grand Traverse Bay of Ottawa and Chippewa Indians, and the Pokagon Band of Potawatomi in Dowagiac, Michigan.

Over the past 3 years, VHA personnel attended Pow Wows, American Indian health fairs, annual meetings with IHS, and VHA presentations at tribal chair meetings.

In April 2014, Battle Creek VAMC entered into MOUs with the Pokagon Potawatomi and the Nottawasippi Huron Potawatomi to provide telemental health for tribal Veterans at the Tribal offices via telehealth technology through the Battle Creek VAMC. The MOUs provide for a part-time VA Tribal Outreach Worker for each tribe location to assist in connecting tribal Veterans to VA's mental health providers. This new telemental health project currently has a small number of newly-enrolled, younger American Indian Veterans utilizing their VA benefits for their healthcare needs. It is anticipated that 130 Tribal Veterans within the Nottawaseppi Huron and Pokagon Band of the Potawatomi Nation will benefit from this project to bring access to mental health services to them in a location that is easily accessible and acceptable for them.

In addition, the Grand Traverse Bay Band of Ottawa and Chippewa Indians and VA are working on a Reimbursement Agreement, under which VA will reimburse the tribe for direct care services provided by the tribe to eligible American Indian Veterans. Aleda E. Lutz VAMC will be representing VHA at health fairs held during 2014 at the Little Traverse Bay Bands of Odawa Indians and Grand Traverse Bay Band of Ottawa and Chippewa Indians. In addition, the Aleda E. Lutz VAMC is beginning a new partnership collaboration with Little River Band of Ottawa Indians and will be attending the Veterans' Warrior Society meeting in August to expand outreach to tribal Veterans.

American Indian Outreach Tribal Veteran Representative (TVR) Training

The Battle Creek VAMC and Aleda E. Lutz VAMC, along with VISN 12's Oscar G. Johnson VAMC, held the third annual Tribal Veteran Representative (TVR) Training. VISN 11 also conducted two TVR Trainings in 2013 for tribal members and another was held July 21–24, 2014, in Farwell, Michigan.

TVR training in Michigan promotes the practice of having an American Indian TVR in Federally recognized tribes throughout Michigan. The representative assists Veterans in understanding how to access benefits while also allowing VA to develop positive relationships with American Indian tribes in Michigan. The value in tribal members participating in the training is that many tribal customs are shared during discussions. This enhances the healthcare team members' cultural understanding and appreciation of American Indian Veterans' contributions to our country.

Conclusion

VHA, VISN 11, the Aleda E. Lutz VAMC, and the Battle Creek VAMC are committed to providing the high-quality care that our Veterans have earned and deserve. We appreciate the opportunity to appear before you today, and we appreciate the resources Congress provides VA to care for Veterans. We are prepared to answer questions you may have for us.

FOR THE RECORD

TRIBAL CHAIRMAN, GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS

WRITTEN BY ALVIN V. PEDWAYDON,

My name is Alvin Pedwaydon and I am the Chairman of the Grand Traverse Band of Ottawa and Chippewa Indians (GTB or Grand Traverse Band). I am a Vietnam-era veteran and a resident of Northwest Michigan who has directly encountered healthcare issues, both as a provider in my capacity as Chairman of Grand Traverse Band, and as a recipient as a veteran and tribal member. Grand Traverse Band has 4,100 members or which 1,500 reside in rural Northwest Michigan. My

testimony reflects both my position as Chairman of GTB and my individual position as a Vietnam-era veteran and resident of rural Northwest Michigan.

Grand Traverse Band has a storied and turbulent history of military service against and for the United States. Based on our sovereign status as an Indian Nation, like other Indian Nations in the United States, we have fought against the United States and we have fought for the United States. The last hostile encounter between GTB and the United States was the war of 1812; and our resistance to the United States' attempted Indian removal of our ancestors to Kansas and Oklahoma in the 1830s and 40s. Our ancestors have nevertheless willingly and gratefully served with honor in the United States armed forces since the Civil War. Members of our Tribal Council, for example, have great-great grandparents who were participants in Company K, Michigan Ottawa Indian Sharpshooters, a total Ottawa Indian Company from our area that fought on the Union side in the Civil War. Our ancestors have also served proudly and honorably in World War I and II, Korea and Vietnam, Gulf (Operation Desert Storm) and the Iraq and Afghanistan wars. GTB also honors its members who participated in the "Siege of Wounded Knee" in 1973 as warriors for Indian Country.

It is this historical complex relationship between Indian Tribes and the United States that defines the scope of our healthcare problems as manifested in our healthcare delivery systems. The history of federal Indian law and the relationships of the Tribes to the United States is a quagmire of complexity that represents both the pain and promise of federal Indian law and our historical relationship with the United States. Clearly Indian Tribes want to maintain their sovereign status as indigenous inhabitants to this continent and we have fought ferociously over the years to maintain this sovereign status. The United States has recognized this sovereign status in the implementation of a complex federal statutory system of federal domestic services.

In the area of healthcare we must content with the Indian Self-Determination and Educational Assistant Act (ISDEA); the Indian Healthcare Improvement Act; and services offered to veterans under Veterans Administration (VA) delivery systems. The Indian Healthcare Improvement Act (IHCIA) achieved permanency status in the landmark legislation, the Patient Protection and Affordable Care Act (ACA), signed by President Obama in March of 2010. We applaud this permanency and recognition of tribal sovereign status in the ACA. The defining concept of the ISDEA and the IHCIA is self-determination for Indian Tribes. We administer a comprehensive and expensive healthcare delivery system for our tribal members in Northwest Michigan. Indeed, we are probably the second biggest healthcare payor and provider in Northwest Michigan. The defining characteristic of ISDEA and IHCIA is administration by the tribes under a well-defined self-governance concepts and processes that have had the opportunity to develop detailed and complex federal regulations governing healthcare delivery to tribal members. In a thumbnail, those regulations consist of approximately 1,000 pages of CFR regulations, or more appropriately, digital screen images, which the tribes have had the opportunity to implement and develop by negotiated rule-making.

By any measure of modern bureaucracy, both the ISDEA and IHCIA have been a resounding success nationwide for Indian Country. We still argue with the Health and Human Services Department (HHSD) over the scope of the costs and associated indirect costs, but the Tribes have generally prevailed on the merits in requiring HHSD to fully fund indirect costs. We are now confronting and coordinating a MOU agreement with the VA to deliver reimbursement costs for eligible veterans who access our tribal healthcare system. This effectively melds two systems of healthcare delivery, and as expected, we have had problems in fully implementing all of the VA eligible activities into our existing Indian healthcare system.

In particular, the VA system does not have statutory authority similar to the HHSD that permits an Indian tribe to negotiate a 638 self-governance contract under ISDEA to ultimately culminate in a totally administered tribal program. We would suggest that such statutory authority would provide opportunities for Indian tribes and the VA to work out alternative delivery systems for rural-based Indian veterans. Presently, the VA uses an MOU agreement on the model of a "one size fits all" regardless of the individual circumstances of the demographic picture of the service population. For example, it has been GTB's experience that it is cost-effective for us to bring dental and eye care services directly in-house at our healthcare clinic, but that it is not cost-effective to bring auditory services in-house. Therefore, our service population generally has quick turn-around time for dental and eye care services and delayed service for auditory benefits.

In my own personal experience, because of the remoteness of our location and the necessity of my application to go through a centralized processing VA system, I had to wait eight months to receive my hearing aid. In my position as Tribal Chairman,

a very public position, this was extremely frustrating and detrimental to me in effectively administering my office, which requires participation in public meetings. I would suggest that VA statutory authority to negotiate with a Tribe, beyond a simple MOU agreement for direct in-house service, might be a solution for rural Native veterans who do not have access to a VA hospital but do have access to an Indian health clinic.

We applaud the efforts of the VA to have a tribal liaison office and we would suggest that VA services follow the Indian Health Services to have native-specific care modalities, like the Indian Health Service and tribal clinics. Currently, the VA does not make any concessions in services to Native-based beliefs. Though the VA is subject to Indian preference hiring, the VA has not implemented an active Indian preference hiring system for our area. Finally, because of the last decade of war, we unfortunately have a whole generation of wounded warriors suffering from PTSD. This population should receive special attention by the VA and the focus for rural Native Americans should be on establishing pilot PTSD programs for rural Native Americans directly serviced by existing Indian healthcare clinics.

I want to thank you for this opportunity to present these views of the Grand Traverse Band and my personal experience individually and to personally commend you for taking the time to address this important issue for rural Native American veterans and their healthcare.

FROM: THE LITTLE RIVER BAND OF OTTAWA INDIANS

Good Morning,

I am Larry Romanelli, Ogema or Chief and the elected leader of the Little River Band of Ottawa Indians in Manistee Michigan.

I am unable to attend in person due to conflicts in scheduling but want to offer my support for efforts of the House Veteran's Affairs Committee in looking at services to Native American's in rural areas.

It is a well-known fact that Native Americans have the highest record of service per capita when compared to other ethnic groups in serving the United States and have since the war of 1812.

A little known fact is that the U.S. Government used other Native Americans from other tribes besides the Navajo to secretly communicate during World War II. While Navajo Code Talkers are the most notable and deservedly respected, members of our own Tribe were documented as "Code Talkers" including members of my own family who spoke in the Odawa or Ottawa language to keep the enemy from being able to understand the communications.

It is a great thing that healthcare for veterans has made major improvements over the years however for many Native American veterans, access to such healthcare remains a roadblock. Again, Native American veterans represent the largest number of those rural vets.

I thank the efforts of the House Veteran's Affairs Committee for taking the time and effort to address this issue. Migwetch (Thank you)

Aaron A. Payment, MPA

Office of the
Tribal Chairperson

523 Ashmun Street
Sault Ste. Marie
Michigan
49783

Phone
906-635-6050

Fax
906-632-6829

Email
aaronpayment@saulttribe.net

FaceBook
'Aaron Payment'

HOUSE COMMITTEE ON VETERANS' AFFAIRS

Subcommittee on Health
Field Hearing: August 27, 2014
Traverse City, Michigan

Testimony of Aaron Payment, Chairman
Sault Ste. Marie Tribe of Chippewa Indians

Members of the House Committee on Veterans' Affairs Subcommittee on Health:

Good afternoon and thank you for inviting me to share our tribal issues on Native American and rural veteran access to care.

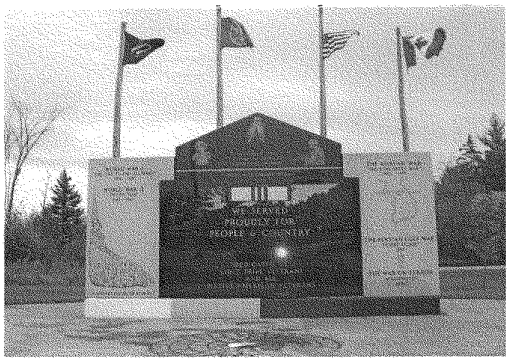
My name is Aaron Payment and I am the Chairperson of the Sault Ste. Marie Tribe of Chippewa Indians.

Sault Tribe is working toward VA reimbursement for tribal health services for Native American veterans, and eventually, non-Native veterans. The tribe and VA signed an MOU last year for the tribe to provide optometry services to veterans in the Manistique area.

My tribe is one of the largest east of the Mississippi River with 41,000 members. We were re-recognized in 1972 after a 20-year struggle. The 1936 Treaty of Washington recognized my tribe's aboriginal territory where we have resided since time immemorial and where we continue to reside today.

Honoring our warriors is a significant part of our tradition. A high percentage of our people serve or have served in the military and we honor them not only in daily life but also with special feasts, powwows, memorials and ceremonies. The tribe strives to help all members as much as possible and understands that veterans often have special needs. The Sault Tribe is proud of tribal members who have served in the armed forces and continue to support them when they return home from service.

Sault Tribe's Health and Human Services Program spreads across the tribe's seven-county service area in the Eastern Upper Peninsula. Indian Health Service, grants and third-party revenue fund our tribal health services. There are four tribal health care clinics providing primary care in Manistique, Munising, St. Ignace and Sault Ste. Marie. The four community health sites are located in Hessel, Newberry, Escanaba and Marquette. Health services include clinical ambulatory care, community health, purchase referred care, dental, optical, physical therapy, behavioral health and traditional medicine.



Sault Tribe's Monument to War Veterans on our reservation in Sault Ste. Marie. Above the monument, the US, MIA, Sault Tribe, and Canadian flags wave proudly. It is dedicated all Native American veterans everywhere. The last section honoring our warrior women was completed in 2007.

The Tribe's service area covers 8,500 square miles, all rural. Home for many of our veterans limits their ability to seek quality health care through the Veteran's Administration (VA) due to lack of transportation and hazardous weather during the winter months. Sault Tribe has worked hard to provide clinic locations through our seven-county service area to ensure all veterans, and Sault Tribe members alike, receive the same reasonable access to quality health care.

Last fall, the Sault Tribe entered into a Memorandum of Understanding with the VA to provide optometry services to all veterans seeking care in the Manistique and Munising area. Our clinics now have the ability and the capacity to see patients on behalf of the VA and receive reimbursement for seeing and treating these patients. This is a collaborative approach between an IHS clinic and the VA that enables the Sault Tribe to offer veterans quality service without having to travel long distances for care. This service is however limited to the Manistique clinic and optical services only.

Native Americans have long identified with their own people and feel most comfortable receiving care from tribal employed doctors who understand and embrace the cultural element of Native American health care.

Sault Tribe is seeking an agreement with the VA that would allow its members who are veteran, as well as non-Native veterans, to receive care at one of the tribal clinics in the seven county service area and receive reimbursement payments from the VA for providing care to the veterans who seek quality care without the burden of travel and financial stress created by the large distances between reservations and VA clinics and hospitals.

We are asking for your support to encourage the VA to develop strong relationship with tribal health facilities through these agreements.

STATEMENT FOR THE RECORD OF
THE AMERICAN LEGION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

PROVISION OF CARE TO NATIVE AMERICAN VETERANS AND RURAL VETERANS IN NORTHERN MICHIGAN THROUGH THE DEPARTMENT OF VETERANS AFFAIRS

AUGUST 27, 2014

1608 K Street N.W. ♦ Washington, D.C. 20006 ♦ www.Legion.org ♦ (202) 861-2700

STATEMENT FOR THE RECORD OF
THE AMERICAN LEGION

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

PROVISION OF CARE TO NATIVE AMERICAN VETERANS AND RURAL VETERANS IN NORTHERN MICHIGAN THROUGH THE DEPARTMENT OF VETERANS AFFAIRS

AUGUST 27, 2014

Recent struggles by the Department of Veterans Affairs (VA) to deliver timely care to veterans has cast into sharp focus the problems many veterans face receiving care from VA. Often the veterans who are most at risk are rural veterans, and in particular, Native American veterans who can often face extra challenges dealing with accessing care because of the unique challenges they face due to living on reservations.

The American Legion works diligently to ensure all veterans are properly served by the agency dedicated to provide their care – the VA. The American Legion has, for the past decade, conducted a program to study care at VA facilities called the System Worth Saving (SWS) Task Force. The SWS Task Force was founded in 2003 specifically to determine areas where VA could improve care for veterans, as well as to determine what areas of excellence could be replicated throughout the healthcare system.

In January and February of 2012 the SWS Task Force conducted a dedicated study of Native American health care for veterans in the Southwest, and throughout the Arizona and New Mexico regions. While there are vast differences between tribes and reservations, and each region presents its own unique challenges, many of the lessons learned through that research are applicable across the country where Native American veterans, a unique and honorable cohort of veterans, seek care.

The 2012 report found the following:

Background:

The Native American and Alaskan Native veterans served honorably in the United States Armed Services during all wars. There are many specific health issues that affect the Native American and veteran population such as depression, substance abuse, and various other mental health illnesses.

It is important to take into account the differences Native American veterans exhibit when trying to provide assistance to the Native American community. Even some of the most well intentioned federal regulations can inadvertently be in conflict with the exercise of their religious freedoms, culture, and century old traditions. They use their own Indian Health Services (IHS) because has been historically proven to be a more understanding system of their culture and personal health. It is important that the VA/IHS or other agencies take these cultural beliefs into consideration when conducting outreach and/or providing health care services.

According to the VA Medical Center's Native American Program Coordinator, understanding the complicated Native American culture and health care needs is fundamental for delivering proper health care to the community. This is accomplished by integrating health care through partnerships and collaborations with Indian Health Services (IHS), tribal medical centers, Intertribal councils, tribal Department of Veterans Affairs, and the Department of Veteran Affairs (VA).

According to the 2010 United States Census, there are 200,000 Native American veterans residing in over 565 recognized tribal entities across the country. The VA Office of Tribal Government Relations was created in January 2011 in response to President Clinton's Executive order 13175, and President Obama's Memorandum on Tribal Consultation dated November 5, 2009. The VA officially established the Office of Tribal Government Relations (OTGR) in January 2011 as result of an increased Native American veteran population in order to connect tribal leaders of federally recognized Indian tribes, pueblos, bands, villages, and nations to better provide services and benefits to a unique population of Native American and Alaska Native veterans. According to the VA Office of Tribal Government Relations, Native Americans and Alaska Native Americans have one of the highest representations in the armed forces when compared to other minority groups.

It is also important to fully understand the dynamic relationship between IHS and VA in regards to providing healthcare to Native American veterans. On June 24, 2003 and October 10, 2010 VA signed a memorandum of understanding (MOU) with IHS in order to accomplish several goals for Native Americans and their healthcare which include:

- Cultural awareness among native American veterans
- Improve communication among the VA, Native American veterans and Tribal governments with assistance from Indian Health Services
- Encourage partnerships and sharing agreements among the Veteran Health Administration (VHA)
- Ensure appropriate resources are available to support programs for Native American veterans
- Improve health-promotion and disease prevention services
- Improve access to quality health care and services

The 2010 MOU continues to be implemented with various workgroups to put into place sharing agreements, and other interagency efforts that are contained under the current IHS and the VA current agreement. The workgroups between IHS and VA are to improve services for Native American veterans in regards to benefits, coordination of care, health information technology,

and new technologies (i.e. telehealth). By not making Native American veterans travel far through use of technologies such as telehealth initiatives, IHS and VA have enrolled and treated 700 new veterans, including 400 veterans accessing the mental health services. This has been accomplished by the innovative way the VA has introduced telehealth services in the health care facilities on the reservations.

According to the US Department of Health and Human Services Administration for Native Americans stated that many challenges facing Native Americans veterans are similar to those veterans of all ethnicities. Some of the needs are as follows: access to healthcare, unemployment, homelessness, and mental health issues including post-traumatic stress disorder (PTSD), depression, and substance abuse.

An American Legion System Worth Saving site visit was conducted on January 30- February 3, 2012 and included Past National Commander Ron Conley; The American Legion Director of Veterans Affairs and Rehabilitation, Verna Jones; Media Marketing Director, Phillip (Marty) Callaghan; and VA Office of Tribal Government Relations (OTGR), Thomas Birdbear - Southwest Specialist to the tribal lands on the Navajo Nation Reservation in Chinle; Window Rock, Arizona; Pueblo of Laguna; and Pueblo of Santo Domingo in New Mexico, to learn more about and better understand how access and quality of healthcare services are delivered and are available to rural Native American veterans, and to find ways to help improve the provision of VA services for Native American (NA) veterans.

The first location visited was the Navajo Nation in Chinle, Arizona. During this visit the SWS representatives met and interviewed tribal leaders, tribal veteran officers and veterans about access to healthcare. The Navajo Nation was established on June 1, 1868, and is a semi-autonomous Native American governed territory that covers over 27,000 square miles in northeastern Arizona, southeastern Utah, and northwestern New Mexico. The Navajo Nation is divided into 16 chapters where approximately 10,000 veterans are living on the reservations. The veterans who reside on the reservation in Chinle have to travel four to six hours to the nearest Department of VA located in Phoenix; Prescott; and Tucson, Arizona.

They also met with tribal leadership and veterans at the Pueblo of Laguna reservation located in west-central New Mexico which is approximately an hour and a half to the VA Medical Center in Albuquerque. There are six tribes and 8,500 members within the reservation in which 450 are veterans. Overall, the Pueblo of Laguna tribal veterans were satisfied with the VA's delivery of primary care that was offered at the rural Native American reservation.

Challenges:

There are several challenges that Navajo veterans face while trying to access VA benefits and services. The American Legion believes that better coordination is needed between the tribes and VA services, such as Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA) programs. Veterans also lack consistent and dependable transportation to VA health care and/or integrated IHS/VA health care services while residing on the reservations. Training and accreditation of Navajo Nation

Tribal Veteran Service Officers located in Arizona, New Mexico, Colorado and Utah on Veteran Benefits Administration (VBA) programs was also identified as problematic.

The American Legion also identified restriction of state government in caring for Native American veterans that live in other states as a problem, and there is a greater need to integrate Native American cultural and traditional medicine into the IHS/VA health care regimen, which is primarily more Western-based. The American Legion believes that VA needs to identify patterns/paths for veterans' preferences for health care, and identify referral patterns/paths of VA providers to non-VA providers for health care to veterans.

In order to provide a more integrated and streamlined system, VA should involve VA Community Based Outpatient Clinics (CBOCs) that are on or near tribal land areas for the purpose of triage of care to veterans. Also, they should integrate VA Long-Term Care placement efforts with tribal health and IHS providers for placement of Veterans in nursing homes/long term care facilities while developing and maintaining routine dialogue and communication with Veteran service staff and officers on tribal lands.

VA and HIS need to fully understand dual eligibility status (between IHS and VHA) and its application to veterans. According to the Office of Tribal Government Relations, although Native American veterans can receive health care from either VA and/or IHS they are four times more likely than other veterans to report unmet health care needs.

Several other barriers that Native American veterans residing in rural, or highly rural areas face while attempting to access healthcare include the challenge of having to travel great distances to access VA health care services, technological barriers that other cohort groups don't have due to lack of computer, internet, and in some cases, even telephone service. And the additional challenges of scheduling early healthcare appointments for veterans, which can cause a veteran to get up at 4 am and leave their homes for an 8 am or 9 am appointment at Vet Centers or VA Medical Centers.

Finally, the extremely high percentages of homelessness among the Native American Veteran Community which, in many cases can be attributed to the severe lack of local employment opportunities, lack of shelters for women veterans with children, and lack of affordable housing. Unfortunately, the native American culture does not allow easy access to programs such as building homes or having transitional homes for homeless veterans due in large part to the property restrictions on the reservations. One example is that Native American reservations are considered sacred land to the Native American community, and not eligible for building.

Recommendations

- Better coordination is needed between the tribes and VA services such as Veterans Health Administration (VHA), Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA) programs.
- Consistent and dependable transportation to VA health care and/or integrated IHS/VA health care services that are available on the reservations.

- Training and accreditation is needed for Native American Tribal Veteran Service Officers on Veterans Benefits Administration (VBA) program.
- IHS and VA need to continue to improve education and outreach to the Native American veteran population, so they become aware of their entitled federal and state benefits.
- IHS and VA need to provide Native American veterans that reside on reservations equal access to IHS/VA physicians, and mental health care professionals, in order to obtain VA healthcare benefits while respecting and addressing cultural differences.
- VA and IHS need to collaborate with local Tribes in an effort to utilize the existing Native American health care infrastructure in order to effectively serve the Native American veteran population who reside on reservations.
- IHS and VA need to train Tribal Veterans Service Officers on the reservations to be certified, and or accredited, in order to provide benefit claims and related assistance to Native American veterans.

Conclusions:

The American Legion site visits across the country have found several of these key points to remain critical areas of focus:

- As always, VA coordination with agencies outside VA remains an area in need of improvement. Much as with the Department of Defense, VA would benefit from improved communication plans with Indian Health Services.
- As in most rural regions, transportation remains problematic.
- Better training and outreach will improve access and use of services, and will maximize efficiency of services used.
- Better utilization of on-reservation HIS and VA coordinated care can meet the unique cultural needs of Native American veterans.

Native Americans serve in this country's armed forces at a higher percentage per capita than any other ethnic group. Their long tradition of honorable service cannot be met with substandard service from the VA and IHS services designed to serve them.

The American Legion thanks the Committee for their attention to this critical issue, and extends our offer to work with the Committee and the community to find solutions for these veterans and ensure their needs are met. Questions regarding this topic or testimony should be directed to The American Legion Legislative Division through Ian de Planque at ideplanque@legion.org or (202) 263-5755.