S. HRG. 118–301

FRONTIER HEALTH CARE: ENSURING VETERANS' ACCESS NO MATTER WHERE THEY LIVE

HEARING

BEFORE THE

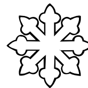
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

MAY 15, 2024

Printed for the use of the Committee on Veterans' Affairs



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55–729 PDF WASHINGTON : 2025

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FRONTIER HEALTH CARE: ENSURING VETERANS' ACCESS NO MATTER WHERE THEY LIVE

WEDNESDAY, MAY 15, 2024

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

The Committee met, pursuant to notice, at 3:30 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Murray, Brown, Blumenthal, Hassan, King, Moran, Boozman, Rounds, Tillis, Sullivan, and Blackburn.

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

Chairman TESTER. Good afternoon. I want to welcome everybody to today's hearing on access to health care for rural veterans. We are going to take a closer look at whether VA is meeting the needs of rural veterans and what needs to be done better.

On our second panel we have a gentleman by the name of Chauncey Parker, who is going to join us. Good to have you here, Chauncey. He is a native veteran from Montana, just down the road from where I live, as a matter of fact. Chauncey and his team at the Great Plains Veterans Services Center—Rocky Boy, do an incredibly good job for rural and native veterans, and I believe his insight, albeit on the second panel, to the challenges we have today is going to be key.

I want to also thank Wade Vlosich. Wade, thank you for being here. He has done important work in Montana gathering feedback from veterans and staff and making recommendations to improve health care and services for veterans across our state. This included traveling to every facility in Montana to meet with folks, learn about the difficulties of accessing health care across long distances and challenging geography.

If you want to understand the barriers that rural veterans face, you need to walk a mile in their shoes. More than 2.7 million veterans enrolled in VA health care live in rural or frontier areas—that is code for "remote"—and the VA must deliver quality health care and benefits to them, regardless of where they live. Key to that effort, and particularly difficult in rural America, is recruiting and retaining providers and support staff. That starts with ensuring the VA continues to aggressively recruit and retain high-demand clinicians in rural areas. It also includes access to transpor-

tation benefits and services, including beneficiary travel reimbursement. Last fall, with the help of Senator Moran, we introduced the Road to Access Act, which would improve the beneficiary travel claims process by reducing the burden on our veterans.

And we need to make sure rural veterans can access lifesaving emergency air and ground ambulance transportation. We have got a bill called the VA Emergency Transportation Access Act that is going to ensure changes to the VA's reimbursement rates, will not reduce access to this special mode of transportation that is so critically important for rural America.

And finally, any effort to expand access to rural veterans must include outreach to ensure that rural veterans know what benefits and services are out there for them. That includes expanding access and outreach to our Native American veterans who, by the way, serve the Nation at a higher rate than any other minority in this country. Yet, access to VA is at some of the lowest rates.

And programs and strategies for health care staffing and services must be suitable for rural communities. Some of them may work well for urban veterans but not so much for rural veterans. And that is why I required the Department to develop and institute a rural-specific recruitment and retention strategy as part of the PACT Act, which was rolled out earlier this year. This kind of targeted planning and programming needs to spread across the VA to include research, direct care offering, grant programming, and much more. And I look forward to hearing more from our witnesses about these topics, and more.

I think I will get right into the panel. I want to make some introductions here. First of all, good afternoon.

On our first panel we have Dr. Peter Kaboli. He is accompanied by Ryan Heiman from VHA Member Services; Leonie Heyworth, from the Office of Connected Care, Telehealth Services; and the other guy that has got a tough name for me to pronounce, Wade Vlosich. How is that? Is that okay?

Mr. VLOSICH. It is Vlosich, like sausage.

Chairman TESTER. Oh. Vlosich. Why didn't you say so?

He is the Director of the VA Oklahoma City Health Care System.

Dr. Kaboli—by the way, why don't you guys just have a name like Tester or Rounds or something like that, okay?

[Laughter.]

Chairman TESTER. That is for good reason you don't.

But your entire written statement, Dr. Kaboli, will be entered into the record. I would ask that you try to keep it around 5 minutes. And with that the floor is yours.

PANEL I

STATEMENT OF PETER KABOLI, MD, MS, EXECUTIVE DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RYAN HEIMAN, MHSA, CPTA, DEPUTY EXECUTIVE DIRECTOR, VHA MEMBER SERVICES; LEONIE HEYWORTH, MD, MPH, DEPUTY DIRECTOR FOR CLINICAL SERVICES, OFFICE OF CONNECTED CARE; AND WADE VLOSICH, DIRECTOR, VA OKLAHOMA CITY HEALTH CARE SYSTEM

Dr. KABOLI. Thank you, Chairman Tester and Ranking Member Moran and the Members of the Committee. Thank you for this opportunity to appear before you to discuss the Veterans Affairs efforts to enhance the well-being of rural veterans by addressing their unique challenges.

I am joined by Mr. Ryan Heiman, Deputy Executive Director of Member Services; Dr. Leonie Heyworth, Deputy Director for Clinical Services for Telehealth; and Mr. Wade Vlosich, Director of the VA Oklahoma City Health Care System.

Growing up in rural Lee County, Iowa, I experienced rural health firsthand. I attended medical school at the University of Iowa, and have since served rural veterans as a hospitalist, including as a tele-hospitalist filling gaps in rural sites.

VA strives to bridge the gaps between veterans in rural areas and resources. Much of that work has been led by our five Rural Health Resource Centers in Portland, Oregon; Salt Lake City, Utah; Gainesville, Florida; White River Junction, Vermont; and Iowa City, Iowa, where I have practiced hospital medicine for 26 years.

We serve all 4.4 million veterans who reside in rural communities, making up a quarter of all veterans. Most choose to live in these communities and appreciate the benefits of rural life. However, long travel distances and broadband limitations can make accessing care difficult. Rural veterans have a higher rate of enrollment in VA care, at 61 percent, compared to enrollment rates of only 41 percent for urban veterans.

This higher enrollment rate and dependence on VA underscores the need to focus on four key challenges for rural populations. The first is geographic distance, second is telehealth and the digital divide, third is social determinants of health, and the fourth is workforce.

For geographic distances, there are two ways to overcome this for rural and frontier veterans—either bring the veterans to us through transportation or bring the care to them through telehealth and home services. VA supports the Veterans Transportation Service, which fielded requests for over 900,000 rides in 2023, including 105,000 rural trips. ORH also supports the Highly Rural Transportation Grants program that provided 19,000 trips, averaging 74 miles each way, serving rural counties in 26 States and 58 Tribal communities. VA also manages and continues to streamline the Beneficiary Travel Self-Service System to reimburse travel costs and improve access.

The second key challenge is the digital divide and the use of telehealth. VA has significantly expanded telehealth services with a 347 percent increase in use and a 3,100 percent increase in home video services over 5 years. In fiscal year 2023 alone, VA delivered over 2.9 million telehealth episodes to 770,000 rural veterans. One current challenge is the state level variability, regulating controlled substance prescribing in telemedicine, and VA has requested clarified authority to standardize these services.

The third challenge for rural populations involves social determinants of health, including special populations like American Indian and Alaska Native veterans, who serve at high rates and disproportionately live in rural areas. Key initiatives include exempting or reimbursing $3.2 million for 180,000 copayments for over 4,000 eligible veterans; providing supportive housing for homeless veterans, with 29 Tribes participating in a joint VA-Housing and Urban Development program; and the third is enhanced efforts to reduce the high suicide rate among American Indian, Alaska Native veterans, including $52 million in grants and collaborations with tribal communities.

The fourth key challenge is workforce. Although we all know we have a national shortage of health care providers, the shortage impacts rural communities more acutely. In rural locations they lack a deep bench of staff, so when one position is vacant it disproportionately impacts that site of care. So, to address this need, Office of Rural Health and Workforce Management developed the Rural Recruitment and Hiring Plan, and we disseminated that in 2023.

So let me end with three examples that illustrate how we address the unique health care needs of rural and frontier veterans.

The first is we developed a novel tele-HIV program to remote and insular islands, like Guam and American Samoa, that ensures highly specialized care.

A second example is we have expanded home pulmonary rehabilitation services to 35 sites, which supports the PACT Act and veterans with toxic exposure and lung disease.

And we are launching a new program called SCOUTS that hires former military medics to be trained as intermediate care technicians in emergency rooms, to engage with older veterans and provide close follow up through telehealth and home visits.

So, Chairman Tester and Ranking Member Moran, thank you again for the invitation to join this important discussion. We value our ongoing engagement as we embrace our shared responsibility to better serve those who have served, and we look forward to answering your questions.

[The prepared statement of Dr. Kaboli appears on page 45 of the Appendix.]

Chairman TESTER. I appreciate your testimony, and I assume the other three are there to support you in the Q&A.

Before we get to the important questions about rural veterans' health care, you were an Iowa practicing doctor for 26 years?

Dr. KABOLI. Yes. I am still there. I have got to see patients on Monday.

Chairman TESTER. Did you deliver Caitlin Clark?

Dr. KABOLI. No.

[Laughter.]

Chairman TESTER. Just curious.

Dr. KABOLI. But it is Iowa, so we all know each other.

Chairman TESTER. Okay. Well, that is good. That is good.

Mr. Heiman, the most common complaints and casework requests I get from veterans in Montana are related to the Beneficiary Travel Self-Service System. That is your bailiwick. The system is getting better, but there is still room for improvement, from a user-friendly standpoint.

Can you give me an update on your work with veterans to improve that claims submission process?

Mr. HEIMAN. First of all, thank you, Chairman Tester. I appreciate your interest and your staff's interest over the years, quite frankly, on this topic.

Last year we implemented a veteran survey. It was in partnership with the Veteran Experience Office. And so far, we have had over 11,000 veterans that have taken that survey. From the period of October 2023 to April 2024 we have seen an improvement. We have seen a 16 percent improvement in ease and simplicity associated with the BT app, and we have seen a 17 percent overall increase in satisfaction.

Another important note that we found interesting that I would share with you, because some of our concerns we get are from some of our more seasoned veterans, we will call them, but this population of veterans, of the 11,000, 80 percent are over the age of 50, that are responding to our survey.

So, I would attribute it to a few things. There have been several enhancements to the Beneficiary Travel Self-Service System (BTSSS) application, specifically some integrations that we have completed is with the patient check-in application. So, it is really a seamless experience for veterans, as they are using that patient check-in application, as well as an important one with My HealtheVet, where when they log into My HealtheVet they are not having to log in again to get to the BTSSS portal. Login issues were some of the early on concerns that we heard.

Chairman TESTER. I can attest to that.

Mr. HEIMAN. Yes. The second portion of this, I think, that is important is that we launched, in late 2022, a centralized team, or claims processing team, within our Veterans Transportation Program. We have helped, since then, 57 VA Medical Centers, specifically, to help them with their claims inventories and get them back to solid ground. And that is something that we have seen that has helped, and it improves the overall turnaround time for those claims.

Chairman TESTER. So, as has already been pointed out by you, Mr. Kaboli, 61 percent of rural veterans are enrolled in VA, 41 percent urban. This is for you, Dr. Kaboli, and Mr. Vlosich. How is VA using the new hiring authorities in the PACT Act to ensure that there is sufficient staff at rural facilities to accommodate newly eligible veterans?

Dr. KABOLI. Yes. Thank you for that question, Chairman. What is nice about the new authorities with the PACT Act is it adds to the already large array of things that we can do. And as you mentioned, the work that we did with workforce management to de-

velop a Rural Recruitment and Retention Plan, that came out in the end of 2023. One of the things that we have been doing is really disseminating that, which includes all the tools that are available, whether it is things that already existed, like the Education Debt Reduction Program—that is a program that one of my colleagues took advantage of to come to the Iowa City VA Medical Center, and is still there—and the other educational repayment programs.

One of the specific things in the PACT Act is the buyout provision. I know so far there have been 15—I think 10 have already started, and there is a total of 15. I am familiar with 3 of them at the Tomah, Wisconsin VA Medical Center, where I see patients from time to time. So, I think there are tools that we can use, and we appreciate that.

Chairman TESTER. Okay. Mental health is a big issue. It is something we hear about a lot in this Committee. It is something that is a problem in Montana. We lead the Nation in suicides, us and Alaska, one and two or two and one.

The VA, what are they doing about getting providers into rural areas? I am talking about mental health providers. And specifically, what guidance have you received, either one of you, Mr. Kaboli or Mr. Vlosich, what guidance have you received from VA regarding recruitment and retention of mental health folks in 2024? And might I be specific, in the last 6 weeks.

Dr. KABOLI. Thank you for that, and I will go first, and then you can fill in. I would say a couple of things. First of all, I have been in my position for 4 months but acting for about 20 months. Everything that I have heard over the last few years has really been for mental health, it is continue forward. And I have not heard anything change for that, even in the last 6 weeks?

Chairman TESTER. So, you have not heard, there has been nothing coming down saying you need to cease hiring for mental health?

Dr. KABOLI. Not for mental health, no. That is one of those that I was told those are exempt and that we should continue to move forward on those, even as part of, you know, the strategic approach to looking at hiring, that mental health we should be moving forward.

I would like to add one more thing about it.

Chairman TESTER. What would your advice to the VA be if they came down with a directive that said, "We are going to freeze all hiring, including mental health"?

Dr. KABOLI. Oh, I think that would be a terrible idea. My advice would be to rethink it pretty quickly. You know, the thing about mental health especially is one thing that we can do with mental health is the use of telemedicine, and you know that. But I think we can fill gaps very quickly using the clinical resource hubs and other resources to ensure that there are providers so there are not wait times, especially for urgent needs.

Chairman TESTER. Mr. Vlosich, do you have anything you would like to add?

Mr. VLOSICH. Yes, and we are continuing to recruit for mental health providers. One of the things we have noticed in a rural setting where we have kind of, as we have gone out and talked to vet-

erans, what we are doing is focusing our efforts into hiring staff that are boots on the ground. A lot of our older rural veterans are saying, “Hey, I like the virtual option every once in a while, but I really want a doctor face-to-face.”

So to go to your PACT Act incentives, we have been able to start to recruit mental health providers, boots on the ground, due to the incentives that we have been able to provide through the PACT Act.

Chairman TESTER. You know, before I get to Senator Rounds, I just want to say this. I could not have answered my question any better than you guys answered my question. You need to ensure the VA is doing what you guys are saying, because quite frankly, mental health continues to be a crisis in this country, both in the civilian world and especially in the veteran world. And it is incumbent upon us to make sure that we have the providers there, we have the help there, we have what the veteran needs, especially if they are in crisis.

Senator Rounds.

HON. MIKE ROUNDS,
U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman. First of all, I want to thank our guests for joining us here today, and for your service to our country.

Dr. Kaboli, I would briefly like to talk about the need to appropriately resource VA facilities in rural America. I am encouraged that the Department is expanding facilities in Hot Springs, South Dakota, and allocating additional personnel to Fort Meade, which is near Sturgis, South Dakota.

Can you talk about the importance of appropriately resourcing VA facilities in locations such as these in South Dakota?

Dr. KABOLI. Yes. Thank you for that question, Senator Rounds. I would be happy to.

So, I am also in the Veteran Integrated Network (VISN) 23 in Iowa, so Hot Springs and Fort Meade are obviously in our VISN. And I know you were involved with the AIR Commission and the reports that came from that.

I think we all are looking at better ways to provide services, and places like Hot Springs and Fort Meade, being 90 miles apart, what are the things that need to be in one location, what can be shared, what needs to be in both locations.

The other thing, in talking more broadly, even outside of South Dakota, is identifying where there are gaps in care, that we either use care in the community or that we establish new sites of care. We have been working with the USDA to try to identify locations that are ripe for adding either VA sites of care or partnering. We are looking at Craven County, North Carolina, which you are familiar with, Senator Tillis.

Senator TILLIS. You just saved me a question.

Dr. KABOLI. Okay. Well, I can answer it again. But that is one that sort of fits all the needs for both distance of how far veterans would have to travel that already live there and what facilities are around there. It also allows us to partner with a local hospital—I cannot remember if it is a hospital or Federally Qualified Health

Center (FQHC)—that has space, and that is something that we can either lease or, especially with some of the new abilities, but also whether we partner with an FQHC.

There is another, in Polk County, Texas, that just sort of fits that perfect circle of where there is not care, that we could fill something in.

Senator ROUNDS. Well, and just to your point, if we would have allowed the AIR Commission to move forward it would have been devastating to some of our rural hospitals. And, in fact, on a bipartisan basis, we were able to stop the recommendations that were found within that report. And now today we are talking about what we can do to actually improve rural health. The AIR Commission, in my opinion, would not have done that. In fact, it would have hurt it, shutting down emergency rooms in some places but severely restricting access for our rural veterans.

In fact, Dr. Kaboli, as you know, a significant number of rural veterans receive acute care from critical access hospitals like Bennett County Hospital in Martin, South Dakota. It is the only non-Indian Health Service (IHS) emergency room for nearly 100 miles, and its emergency room remains busy caring for an average of 250 patients on a monthly basis.

How important is it to make sure that critical access hospitals like Bennett County Hospital are appropriately resourced, and what would be the impact on care for veterans in rural areas if critical access hospitals in these areas were closed?

Dr. KABOLI. Thank you for that question, Senator. That is a great example of why these critical access hospitals play an important role for not only their community but also for veterans that live in that community, because of the distance they would otherwise have to travel to be cared for by somebody like me who is a hospitalist.

So, for hospital care, 80 percent of rural veterans get care for their hospitalizations outside the VA, and half of those are in rural hospitals and half are in urban hospitals, because a lot of rural residents live close to an urban center and they just come in for care. But those rural critical access hospitals are absolutely important for the community and for us.

So, we need to partner with them. We have a couple of things that we are doing. One is we are starting a pilot program so that patients that are in those hospitals that are veterans, if they need to be transferred out that we can take them, and take them efficiently. But more importantly sometimes it is just keeping them there, that we can continue to pay for the care but keep them there in their hospital, they are in their community, and they are there where there is——

Senator ROUNDS. And, in fact, I agree with you, and I do not mean to interrupt, but I have one more question I really want to ask because it is leading right down that line. I have heard from veterans in South Dakota who say that their care is disrupted when they have repeatedly received prior authorizations for their community care appointments. These requests can take weeks, and are sometimes seemingly denied with no apparent reason involved.

What is the VA doing to make certain that veterans, especially those in rural communities, are not experiencing extra hurdles to

receive the care in the community that they have chosen? And are you aware of the problem that they are having in literally having to go back through and get repeated authorizations for this care?

Dr. KABOLI. Yes, thank you, Senator.

Senator ROUNDS. I think the answer was yes, you are aware.

Dr. KABOLI. Yes, I am aware.

Senator ROUNDS. Okay.

Dr. KABOLI. And then I am going to ask one of my colleagues to maybe help me out with it, too.

I would say two things about it. The first is, you know, as a physician providing care in the VA, I take it very seriously that patients get the care, where they want it, where they are eligible for it, locally. That is totally fine, to make sure the authorizations go in and is managed through that office, the Community Care Office. There are times when authorizations do expire or if it is for a new condition, so they have to be renewed, and I think we need to get better at that.

We have a Referral Coordination Initiative that has really done amazing things in some sites—I can say Ann Arbor, Michigan, is an example—to make sure that the office handles those and then gets them into VA care when we can provide it, and when they cannot, make sure they get care in the community.

Mr. VLOSICH. Yes, the other thing that we are doing, the Department is looking at what we call SEOCs, episodes of care. And so those standardized episodes of care, what we are doing is we are reevaluating them periodically to see how long those authorizations should last. So, you will see some adjusted, some linked in. So, we are really focusing in on how can we improve that experience for our veterans.

So, for instance, in Oklahoma City, one of the initiatives that we have started is called VA Chat. So, if you have a phone or a computer and you need to get ahold of your provider or the Community Care Office about your community care provider, you can just put it in the chat and our staff will respond to them immediately to get them a turnaround, to get some of those authorizations back in place.

We have experienced some of that due to the rules, but what we have done is we have allowed our staff locally to look at authorizations and how we can reenact some of those, to make it easier for veterans.

Senator ROUNDS. Well, I am really glad you have got a workaround on it, but if you need a workaround the chances are the rule may not be right in the first place.

But Mr. Chairman, I have used up my time. Thank you for allowing me the extra time.

Chairman TESTER. Well, it gave Senator Murray a chance to sit down. So, Senator Murray.

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

Senator MURRAY. Thank you. Thank you to all of you for being here today.

I know food insecurity continues to be a problem for our active duty servicemembers, but more needs to be done to address the

fact that when servicemembers transition into the civilian world many of them continue to experience that food insecurity as veterans, especially those who are living in our rural areas. Rural veterans are more likely than other veterans to live in poverty, and almost half of them earn less than $35,000 a year. So, food-insecure veterans are also consistently less likely than their non-veteran peers to be enrolled in SNAP. So, it is really critical that we are able to fund those programs that veterans rely on outside of VA, but which compete each year with other programs under the tight spending caps we have.

As Chair of the Appropriations Committee, I want to make sure we are meeting all the needs of our veterans, such as battling food insecurity, while still funding the VA medical care. VA medical care is a critically important, but it is a skyrocketing cost within NDD, which is why I have argued for making it its own separate third funding category so we can better avoid pitting its funding against the funding of other important programs for our veterans.

Dr. Kaboli, I know VA has worked to implement a screening process to identify veterans at risk of food insecurity, but how can the VA improve its process to more accurately identify veterans who are experiencing that?

Dr. KABOLI. Thank you, Senator Murray. I think you are referring to the Assessing Circumstances and Offering Resources for Needs (ACORN) screen?

Senator MURRAY. Yes.

Dr. KABOLI. Yes. That has just been rolled out in the past year, and I think we are all learning at how best to do that and how to act on positive findings from it. This is where our social workers are just an incredible asset, because they are the ones, once we can make the referral to them, to then connect them to resources in the community, or if they are eligible for SNAP or other programs.

So that is one of the key things, I think, to say how we are going to do it is to use the screen, and then if people screen positive how do you act upon it.

Senator MURRAY. Are you looking to expand any of your existing food insecurity programs?

Dr. KABOLI. The one that I can comment on that is with the Office of Rural Health that we are working on, in partnership with USDA, is a food program that we piloted at the White River Junction, Vermont VA Medical Center, to essentially contract out food shares with local food producers and then veterans can sign up for them. We have done that for a couple of years and now we are expanding it to other sites. And our goal is to be able to come up with a mechanism to do this in partnership with USDA so that we can have this at any site that would like it.

Senator MURRAY. Okay. Thank you very much.

Let me talk about Native American veterans, because as you may know, they serve in the military five times in the national average, and in Washington State alone there are about 6,500 Native American veterans. And as we also know, tribal lands tend to be more remote and isolated from medical services. For example, while 99 percent of urban households have access to broadband, only 65 percent of housing units on tribal lands have the same ac-

cess. This is a huge issue for Native American veterans who rely on telehealth services to access care.

I know the VA has made some progress in that area but more needs to be done. So, Dr. Kaboli, what are some of the ways VA is working to help more rural veterans access telehealth, and is VA looking to expand broadband internet access in tribal areas?

Dr. KABOLI. Thank you, Senator Murray. I will take the first part and then I will have Dr. Heyworth answer.

There are a couple of things I would say. First of all, we are to the point now with lower satellite internet and expansion of other broadband mechanisms that it is available almost anywhere, but it is whether you can afford it or not. You can sign up for some of these services at $100 a month, but if you do not have $100 a month it is hard to afford.

So, a few things that we do. One is to ensure that there are other sites that they can get telehealth at, community-based clinics, or that they can log in from family members or other places. It is hard on tribal lands, and we are working with the Indian Health Service on programs that can potentially help with that. And I will let Dr. Heyworth answer.

Dr. HEYWORTH. As part of the Bipartisan Infrastructure Act, we have been working very closely with the National Telecommunications Information Administration (NTIA), with the VA serving as a consultant to states as they roll that Broadband Equity Access and Deployment (BEAD) program and their digital equity proposals, with veterans as a covered population in that legislation. We want to ensure that we are very involved in the rollout and implementation as the funding goes out.

In addition, we have been working as a member on the Rural Partners Network, which is led by USDA, again along the lines of involvement and making sure that veterans, as a covered population, are involved, as funding is rolled out for broadband expansion.

I also had the honor of being on the Choctaw Nation in Oklahoma earlier this year, and had the opportunity to speak with tribal leaders there about broadband access, affordable access, and about the possibility of ATLAS sites, which stands for Accessing Telehealth through Local Area Stations—I would be happy to talk more about that—and the possibility of those sites as access to care mechanisms on tribal lands.

In addition, we talked a lot about the opportunity for telehealth in the VA IHS MOU, which is an ongoing collaboration between VA and the Indian Health Service.

Senator MURRAY. Okay. Thank you very much. And Mr. Chairman, I have gone over time. Thank you.

Chairman TESTER. Senator Tillis.

HON. THOM TILLIS,
U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Mr. Chair, you know, Senator Sullivan and I have a history of comparing populations, but in the interest of our relationship, I am not even going to mention that there are seven states with smaller populations than the million veterans that I

have in North Carolina. But I am not going to say that, in the interest of——

Chairman TESTER. I am glad you did not make that big——

[Laughter.]

Senator TILLIS. Thank you. I did have a question. I want to go back to what Senator Murray talked about. Right now, with telehealth, we have got to crack the nut on broadband access. But are there authorities right now that are only temporary, or have we permanently authorized the use of telehealth for any sort of provisioning of health care in the VA?

Dr. HEYWORTH. Thank you, Senator Tillis, for that question. I would first like to take a moment to briefly reflect on the tremendous growth of telehealth——

Senator TILLIS. No, 100 percent. I am sorry to cut you off, but if the answer is yes, there are some temporary, not permanent authorizations, I for one think that they need to be permanent. Now, a temporary authorization for telehealth would be tantamount to a temporary authorization for using Tylenol to treat a headache or a pain.

Look, if we want to address the problems of broadband access, we have got to provide certainty to the markets that this is standard operating procedure. The minute we do that in the whole of government, you are going to see capabilities in telehealth we cannot even imagine right now. But if we do this year to year, every 2-year authorization, you are not sending the signal to market and innovators that it is here to stay.

So, I would really appreciate if you could report back to the Committee which specific temporary authorities should be permanent, and please, have anyone in the VA contact my office if they think this telehealth thing is not here to stay. It is kind of like the internet. I think it is going to stick.

So, on telehealth, I think we just need to move forward on that.

I did want to get parochial. I try not to in these hearings. But I have got about a 31,000 number backlog—gives you an idea of how big our veterans population is—for expense reimbursement for travel. Tell me how I can make them feel better about getting timely reimbursement for travel to VA facilities?

Mr. HEIMAN. Yes, thank you, Senator Tillis. I did speak just a little bit earlier. Something that we have put together is a team that is called a claims processing team. I will be happy to look into that for you, for some of your state——

Senator TILLIS. It seems like a big number. I mean, even though we are working with a big base of folks that use the VA, that is a big number. One of the reasons I love my state is in the last census it went from a majority rural state to a majority urban state, but it is basically 49/51. So, I get to observe all the challenges of an urban setting and all the challenges of a rural setting. In this case, the vast majority of these reimbursements are for people in rural area. So, if you could just report back for the purposes of the Committee.

Mr. HEIMAN. Absolutely.

Senator TILLIS. Thank you. And the last question I had, you mentioned Craven County and a project there. You were talking about, to Senator Rounds, the USDA collaboration. You know, I, for

one, think, we have done some work at Womack, and I have talked with Director Crews about this. Tell us what authorities, tell us what the impediments are. Are there authorities that you need? Are there constraints on being even more creative, beyond the USDA? Or is it money, or is it both? In other words, how can I crack the nut on getting really creative, with DoD facilities, USDA facilities, public-private partnerships? What more do we need to be able to have more of a physical presence of the VA in more places, in all our states, not just in North Carolina?

Dr. KABOLI. Thank you for that question. For the sake of time, I will try to be brief. You know, I do not think I can answer all the things that we would need, but, you know, money always helps, but it is not always the thing that you need. Sometimes it is just taking down barriers to creating the relationship.

And what we have found, at least in the work we have done in the Office of Rural Health, is it is the relationship that really matters. So, me being down in Texas a couple of weeks ago and meeting with people from Polk County, I really got a sense of what their need is and what the towns are. Same thing in North Carolina. I was in Fayetteville two weeks ago and getting to meet people there and the State Director for the USDA, and saying, “Hey, we can do this.”

So, I think it is getting the right people together to make it happen. Because we can identify the locations, and we have done that already, and now it is a matter of figuring out whether we can get lease space from existing facilities, like FQHCs or rural hospitals, or if we just buy services there.

Senator TILLIS. Yes, well thank you. I think that is very important. But you should, to the extent it requires authority or it requires gentle nudges from other agencies to come to the table, to please inform the Members of the Committee. I am sure they are all interested in the same outcome. Thank you.

[Department of Veterans Affairs responses to Senator Tillis appear on page 87 of the Appendix.]

Chairman TESTER. Senator King.

HON. ANGUS S. KING, JR.,
U.S. SENATOR FROM MAINE

Senator KING. Thank you, Mr. Chair. Before beginning my questions, it has now been, let’s see, 3 ½ years since the Johnny Isakson and David Roe Veterans Health Care Bill passed, and in that bill was a requirement for the VA to provide back payments for domiciliary care in veteran homes. We still do not have the final rule, 2 ½ years. Eisenhower retook Europe in 11 months. Do you think we can get this rule out sometime? Would you take that message back? Thank you.

Dr. KABOLI. Yes, thank you, Senator King. I will take that message back.

Senator KING. Just send an email that says “Eisenhower!” with an exclamation point.

[Laughter.]

Dr. KABOLI. Okay. And I am sure they are watching it, so thanks for saying that.

Senator KING. Thank you. I want to associate myself with Senator Tillis' context on telehealth. I think it is one of the most important things that we are doing. We ought to be knocking down all barriers. It is better for the patients. It is better for the providers. We have found in Maine that people with telehealth appointments tend to make the appointment more frequently, and then for people with behavioral health, mental health issues, you do not have to sit around in a waiting room and feel uncomfortable about who else is there.

So again, if there are any authorities that you need, any extensions—and I do not think those should be extensions. They ought to be made permanent. I think that is one of the most important things that we can do, particularly for rural veterans. And, of course, internet is important, but then if you can also make telehealth facilities available in Community-Based Outpatient Clinics (CBOCs).

And how about this? How about setting up telehealth kiosks in American Legion posts, VFW posts? We have got places where veterans go in virtually every town in America. And let's think about that as a possibility for expanding access, particularly in communities where broadband access is difficult.

Now, I am confused about personnel. We have seen a report that over the next 5 years you are going to have to hire 21,000 new people to keep up with expected growth. One of the facilities, coincidentally, that is anticipating the most growth is Togus, the veterans hospital in Augusta, Maine. They need to hire nearly 800 new staff. But then Secretary McDonough is talking about zero growth, and also your budget calls for cutting 10,000 FTEs.

I am confused. Are we going to hire the people we need, or not?

Dr. KABOLI. Okay. Thank you, Senator King. I will take a first shot, and then I am going to ask my colleague here to help me out.

I would say we had a lot of discussions over the last couple of days specifically about this, and the word "strategic" came up a lot, you know, how we are doing strategic hiring, and making sure that we are using the FTE and the budget that we have in the right places.

So, over the next, I think, I am guessing, weeks and months, we will be looking at this very carefully to decide where we need to put the resources and where we need to put the people. Because you are right, it does not really compute when you say you need more people but then we are at a keeping FTE even.

I am going to let Mr. Vlosich answer too.

Mr. VLOSICH. At the local level we are working with our VISNs and National Office. For those areas that are growing they are allowing us to move around our FTE. So, we are recruiting FTE, and we are still doing that.

Senator KING. Well, if you are sort of rationalizing the organization, I have no problem with that, as long as we do not end up with less service.

Mr. VLOSICH. No, and I think the services will not be impacted at all. We have got the staff we need in order to accomplish the mission. But what we are doing is we are looking at all of our FTE right now and trying to see where is the best place to put them into.

Senator KING. Okay. Thank you. Mr. Heiman, rural State Maine access, transportation is a huge issue. And a little homely example. The town of Caribou, which is way up in northern Maine, you had a contract deal with a contract to bring one veteran down for dialysis. They put somebody on the staff to do that kind of driving. It saved $7,000 in a month, saved the Veterans Administration. So I hope you will think about where and when additional staff to provide this kind of transportation can really make a difference.

Mr. HEIMAN. Yes, I appreciate that, Senator King. We do have that program that you are referencing at 128 VA Medical Centers. There are over 1,000 vehicles in the fleet that are providing similar type services. I would also reference that this was included in the President's budget submission for fiscal year 2024 in relation to the Highly Rural Transportation Grant Program. This program is something that is critical to highly rural areas. Our proposed change is to increase and expand currently available to 25 States for the county level, to expand it to 50 States, so they would have access to this.

The other expansion is that the eligibility criteria would include tribal and county VSOs.

Senator KING. We will be talking with them at the next panel.

Mr. HEIMAN. Thank you.

Senator KING. But transportation is really important. We are in a large state duel here. I see two of my colleagues. To give you an idea of how tall Maine is, Caribou, which I mentioned, to Portland, Maine, our principal city, Portland, Maine, is halfway between Caribou and New York City. It is a long distance to get to the help.

Chairman TESTER. I do not know if you want to start talking distances.

Senator KING. I know. I know.

[Laughter.]

Senator KING. That is why I prefaced it. I do not want to get into large state duels. He is in a state that you have to fly to get places.

But anyway, the point is transportation is really important for our rural veterans, and I hope that is going to be an important focus. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Senator Sullivan. King has put it on the tee. You can hit the ball now.

[Laughter.]

HON. DAN SULLIVAN,
U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman, and I do want to mention, the panel, look, a number of us—I think Senator Blackburn is leading the effort—we have some concerns, very serious concerns, about these bonuses that were paid out recently. It made a lot of news. I think it is important for the Committee to focus on this.

I do want to mention, though, to the witnesses, we all know the vast majority of the VA, particularly in our states, does really excellent work, so I want to thank you all for that. You are seeing a lot of bipartisan focus on issues that matter to all of us—Alaska Natives, Native Americans, telehealth—and a lot of our veterans

live in the big rural states like ours. I will not talk about how big Alaska is, but I think it is six times bigger than Montana.

[Laughter.]

Chairman TESTER. You can do better than that.

Senator SULLIVAN. And there is no Texas here so I will not do that one either.

But I do want to follow up with what Senator King just mentioned, the staffing issue. You know, we are building out VA facilities in Alaska. We do not have enough VA staff in our state, and we just get nervous when you guys are talking about this dramatic cut that is going to be coming to the states that do not need cuts. We need more. So I just want to reiterate what he said. Hopefully you are going to do it strategically and look at the places where veterans are growing. They are certainly growing in my state, the population. So don't do it in those states.

Can I just get your commitment to make sure you are doing it strategically?

Dr. KABOLI. Yes, sir.

Senator SULLIVAN. Good. Next, I want to talk about, again, related to all of our rural states, the Highly Rural Transportation Program. It is a really important program, I think, for literally every Senator here. In my state we have over 230 communities that are not connected by roads. No roads. So, you have either got to fly there or take a boat in the summer or a snow machine in the winter.

So, this is a really important program. But as you can imagine, the more rural your state is, the more quickly you use up those funds. You know, they are dedicated borough by borough. I have been working on legislation. We are reaching out to the VA, to make the Highly Rural Transportation Grant funding per borough more reflective of the states like represented here—Montana is certainly one—that are so rural that you are blowing through the money really quickly as opposed to a more urban state. We kind of get penalized because it is a one-size-fits-all approach. We have actually been thinking about legislation to up that per-borough grant, so states like ours, represented here, with the exception of Senator Blumenthal, benefit. Do you see what I am saying, how it kind of—you just run out of money way quicker.

Dr. KABOLI. Yes, sir. Thank you, Senator Sullivan. I did a month of my residency in Alaska at the Alaska Native Medical Center (ANMC), in the old ANMC, and then I was just back at the new ANMC last year for an advisory committee meeting, and it is really impressive what they have done there.

Senator SULLIVAN. Yes, they have done a great job.

Dr. KABOLI. Yes. I was so impressed.

Senator SULLIVAN. The VA and the Native Health Care in Alaska have a really good partnership that matters, tremendously, to everybody.

Dr. KABOLI. Yes. And we were at JB and got to see all of the things that were going on there, as well.

To answer your question, I do want to say one thing, and I am going to have Mr. Heiman answer also. The Highly Rural Transportation Grant Program, like you said, there is only eligibility in 26 States right now—Sorry, Senator King, but Maine is not in that

list—because of the way that it was written initially, at a county level. I know there is some legislation pending about changing it to a new definition that basically every state would have some areas that would be eligible.

Senator SULLIVAN. Okay. That might be going in the opposite direction that I am talking about, but maybe we can work with your team. I just want to make sure that if you are a really big rural state and you have run through the money so fast, and then—again, I have 230 communities of people have to take an airplane just to get to the VA, so that money gets burned up really quickly.

So, if there is a way to try to address that. I know that some of my other colleagues have similar concerns. It is just kind of a fairness issue.

Let me just ask one final question. Senator Hassan and I are working on the Link VA Bill, that we have introduced. And the whole point on that is to enable the VA to partner with other entities—I use the example of the Alaska Warrior Partnership, a group we call Battle Dogs, a group we call Connect Vets in Alaska—that have been able to help with integration on issues that might not be a VA issue but a veteran might need help in some other element.

We had a recent example of the Alaska Warrior Partnership was helping with veterans, believe it or not, get sources of fuel to keep their homes warm in the winter in Fairbanks when it is 40 below zero. This really works well. You guys kind of already do it. You have been talking about the USDA. But I know the VA has been supportive of our Link VA Bill. But what are you doing? Is legislation needed? What are you guys doing to kind of integrate those kinds of services? They may not directly be to the VA's relevant mission, but a veteran needs help, with somebody else. How are you making sure they just do not get told, "Hey, that is not our department. Good luck with someone else"?

Dr. KABOLI. Thank you, Senator Sullivan. The Link VA one, I am going to have to look that one up because that is not one that I am familiar with, but I hear what you are saying. And I am sure we have programs that would link to that, so to speak, but without knowing more about it, I am going to not say much because I do not want to say something dumb.

Senator SULLIVAN. Okay. We will get back to you on that, our offices, but we think it is a good bill. I think most of your building is supportive of it, and it is trying to streamline, not create more bureaucracy, to help our veterans. But we can have our teams work together.

Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Segue to Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Thank you very much, Mr. Chair, and thanks to all of you and the entire VA team for everything you do.

I will just add my support for comments you have heard from all of the Senators, I think, about the importance of bridging that digital divide, making sure that we are doing everything we can to make permanent telehealth, and then to make sure that our vet-

erans in the most rural areas of the country have the connections they need, and the devices they need, to access that.

And I will add my voice to the chorus. Let us know what authorities you need, what barriers there are to make that happen, because the veterans we are hearing from in New Hampshire are very, very appreciative of the service, and especially as we do not have a full-service hospital in New Hampshire it is a really important link to both Boston and White River Junction.

I want to talk a little bit more about transportation, another thing that all of us who have rural communities have talked about. Obviously, many rural veterans live very far away from a VA facility. The DAV Transportation Network is particularly important and vital in New Hampshire. This is a network of volunteer drivers who provide veterans free transportation to appointments.

But what the DAV continues to struggle with is getting their volunteer drivers approved through the VA. In fact, when DAV representatives testified before a Joint Committee hearing in March, they told me that the VA needs to standardize and streamline the onboarding process for volunteer drivers. And I will let you know, the volunteers will kind of say to us, "Well, I wanted to do this but it is taking VA so long, I am doing something else to volunteer right now, because I don't want to sit at home idly, not helping people."

So, what can the VA do to help improve this process so that we can get drivers screened and onboarded in the most efficient manner possible?

Dr. KABOLI. Thank you, Senator Hassan. I did not know that was a big problem until 2 weeks ago. I am with the Office of Rural Health, and we have a Federal Advisory Committee. And a gentleman named Joe Parsetich from Montana is on that committee, and he brought that up at our meeting just 2 weeks ago and said this is a big problem. And I said, "Joe, we will look into it." Because now that I know it is a problem, I will bring it to the right people.

Senator HASSAN. We made some improvements in New Hampshire, but literally there are people who would love to be helping make a difference here in getting veterans to their appointments, and they just cannot get cleared.

I also want to build on something that Senator Sullivan was just talking about. When people serve in the military, they often feel that sense of purpose and connection, both to the work they are doing and to the people they serve with. When they leave the military and reenter civilian life, one of the most difficult parts of that transition can be feeling a loss of community. The VA is one of the places where veterans can reengage with one another and can feel a sense of connection to the military community that they have left.

Rural veterans, though, are often more isolated from VA facilities and other community resources that can present these kinds of opportunities. Can you discuss what the VA is doing to engage with and help foster a sense of community and support among rural veterans?

Dr. KABOLI. Senator Hassan, that is a really good question. You know, I think there are so many different things that we do in the

VA that I am sort of struggling to figure out which are the ones that come together to really address that. You know, we do a lot of group visits. There are now group telehealth visits.

One thing that we have learned over the years, though, is that when they do come in, that is part of their community, and they feel that, and that is why telehealth is really important, but sometimes it is important that they come in.

We have also learned that through the Veteran Transportation Service, just that van ride in and talking to the driver. I mean, I know one of our drivers, Connie, and she knows everybody that is on the route, and they all know each other. So, I think that is a really important part, that if we do everything telehealth and have everybody remote, we lose that community.

Senator HASSAN. One of the other things that has been a strength in New Hampshire is a program that Northeast Passage, which is affiliated with the University of New Hampshire, does, bringing veterans to do outdoor activities together in a rural place, providing the equipment, providing the guidance, if you have never kayaked before, et cetera.

But I just think, again, coming back to us with ideas if there are authorities you need but also just being creative about what life in rural America looks like and where are the natural places that people get together. We have put into place things like Buddy Check and Solid Start. But as we are grappling with the real difficulty of a lack of connection, of loneliness, and of veteran suicide, I just think we really need to be thinking about how to foster this community. Thank you.

Chairman TESTER. Senator Moran.

HON. JERRY MORAN,* RANKING MEMBER, U.S. SENATOR FROM KANSAS

Senator MORAN. Chairman, thank you. I do not know that I have questions, but I probably will end up asking a couple. I am, again, troubled, and this is not necessarily the topic of this hearing, but I am wanting to air my grievances, even though it is not Festivus.

[Laughter.]

What I know about veterans and the circumstances they are in is generally by conversations I have with veterans, with the Veterans Service Organizations. But so much of what I know or believe is going on is what we call casework, a veteran who calls, comes to the office, emails us, tells us a story about experiences at the VA. And again, many times those conversations are very complimentary of the VA.

But I am concerned about what I have seen going on for the last 6 months, and only increasing, and it is the number of cases of veterans who call, write, email, or tell me, or my staff, that they want to utilize Community Care but the VA says it is not available to them. I think, by law, that is not a fair statement that the VA should be making. It is my view, based upon what conversations I have had with people who work at the VA, that there is a concerted effort to rein in Community Care and to increase care within

*The opening statement of Senator Jerry Moran appears on page 39 of the Appendix.

the VA hospital. I do not know, Mr. Vlosich, I do not know whether that is something that you would care to comment on.

But what has got me exercised today is this. Over the weekend I usually read my weekly case report from my, particularly, veteran staff caseworkers. Time and time again, I would guess in this report there were a dozen veterans who called to say, "I have been getting chiropractic care in the community. The VA tells me it is no longer available to me." I do not understand why that is.

But here is the one that stands out and has my ire today. This gentleman tells us, this veteran, tells us that he has been receiving cancer treatments in his hometown. He has two more cancer treatments to complete—and I do think there is something going on at the VA in regard to oncology. He has two treatments to complete his cancer treatment, and the VA says that he is no longer eligible for Community Care where those treatments have been occurring. He has 58 treatments completed and he needs 60, and they are saying, "Come to Topeka."

Our research, talking with the VA about the circumstance, is that he was allowed Community Care because he lived 60 minutes from the VA hospital. They have recalculated. He lives 59 minutes now from the VA hospital. It changed his status, his eligibility for Community Care, and he was told to drive.

Now I cannot imagine that you are not going to fix this. I cannot imagine I am telling you this story without it getting fixed. But there is something, a mindset, that this represents, along with all the other instances in which people tell me, "I like my Community Care, but the VA tells me I now need to come to the hospital."

I mean, I have had this conversation with the Secretary and all the way down, and I am always assured that there is no bias against Community Care, there is an explanation that Community Care is costing us too much money. Most of that, in my view, is in the emergency room, of which I am waiting to see what the plan is to care for emergency care, which generally takes place in the community.

So, what am I missing here, or what is going on that I ought to be aware of, that you are willing to tell me? Maybe that is you, Dr. Kaboli?

Dr. KABOLI. I will take a first shot at that, and thank you for the airing of grievances, Senator Moran.

Senator MORAN. I wish I could say these things in a more angry manner, with less of a smile, because this is serious stuff in people's lives.

Dr. KABOLI. It absolutely is. So, the case, in general, we will look back at that specifically. But I think the point about cancer care is really important. So, we have a Close To Home program to try to get care closer to the veteran's home, whether it is in their home or in the community, or bringing the drugs to the CBOC.

There is always an exception that can be made for the best medical interest of the individual or hardship. So, going from 61 minutes to 59 minutes makes zero sense to me, as a physician, that that was allowed to be changed.

Senator MORAN. It should not be, "Oh, your mileage has changed." I do not know whether he moved a mile or it was recalculated. But the fallback would be, but it is in your best interest,

and the law allows in your best interest. If you and your provider say it is in your best interest then we are going to continue. But that was not what the VA decided. That would just be the normal thing for someone to say. "Oh, let's see if we can't find a way to make this work." And instead, it was, "Come here."

Dr. KABOLI. Yes. And I know, as a physician, and I think my fellow oncologists who do this would say, "We would never do that for a patient." So, whatever happened we will look into that example. But I think it serves as an important example of why we should be very careful and look at each individual case.

Senator MORAN. I appreciate that. Anything further?

Mr. VLOSICH. Thank you for the question. I would just echo that. But in these instances, a Medical Center Director has the authority to expand that authorization. So, in that case we would just allow them to continue their treatment, because that is the right thing to do for the veteran.

Senator MORAN. Is there something concerted going on in eliminating chiropractic care within the community?

Mr. VLOSICH. No, not that I know of. I think that there has been an effort to review some of the chiropractic care to where they reach functional stability, but in terms of eliminating chiropractic care, no.

Senator MORAN. I think in these instances it is you can have chiropractic care but only if you come to the hospital, come to Topeka, Wichita, or Leavenworth.

Mr. VLOSICH. In my home state we are not doing that, so I cannot speak to that. But we do provide chiropractic care.

One of the things that we found is that some of our veterans want to continue chiropractic care for years and years, so we like to bring them back in to reevaluate them, because they are not going to get better by doing some of that. It requires surgery.

Senator MORAN. Thank you for allowing me to air my grievances on behalf of Kansas veterans. I do not know that I am asking you to do anything. This is more of a statement for those in the VA who are maybe making those decisions. But Dr. Kaboli if you have any role to play. We have raised this topic with the VA already, and I cannot imagine that cannot be fixed.

But it just highlights what I think is a trend that is troublesome to me. In a state like ours, Kansas, where distances are so great, the error on the side always ought to be for the veteran, and he or she has a choice to make on this issue.

Thank you.

Chairman TESTER. Senator Moran, I think they do need to do something in this particular position. I think, if you feel comfortable with it, get them the name to find out who made the decision, because if they made a bad decision with this veteran—which I think is a bad decision, by the way. People who have gone through cancer care have their own problems—then I think that there should be some follow-up and ask these people why that is going on.

Senator MORAN. Mr. Chairman, I can assure you, and I can assure the veterans at home that we are following up, have followed up with the VA. They are responding to us. They are looking into the facts. And if we do something further, I am happy to have a

conversation with you and my colleagues on this Committee to see if we can't get serious attention.

Chairman TESTER. Any time Senator King winces you know you are on the right track. Senator Blumenthal.

HON. RICHARD BLUMENTHAL, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Senator Tester and Senator Moran. Dr. Heyworth, you are currently an associate professor at the University of California. You are practicing I guess primary care or internal medicine at the VA Medical Center in San Diego, and you are a VA official. So, thank you for all your great work. I do not know how you do it all, but that is not my question.

From what I can gather, you have helped to build the VA telehealth system, which is probably larger in scale than any other maybe in the world. What can hospitals or health care systems learn from the VA experience? It seems to me that the VA is leading the medical profession in this area, as it has done in some other areas, as well, over the years, because of its unique needs—artificial limbs and brain injury, and so forth.

On telehealth, shouldn't our health care system be investing much more heavily in this system of delivering care, not just for rural areas but for others, as well?

Dr. HEYWORTH. Thank you, Senator, for that question. While we are really excited that we are at the point of almost 40 percent of our veterans last fiscal year doing some kind of their care through telehealth, and of all our encounters in telehealth last year, 28 percent were to rural veterans, and we are really proud that we are on our fourth consecutive year of increasing trust and satisfaction scores with telehealth, we still want to do more for all of our veterans.

And part of that is critically making sure that every veteran who wishes to engage with telehealth has the opportunity to do so, which is why one of our key areas of focus is in our Digital Divide Initiatives, such as through our ATLAS program, Accessing Telehealth through Local Area Stations, where we have telehealth access points in rural communities. In the Chairman's State of Montana, we have an ATLAS site in Eureka, for example.

We are also focused on key barriers to delivering care to urban and rural veterans, as you point out, and one key area of critical focus is on the clarification of authority in prescribing controlled substances by telemedicine. VA lacks a standardized approach, so frontline providers like myself are subject to laws in states that are varied, that change frequently, and often lead to a lot of confusion on the front lines about doing the right thing for the prescription of controlled substances, particularly for veterans who rely on these critical treatments for such conditions as opioid use disorder, Attention-Deficit/Hyperactivity Disorder (ADHD), and the like.

So, we have a legislative proposal and would welcome further discussion on this topic. VA has put that together with input from DOJ.

The other key thing I would say, back to talking about our Digital Divide Initiative, is the intra-agency partnerships that we have been engaged with. And I think this is a critical point because the

opportunity for every veteran to engage in telehealth relies, again, on every veteran having the opportunity to access the technology needed and to afford the broadband needed.

So, while, in 2020, we kicked our Digital Divide consult off, and so far we have completed over 166,000 of these consults, which involve social workers working with veterans to understand their eligibility for programs such as the Lifeline Program, or to offer a loaned device through VA, we have our Connected Devices Program. This has been a highly successful program, and our veterans who use these loaned devices in mental health, we have learned, in a recent study that was published in *JAMA*, actually, that they have improved engagement in mental health, they have reduced suicide behavior, and reduced visits, actually, to the emergency room for mental health.

So, access to technology, access to the affordable and needed connectivity I think is a theme, not just at VA, but I think something that all health care organizations can learn from, and we are really proud to have led the way in that area.

Senator BLUMENTHAL. My time has just about expired, but I would like to follow up on these issues with you. And I assume you would believe that, I think you mentioned 28 percent, that is a number that could easily grow, and should grow, whether it is urban or rural.

Dr. HEYWORTH. Absolutely.

Senator BLUMENTHAL. Thank you. Thanks.

Chairman TESTER. Thank you, Senator Blumenthal.

We are going to move to our next panel now. I appreciate you guys' testimony. I appreciate your work. Thank you for being here today. And you are welcome to stay for the second panel, if you have got time.

On our second panel, while we are making that transition, we have got Chauncey Parker, who I recognized in my opening statement. He is from Montana. He is the Executive Director of the Great Plains Veterans Services Center. He works with Native Americans and probably anybody else, too, in Montana, as far as that goes.

We also have Alyssa Hundrup from the Government Accountability Office, otherwise known as the GAO.

And then we have Jon Retzer from the Disabled American Veterans.

And I want to thank you all for being here today.

As per usual, your entire written statement will be part of the record. I would ask you to try to keep your oral statements to no more than 5 minutes, and then we will get into questions.

Chauncey, you are up first.

PANEL II

STATEMENT OF CHAUNCEY PARKER, EXECUTIVE DIRECTOR, GREAT PLAINS VETERANS SERVICES CENTER

Mr. PARKER. Thank you, Chairman Tester, Ranking Member Moran, and Members of the Committee. Thank you for the invitation to come here and speak on some of the boots on the ground

that we are doing as veterans organization, specifically amongst the Native community as well as rural communities in Montana. So thank you.

Just real quick, our organization, Great Plains Veterans Services Center, we are a nonprofit organization providing support to three Native reservations through our support services, and to 28 of 56 counties in Montana with our transportation.

We primarily serve our Native population but we also serve a rural and frontier population. That frontier population is very remote, and I think a lot of the discussion on the transportation particularly concerns us as we provide those services to those veterans.

But one of the big things, the reason we started our organization, is to help bridge that gap between VA and our veterans. And why do we need to bridge that gap? It is because when we first started the organization there was a lot of lack of services from the VA being provided, not just to Native veterans but rural veterans, as well. And as I mentioned, transportation is one of those big issues.

We are a sub-grantee of the Highly Rural Transportation Grant. That is provided to our local American Legion post. Under that particular program, we are having a very difficult time in being able to manage that. One big thing, as I mentioned, we serve 28 of 56 counties in Montana, and we are currently working under a funding that is less than half of what we originally requested to do that. So we are providing transportation with five drivers, full-time and on-call drivers, to those 28 counties.

It has been very difficult, but we have still been able to make it work. Thankfully, as a nonprofit organization, we have other means to be able to meet those goals. For example, last year our organization had driven over 160,000 miles, providing support to the veterans in Montana. Now that is a lot of mileage, and being able to continue to do that, despite the fiscal challenges, is part of our mission, the reason why we are there, again, to bridge that gap between the VA and our veterans.

Within that transportation program, another issue, I think, we have been running into, as well, as while this is a rural program and available to rural veterans there are a few counties in Montana that do not, per the VA's rules, do not classify as rural. And because of that there are communities in those counties that we cannot provide that service to. We still get requests, and we still honor those requests under our different funding means. But those are one of the areas that this particular program, we have run into challenges in.

Another area is our mental health and access to health care services. We are also a grantee of the Staff Sergeant Fox Suicide Prevention Grant Program. We are providing that service to three Native American reservations. An issue that we have run into in this particular area is that cultural barrier. As I mentioned, we are primarily serving a Native American population under that Staff Sergeant Fox program.

One of the largest means that we have, amongst our Native communities, in order to be able to provide that outreach to those veterans is outreach events, getting them together in groups. But unfortunately one of the stipulations under this particular program is

we are not able to provide meals to those veterans. So part of our Native culture is a lot to do with food, and having that ability to be able to bring that in around a meal is very difficult if we are not able to provide that. But again, part of our other methods, as a nonprofit organization, is we have other fiscal and funding options that we can use, again, to bridge that gap.

Another issue that we have encountered——

Chairman TESTER. I need to get you to wrap, Chauncey. Go ahead.

Mr. PARKER. Another issue we have encountered is just the visibility from the VA. We are rural. We are frontier. There is not a lot of visibility from the VA. It has improved somewhat. You know, we have had a PACT Act event. These PACT Act events are definitely helpful. But being able to see that visibility from the VA, specifically in Montana, would definitely be helpful in trying to get the resources to our veterans.

[The prepared statement of Mr. Parker appears on page 59 of the Appendix.]

Chairman TESTER. Thank you very much for your testimony.

Next, from the GAO we have got Alyssa Hundrup. Alyssa?

STATEMENT OF ALYSSA HUNDRUP, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE

Ms. HUNDRUP. Good afternoon, Chairman Tester, Ranking Member Moran, and Members of the Committee. Thank you for the opportunity to discuss our work on the Department of Veterans Affairs' efforts to improve access to health care for veterans living in rural areas. My testimony today covers findings and recommendations we have made related to rural health care issues.

Rural veterans represent a significant proportion of our Nation's veterans, and VA projects this population will continue to grow. The definition of "rural" can mean different things. For example, it can mean driving 45 minutes or even more than 4 hours to reach the closest VA medical center, and in some cases, as we have talked about already, driving is not an option, such as in remote Alaska, and veterans may need to fly long distances to receive care. These long distances, along with limited access to broadband, internet, and staffing shortages affect rural veterans' access. The challenges can lead to disparities in accessing quality of health care for veterans in rural areas. For instance, VA research has shown rural veterans experience worse health outcomes such as higher rates of cardiovascular and suicide deaths than those who live in urban areas.

Our past work has highlighted various approaches VA has taken to improve rural veterans' access to care. However, more work needs to be done to address this critical issue.

For example, in our May 2023 report, we examined efforts made by VA's Office of Rural Health, whose mission is to improve the health and well-being of rural veterans. The office does this by funding specific initiatives that seek to expand existing health care services to rural veterans as well as by funding research. For example, VA researchers are studying various interventions, such as

knee or cardiac rehabilitations, that could be done through telephone or video visits.

However, we found that the office has only communicated this research funding availability informally, such as by word of mouth. As a result, many researchers may be unaware of funding, resulting in missed opportunities for relevant research. We recommended the office develop a policy to communicate available research funding opportunities across VA. VA agreed with this and anticipates developing a communication plan by this September.

We also found the Office of Rural Health had not defined the level of performance the office aims to achieve. For example, the office collects data on the number of clinicians it trains through funded projects, but it has not defined how many it should train each year to help achieve its goal of reducing health care workforce disparities. We recommended that the office develop performance goals to help inform its decision-making, which will allow it to more clearly measure its progress toward meeting its mission. VA also agreed with this recommendation, and stated that the office is developing a new strategic plan that will include performance goals, and estimated it will finalize this plan by the end of the month.

Additionally, in December we issued a report examining VA mobile medical units. This is one important tool VA can use to deliver care to veterans living in rural areas. These units help VA medical centers expand clinical services, such as by providing oncology, primary care, or audiology services. However, we found VA lacks accurate and complete information about mobile medical unit operations and performance, potentially resulting in missed opportunities to leverage these units to increase access to care for rural veterans.

For example, VA reported there were 52 units nationwide, yet we found at least 9 that did not meet the definition of an active unit. Some of these units were no longer operable due to maintenance issues, faced staffing challenges, or had been repurposed for other non-clinical uses. We recommended VA assess the reliability of the data it reports on mobile medical units. More reliable information will give a more complete picture of their performance, which would then better position VA to understand the types of circumstances when using mobile units are most effective and help ensure they are fully leveraging this important tool to increase access to care and improve outcomes for veterans.

We are monitoring steps VA is taking to implement our recommendations, and also continue to examine other VA efforts related to rural access to care. For example, we currently have work examining VA programs that are looking to help veterans access telehealth services, such as its Accessing Telehealth through Local Area Stations, or ATLAS program.

In closing, in light of the unique challenges rural veterans face, it is essential that VA take a proactive, multi-pronged approach to ensure their access to care.

This concludes my prepared statement. I would now be happy to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Hundrup appears on page 62 of the Appendix.]

Chairman TESTER. There will be questions for all three of you. Jon Retzer from the DAV, you are up.

STATEMENT OF JON RETZER, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. RETZER. Thank you, Chairman Tester, Ranking Member Moran, and Members of the Committee. DAV is pleased to offer our view on issues impacting rural veterans.

Veterans living in rural communities face a number of unique health care challenges due to the scarcity of medical resources, a problem that is intensified for those with service-related injuries and illnesses. Of the 4.4 million veterans living in rural areas, 2.7 million are currently enrolled in the VA health care system. Approximately 58 percent have at least one service-connected condition, and 56 percent are 65 years or older.

To meet the health care needs of all enrolled veterans, VA must ensure that its overall health care strategy has properly balanced the needs of rural veterans and addresses the special challenges they face.

Mr. Chairman, the greatest and the most obvious obstacles to health care for many rural veterans is availability of transportation to access needed care. One major shortcoming of the VA Beneficiary Travel Program is that the mileage reimbursement rate of 41 cents per mile falls short of covering the actual expense, including gas and other associated costs, which can create a barrier to getting the care that they need and deserve. We recommend the Secretary exercise his full authority under the law to adjust the mileage rates to 67 cents, in alignment with the current rate for government employees.

In addition to VA transportation program, DAV continues to fill a gap in transportation needs. In fiscal year 2023, DAV Transportation Network, with 3,200 DAV volunteer drivers, provided no-cost transportation for ill and injured veterans across the country, logging nearly 9.3 million miles. With a total value of $96 million, DAV has donated over 3,700 vehicles to VA since 1987 to support this critical transportation program, and we appreciate that Senator Hassan brought up the issue with regard to our challenge with onboarding and screening issues with the VA to get our volunteer drivers into the much-needed program. And we ask that the Secretary create standardized screening processes and onboarding processes to help that in a timely manner.

In addition to transportation nationwide, clinical staffing shortages impede timely health care delivery to rural veterans. According to the report by the Health Resources and Services Administration in 2023, 65 percent of rural areas were found to have a shortage of primary care physicians. Due to limited access to VA service in rural communities, rural veterans rely heavily on VA's Community Care Network. However, the medical care staffing shortages, basic services, and specialized care can be difficult to access in a timely manner.

In addition, there are also concerns about quality and the cost of that care. A recently VA-commissioned report titled "The Urgent Need to Address VHA Community Care Spending and Access Strategies" has raised notable concerns about VA's Community

Care Program. The "Red Team" report unanimously concluded that VA needs to take urgent action to protect both VA's health care system and its Community Care Program. The report noted that VHA has insufficient information to know whether referrals to community providers will result in the veterans receiving either the soonest or the best care.

It also found that community providers are not required to demonstrate competency in diagnosing and treating the complex care needs of veterans, nor understanding military culture, which is often critical to providing quality care for veterans. Unfortunately, the Veteran Community Care Program referral process generally does not provide veterans with information about quality of care in the community or accessibility data that would allow them to make truly informed choices about where they receive care.

Finally, the report found that the lack of care coordination between VA and community providers is a significant cause for concern for veterans who must rely on both avenues of care. DAV strongly believes that VHA should guide veterans to care based on quality and accessibility, whether to be in the VA or in the community. Neither VA nor Community Care can easily be accessible in every area of the country. Therefore, VA must optimize the use of mobile and virtual resources to provide care for those veterans who do not have better options.

To ensure best outcomes for veterans, DAV continues to advocate to keep VA as a primary provider and the coordinator of veterans' health care, regardless of where veterans live or how they access their care.

Mr. Chairman, we urge Congress and the VA to require community providers to meet the same training, certification, and quality of care standards as VA providers.

In closing, to address the specific needs, geographic barriers, and unique challenges veterans face in accessing health care in rural communities, VA must implement targeted strategies and develop creative solutions to fill existing gaps.

Chairman Tester, this concludes my testimony, and I am pleased to answer questions you or Members of the Committee may have.

[The prepared statement of Mr. Retzer appears on page 76 of the Appendix.]

Chairman TESTER. I want to thank you all for your testimony. We will get going with questions right now. We are going to start with you, Ms. Hundrup. Are the VA current offerings sufficient to meet the transportation needs of rural and highly rural veterans?

Ms. HUNDRUP. Thank you. I think the short answer is no, but there are multiple programs, which is good news. There is the Veterans Transportation Service, that we are aware of, the mileage reimbursement. And what I would mention also is that we do have a current engagement looking at the Veterans Transportation Network, so we will be able to talk much more of that soon. That is coming your way.

But more broadly I think I would say we are very glad to see VA taking a multi-pronged approach, which was the right thing to do. There is not one solution to this. So I think looking more broadly, I think we have to look at VA bringing veterans to the brick-and-

mortar facilities as well as transporting health care to them. I think it needs to be all of the above. So whether that is through telehealth or mobile medical units, getting that care to the veterans.

So I think there are great efforts in all of those regards, and more work remains in that area.

Chairman TESTER. Chauncey, from your perspective, in Montana, your neck of the woods, what is Montana veterans' experience with accessing VA Transportation Services? What are their overall views on that? Is it positive, negative, otherwise?

Mr. PARKER. There have definitely been challenges, for sure. There is positive and there is also negative.

Chairman TESTER. What are those challenges?

Mr. PARKER. Challenges is getting in touch with the VA Transportation, requests for transportation specifically through the VA's programs. So when they do have those challenges, a lot of times they will end up turning to ourselves to provide those services. So being able to contact the VA itself is definitely a challenge.

Chairman TESTER. Do you have capacity to provide those services?

Mr. PARKER. Currently we do, but again there are challenges there. If this continues, being able to continue to provide those services will be a challenge.

Chairman TESTER. You are a secondary provider. In other words, you are looking for them to be the primary provider. Okay.

Mr. Retzer, you talked in your opening remark about DAV drivers and volunteers. I want you to flesh this out a little bit more about what are the barriers that DAV faces in recruitment and maintaining volunteer drivers.

Is Mr. Heiman still in the room here, by the way?

Mr. RETZER. Thank you for that question, because this has been an ongoing issue.

Chairman TESTER. He is. Good. This is for you, by the way. Go ahead.

Mr. RETZER. And I appreciate that. We are directing that to the people who need to hear this, most importantly, because we have many volunteer drivers in our fraternal organization, and in the community, who want to help veterans get to the care that they deserve and need. And they know, and we know, as an organization, since 1987, that transportation is a must to be able to get them there.

And so what is happening is throughout the country, the standard in which they are being screened and onboarded is very inconsistent, and that is to the point of where Senator Hassan had brought up, that we are losing volunteers because of that. And just like we testified in our oral here is that 3,200 last year, drivers, volunteered to assist, and there are so many more that want to help, in very rural areas.

Chairman TESTER. So talk to me, if you can. If you cannot, that is fine. But tell me what the barriers are. Tell me, if I want to be a volunteer driver, what do I have to go through to get that ability to be a volunteer driver, which means you do not pay me a damn nickel.

Mr. RETZER. Right. So thank you for that. The issue is for our volunteer drivers there is a screening process, a medical screening process that they have to go through, that is quite——

Chairman TESTER. Is that medical screening process given by the VA or somebody else?

Mr. RETZER. By the VA.

Chairman TESTER. Okay. At the closest VA?

Mr. RETZER. Yes.

Chairman TESTER. Okay. Anything else, other than a medical screen that they have to go through?

Mr. RETZER. And then also making sure the background checks are done adequately.

Chairman TESTER. And how quickly is that process done?

Mr. RETZER. That is inconsistent throughout the areas that we have been told. We had a situation where we testified last year where it was over a year in the process for a veteran, so we had lost numerous veterans to that process.

Chairman TESTER. So the reason I bring this up is because you are not the first one to bring this up. I have had my local DAV say we have got people we can get driving, but by the time they jump through all the hoops they have run out of gas—no pun intended. And so I think that is really important. We need to make sure our veterans are safe. We need to make sure they are in a good rig, going to the appointments, and you do not have a ding-a-ling driving them around. Okay?

But the bottom line is that this can be done much quicker, and it can be done much more efficiently. And we need to keep that in mind, because these folks are volunteers, and they might just say, "You know what? I would love to be a good guy but I can't wait this long."

I will turn to you, Senator King.

Senator KING. To follow up, time is often the problem. When you talk about screening, I mean, that is something that I think the DAV has to work with the VA to accelerate that process. And it would be helpful if you could document it. In other words, how many people walked through the door and said, "I would like to be a volunteer driver" and how many people end up being a volunteer driver, and what the losses are.

The other piece that you mentioned is the mileage, and I just want to be sure I have got this right. So a volunteer driver gets mileage reimbursement of 41 cents a mile. Is that right?

Mr. RETZER. Yes, Senator, currently.

Senator KING. And a government employee gets a reimbursement of 57 cents a mile.

Mr. RETZER. It is 67 cents, effective January 1st of this year.

Senator KING. It is 67.

Mr. RETZER. That is for a POV, and——

Senator KING. What is wrong with that picture?

Chairman TESTER. The very first bill I carried was increasing the mileage reimbursement, and I do not think it has been moved up since 2007.

Senator KING. Well, let's get after it. I think that is something that, to me, that just makes common sense.

Ms. Hundrup, I was very interested in your testimony when you talked about mobile vans, which it sounds like the GAO concluded are not being adequately used, are not being adequately deployed, you do not have the data. Is that correct?

Ms. HUNDRUP. It was really hard to tell based on the poor data. Because of the inaccurate and incomplete data, we were not able to determine just how many there were or how many were performing for what types of services.

Senator KING. One of my favorite mottos is "Does it work, and how do you know?"

Ms. HUNDRUP. And in this instance we did not have the information to be able to know, and I do think this is an important tool that could be leveraged further. But it is almost as if each medical center is left to its own devices to run these and see how it works for them.

I think there are great things happening out there. We talked to folks on the ground all across the Nation that had mobile medical units. They were using them effectively. It is just we do not know nationwide. So I think there is a missed opportunity.

Senator KING. Well, one nice thing would be if there was some kind of clearinghouse so that the ones that are being used effectively could become templates for others.

Ms. HUNDRUP. Exactly. I think there are a lot of great things, and folks can learn from each other instead of having to reinvent the wheel—no pun intended here—but to learn best practices and put that into place.

Senator KING. That was better than running out of gas, for the record. Sorry. Yes, that was on short notice.

This is a question for you but it is also for our VA folks who are here. The biggest challenge for seniors, including senior veterans, is falls. And I am working on legislation to set up a Falls Prevention Office in the VA. And by the way, if we can prevent them we would save a lot of money. Nationally, the medical system spends $38 billion a year on falls, and yet Medicare, for example, will not pay for a grab bar that costs $50, or a bathmat, a non-slip bath mat.

So I would hope that the GAO could think about where could the VA beef up its prevention activities, and I am thinking these vans could be screening vans to develop prevention. Because often diseases are much easier to treat when they are caught early, particularly cancer.

So I hope that is something you will look at, and I hope the VA will follow up on that, on the issue of prevention and falls.

Mr. Retzer, I would appreciate it if you could synthesize your testimony and come back to us with five things we can do to improve the Community Care interface, because that strikes me. You mentioned it as a significant problem, and the report talks about staff in Togus, for example, in Maine, have come up with workarounds of the current system in order to make the interface between Community Care and the VA better. So I would appreciate it if, for the record, you could talk to your members, and based on the experience of the DAV, tell us how we can improve that system. Because that is going to be a bigger and bigger part of this, the whole VA medical system.

And Mr. Parker, I appreciate your testimony, and again, I am going to ask you to do a little homework. To what extent, and how could the VA improve its service to Native American veterans, of whom there are many. And part of it is also employment services, so that when a Native American veteran comes back to the reservation they have employment opportunities outside of the military.

So I hope you can supply the Committee, for the record, some thoughts about five ways the VA could improve its service to Native American veterans. It would be very important for us.

Thank you. Thank you, Mr. Chairman.

Chairman TESTER. My staff reminded me that just for the record, Mr. Heiman, medical screening in Montana is done at two facilities, Fort Harrison, which is our hospital, and Billings, which is a super-clinic. Now, to put this in perspective for you, I live halfway between Plentywood and Helena, maybe not even halfway, actually, and it is a 3-hour drive for me to get to Helena. Helena is where Fort Harrison is.

We have got some great CBOCs, and, in fact, we have got some great doctors. So we could use assessments from doctors. They CDL assessments are also accepted, and that is good too except a CDL is not what most people have if they are a volunteer driver. They are driving a semi if they have got a CDL, okay. So that is kind of where we are at.

And I say that because DAV transportation is really, really important in rural states. It is really, really, really important. And if you could do some things to make it so that it is more user friendly to get drivers, and this program can continue. And it really is a program that helps our veterans and does not cost money. So if you could do that.

I have got a couple more questions on telehealth. Ms. Hundrup, while looking at the VA's telehealth program will you review how ATLAS program has helped address the digital divide for rural veterans? Have you done that review, and if you have not, will you do that review?

Ms. HUNDRUP. Yes, thank you. We are actually in the process of completing that review now, so that report will be coming to you this summer. But preliminarily I can tell you that we are looking at specifically at ATLAS and its efforts to address the digital divide. Right as of fiscal year 2023 there are about 24 active sites. The use has been very low. I think 14 of those have had almost no use, and there is not much going on out there. I think the Office of Connected Care, when we have talked to them, they recognize that some veterans are really not aware of the availability of these sites, and that is contributing to the low use. So they are working on additional promotional materials.

Where there has been use we have had very positive feedback. It has helped reduce travel time, especially in the winter. It has also helped where there is limited digital proficiency. But I think it is another theme that we are seeing in terms of missed opportunities here, where because of the lack of awareness it is not being utilized to the extent that it could be. So I think it is going to be really important for the VA to work on that promotional material. Otherwise, it is a great resource that is just being underutilized.

We are also looking at changes to the ATLAS program. As I am sure you are aware, it started as a pilot program. And since it is now shifting over to a grant program that goes back to, I think the John Scott Hannon Act of 2019. And as you are acutely aware, I think you are also aware that it is not until fiscal year 2026 that they are planning to administer these grants. We are working on getting additional details about why there is the need for this information, so we appreciate your questions in this regard, as well.

Chairman TESTER. Absolutely. One of the things that Senator Tillis brought up was predictability in a program, and that is the VA's issue. Predictability is something that business looks at, and veterans look at. And so I want to reinforce his comments because I think they were good ones.

Chauncey, the veterans you serve, do they utilize telehealth, number one. And number two, is that what they prefer?

Mr. PARKER. Yes, Senator Tester. We do have veterans that do utilize it but not to the extent that I think we are expecting. A lot of them are the younger veterans. We have a number of the older veterans who prefer that in-person talk with their providers. However, though, I still think having that ability—because we are going to be having a new generation coming up that will have that access, and getting that access in now will be very beneficial.

Chairman TESTER. Is internet connectivity an issue in Indian Country?

Mr. PARKER. It is. Yes, Senator.

Chairman TESTER. So hopefully the Bipartisan Infrastructure Bill, hopefully they are laying fiber right now, in Rocky Boy. Are they?

Mr. PARKER. They are.

Chairman TESTER. Okay, good. That is good.

[Laughter.]

I do not have any more questions. Do you? Senator King.

Senator KING. I am very interested in the potential of the vans as mini-CBOCs. You have got VA hospital, you have got CBOCs, but then there are a lot of territory where for people it is still a long drive.

And my first job in Maine was with the National Legal Services Program in a very rural area. But we did not sit in our office and wait for people to find us. I used to go out, once a week or so, and go to three small towns. But it was predictable. Everybody knew the lawyer was going to be in Milo, in the town office, Thursday morning at 10, and then Dover-Foxcroft, and then Greenville. In Greenville it was the fire station.

But I like the idea of thinking about using the vans on a predictable schedule to cover some of the really rural areas for screening but also for perhaps some kind of primary care treatment. It sort of fills out the system in a rural area. And I hope that is something you can take back and that the VA will think about it. I think the vans have tremendous, it sounds like, unmet potential if there are only 51 of them in the whole country. So I hope you all will think about that.

Thank you, Mr. Chairman.

Chairman TESTER. Yes, I just want to add to that. I think the predictability is the issue here. If you show up in a town once, no-

body is going to show up. If everybody knows what day you are coming, and you come that day, you are going to get more and more and more and more customers, to the point where it really could be a pain in the neck, but that is exactly what we want, okay. So it is good.

I want to thank you guys for your testimony today. I appreciate it very, very much. I also want to thank the VA testifiers for sticking around. I appreciate that, guys and gals. I do know that your hearts are in the right place to improve access to care for our rural veterans, and I know that working together we can fix the problems that are there, truthfully. You listen to the folks that are on the ground, you take the inspector general's comments seriously, we can get to a point where every veteran—and by that I might add, regardless of what Tillis says, rural America, we have a lot of veterans living there. A very high percentage of the overall population are veterans. So this is no small issue.

We will keep the record open for a week. If questions are headed your way by anybody on this Committee I would ask that you would answer them as efficiently and as quickly as possible.

As of right now this hearing is adjourned.

[Whereupon, at 5:11 p.m., the hearing was adjourned.]

APPENDIX

Opening Statement

Opening Statement of Senator Jerry Moran
"Frontier Health Care: Ensuring Veterans' Access No Matter Where They Live"
May 15, 2024

Thank you, Chairman Tester.

Good afternoon and welcome to our witnesses. I appreciate you being here today to discuss the importance of making certain our rural veterans are receiving the health care and support they deserve.

Rural America is home to a significant portion of our nation's veteran population. These individuals have performed the same duty, and have made the same sacrifices as veterans from urban areas, yet they face unique challenges and barriers when trying to access high-quality care from VA.

For example, rural veterans often experience limited access to healthcare facilities, shortages

of medical professionals, unreliable broadband connectivity, and large geographic distances to travel to receive care. These issues, and many more, contribute to the difficulties rural veterans face in receiving the timely and quality care they have earned and deserve.

The issue of broadband connectivity cannot be overlooked. In this day and age, access to a reliable internet network is not only a convenience, but a necessity. Many rural communities face challenges with unreliable connectivity, which creates a disconnect when they attempt to utilize telehealth services.

When telehealth is not an option, rural veterans often run into transportation barriers as there are limited public transportation options, and they must travel extremely long distances to VA facilities. This is why I am leading the *Road to Access Act* with Senator Tester, to improve VA's Beneficiary Travel Program.

That is also why I will always protect the right of veterans to seek care in the community when VA is unable to offer them timely, accessible care.

It is critical that our veterans receive the care they need, when they need it, regardless of where they call home.

I look forward to hearing from each of our witnesses today on this important topic. Thank you, Chairman. I yield back.

Prepared Statements

STATEMENT OF PETER KABOLI, MD, MS
OFFICE OF RURAL HEALTH
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

"FRONTIER HEALTH CARE: ENSURING VETERANS' ACCESS NO MATTER WHERE THEY LIVE"

MAY 15, 2024

Chairman Tester, Ranking Member Moran, and Members of the Committee, thank you for this opportunity to appear before you today to discuss the Department of Veterans Affairs' (VA) extensive efforts to enhance the well-being of Veterans in rural areas by addressing their unique needs. I am joined by Ryan Heiman, Deputy Executive Director, Member Services; Dr. Leonie Heyworth, Deputy Director, Telehealth Services, Office of Connected Care; and Wade Vlosich, Health Care System Director, VA Oklahoma City Health Care System.

Nearly a quarter of all Veterans, over 4.4 million, reside in rural communities. These Veterans often face challenges that differ from those of their urban counterparts. Many prefer living in rural communities for their proximity to family, friends, and the community; the availability of recreational open spaces; increased privacy; lower living costs; and less crowded towns and schools. However, the geographical isolation of rural areas can make accessing VA care and other services difficult. VA is consistently striving to bridge the gap between Veterans in rural areas and available resources.

VA's Offices of Rural Health and Engagement

VA continues to prioritize connecting Veterans to the "best and earliest care" and hiring "faster and more competitively." These practices are particularly pertinent in rural settings where Veterans can face health care access barriers due to provider shortages. Digital technologies can help overcome these barriers, but many rural communities lack high-speed internet access.

Established in 2006, the Office of Rural Health (ORH) was created to provide innovative solutions for the unique health care needs of Veterans in rural areas. ORH supports targeted research, develops new care models for system-wide implementation, and serves over 4.4 million Veterans living in rural areas.[1] Among these Veterans, 8% are women, 11% identify as members of a racial minority, 54% are aged 65 or older, and 44% earn less than $55,000 annually. ORH's components include Veterans rural health resource centers, field-based satellite offices, and Veterans Integrated Service Network (VISN) rural consultants. These entities all serve as communication channels between VA Central Office, ORH, and Veterans Health Administration (VHA) field

[1] Over 2.7 million Veterans enrolled in the VA health system live in rural areas.

operations. ORH collaborates with other VA offices to identify, support, and disseminate novel solutions for Veterans in rural areas, including improved access to care, expanded efforts, and community engagement. The initiatives aim to enhance mental health, primary care, telehealth, workforce development, and innovation.

VA has also made significant strides in strengthening networks from the time of the inaugural President's Rural Prosperity Interagency Policy Council's Federal Resource Fair earlier this year. The Office of Rural Engagement (ORE) has collaborated with others to provide information and expertise at resource fairs throughout the country. These fairs feature roundtables with local leaders and Federal officials and highlight available resources for rural communities; additional discussions are tailored to support aging Veterans who face difficulties accessing VA services. VA is also exploring potential collaboration with the U.S. Department of Agriculture (USDA) to better serve Veterans' health care needs in rural areas, including collaborations with USDA-supported hospital system and services. The agencies are looking at pilot sites in Ohio, North Carolina, New Mexico, Texas, and Washington.

Rural Staffing and Recruitment

VA is committed to employing top-tier health care teams to provide the best care for Veterans. Unfortunately, the gap between supply and demand for clinical and nonclinical staff is more pronounced in rural areas. In fiscal year (FY) 2022, turnover rates within the VHA hit a 20-year high, at 11% for VHA overall and 12.1% in rural facilities. Fortunately, for FY 2023, the *Sergeant First Class Health Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022* (P.L. 117-168) gave VA unprecedented authority to enhance staff recruitment and retention. Leveraging this authority, VA launched its *Rural Recruitment and Hiring Plan*, aiming to increase staffing levels in rural facilities, engage stakeholders in recruitment and onboarding, and empower leadership.

The plan also leveraged the U.S. Department of Health and Human Services' Health Resources & Services Administration's Rural Veterans Health Access Program, providing funding to states to work with providers and partners to improve access to needed health care services and coordination of care for Veterans living in rural areas. It included a newly authorized contract buy-out program for rural health providers, in return for a 4-year service commitment at a rural VHA facility. Additionally, VHA established a full-time program manager for Stay in VA, a practice focused on employee retention through engagement, targeting rural facility retention, and a national sourcing function to provide physician/provider recruiters with leads to exceptional candidates for rural health recruitment. While VHA grew by 7.4% overall, rural VHA facilities grew by 7.7%, the highest growth rates in over 15 years. By leveraging the incentives and authorities provided in the PACT Act, VHA also saw a significant decrease in turnover from the highest levels in FY 2022 to some of the lowest levels seen in VHA history in FY 2023, ending the year at an 8.4% total loss rate for VHA and a 9% loss rate for rural facilities. VA continues to use workforce data to shape its recruitment and retention strategies through workforce resource blueprints, offering incentives such as the

expansion of 3R incentives (recruitment, retention, and relocation) and the new critical skills incentive afforded by the PACT Act, as well as the student loan repayment program, education debt reduction program, special salary rates, and expedited hiring authority for graduates.

Enhancing Care through Telehealth

For over two decades, VA has been implementing telehealth, enhancing care through video, image, and data exchange. In the past five FY's, VA significantly expanded these efforts, with telehealth use increasing by 346% and home video services by approximately 3,100%. Nearly half of Veterans in rural areas who have used video-to-home prefer it over other modalities of care, and about 40% of all patients access part of their care through synchronous, asynchronous, and remote patient monitoring telehealth modalities.

Telehealth is a critical capability that enables VA to increase clinical capacity and address health care disparities in rural areas by sharing clinical services across its system. In FY 2023, VA delivered more telehealth services than in any previous year, while also achieving increased trust and satisfaction rates. Over 11.6 million telehealth episodes were delivered to more than 2.4 million individual Veterans, including over 2.9 million episodes to over 770,000 Veterans in rural areas. Between October 1, 2023, and April 20, 2024, over 1.8 million Veterans have participated in over 6.3 million telehealth episodes, with more than 567,000 Veterans in rural areas participating in 1.6 million telehealth episodes. Beyond VA, telehealth has been embraced by the U.S. health care system, including other Federal providers, as a means to deliver needed care to those in rural and underserved areas.

VA has launched several telehealth initiatives to meet Veterans' needs, including the Clinical Resource Hub (CRH) program. This program established regional telehealth centers to address clinical service needs in underserved areas. All 18 regional CRHs offer primary care, mental health care, and suicide prevention services to VA outpatient sites. In FY 2023, the CRH program provided 372,845 Veterans with 903,089 encounters across 43 specialties, including 40,835 encounters for Suicide Prevention Services. Additionally, 40% of Veterans served through the CRH program in FY 2023 resided in rural areas. Furthermore, VA continues to help Veterans bridge the digital divide through education, help desk support, and the direct provision of internet-connected devices.

In FY 2023, VA implemented 23 Virtual Health Resource Centers that function as in-person support centers at VA facilities where Veterans can get assistance understanding and using VA's digital services, such as mobile applications, telehealth, and MyHealtheVet. In FY 2023, VA's Connected Care Help desk received 216,423 calls from Veterans to assist with their technology, receiving a 91% satisfaction rate. VA also completed 33,157 digital divide consults during FY 2023 and managed over 110,000 internet-connected devices provided to Veterans to enable digital connectivity with their

VA benefits. In collaboration with public and private organizations, VA has continued work on the Accessing Telehealth through Local Area Stations program, establishing telehealth access points in Veteran communities, providing private spaces for VA health care professionals to connect with Veterans and their caregivers remotely through video telehealth.

VA also launched VA Health Connect, modernizing the Veteran health care experience by offering a 24/7 virtual care option on the phone, through VA Video Connect, or through chat with a real person. It allows Veterans to speak with a nurse; schedule, confirm, or cancel medical appointments; talk to a medical provider about an urgent or developing issue; refill and request medication renewals; and check on the status of medications with pharmacy professionals. As part of VA Health Connect, VA developed a Tele-Emergency Care (Tele-EC) capability similar to a nurse advice line. Tele-EC uses clinical contact centers to triage and connect Veterans or caregivers to a licensed emergency medicine practitioner, addressing acute medical needs over video or phone or directing them to appropriate resources. Tele-EC is currently available in 13 VISNs, and VA plans to go Nationwide by the end of the year. Since last year, Tele-EC has triaged over 15,000 calls, with a median wait time to speak to a provider under 10 minutes. Veterans uses Tele-EC would have otherwise been referred to an emergence department or urgent care. This potentially reduces community care costs as the data show that many issues are resolved over video or the phone. Over the past year, nearly 85% of Veterans who have used Tele-EC say they were satisfied with their visit, and the same percentage of Veterans trust using Tele-EC in the future.

Supporting Rural Native Veterans

Meeting the needs of Veterans in rural areas also involves ensuring that our American Indian and Alaska Native (AI/AN) Veterans receive the care and benefits they have earned. AI/AN Veterans serve in the military at one of the highest rates among all racial and ethnic groups and are more likely to live in rural communities. Our AI/AN Veterans face significant health care disparities, exacerbated by barriers related to care access, coordination, and navigation. Moreover, the generational trauma and racial discrimination experienced by rural AI/AN Veterans contribute to their distrust of VA and other Federal systems. e

Health Care Copayment Exemptions. In April 2023, VA implemented section 3002 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315), ensuring that AI/AN Veterans receive necessary care. As of April 1, 2024, VA has exempted or reimbursed nearly 180,000 copayments for more than 4,000 eligible Veterans, totaling approximately $3.2 million. VA continues to process exemption applications and plans to promote the exemption process at more than 25 engagements this fiscal year.

Health Care Access. Alongside the Indian Health Service (IHS), VA offers health care at IHS clinics in Chinle and Kayenta, Arizona. These clinics, referred to as a "clinic-in-a-clinic," launched in February and March 2024 and expand health care options for more than 400 VA-enrolled AI/AN Veterans. We are also exploring the potential to open

more clinics in Arizona, New Mexico, and South Dakota.

Supportive Housing. In collaboration with the Office of Native American Programs at the U.S. Department of Housing and Urban Development (HUD), the tribal HUD-VA Supportive Housing program aims to provide permanent supportive housing for homeless AI/AN Veterans and those at risk of homelessness. This program combines hybrid Indian Housing Block Grants for rental assistance with VA case management and supportive services, helping Veterans secure and maintain housing. Currently, 29 Tribes participate, with grant funding to support approximately 600 AI/AN Veterans' households. Another service that homeless veterans are referred to is the Department of Labor's (DOL) Homeless Veterans' Reintegration Program (HVRP), a competitive grant program whose sole purpose is to work with veterans who are experiencing homelessness, or who are at risk of homelessness. DOL's Veterans' Employment and Training Service (VETS) funds HVRP grantees across the country that serve AI/AN veterans in rural areas.

Suicide Prevention. In 2021, AI/AN Veterans had the highest suicide rate of any racial or ethnic group. VA is working to reduce this by enhancing access to care, offering culturally significant treatments, and expanding support networks. VA collaborates with Federal, Tribal, State, and local governments to promote a public health approach to suicide prevention. This includes initiatives like granting $52.5 million to 80 community-based organizations through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program and bolstering collaborative efforts with tribal communities as part of the VA and Substance Abuse and Mental Health Services Administration's joint Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families.

Transportation Barriers

Veterans in rural areas are disproportionately impacted by longer drive times to health care services. This leads to lower rates of diagnostic testing, such as spirometry for chronic obstructive pulmonary disease diagnosis; fewer screening services like osteoporosis screening in women aged 65 and above; and reduced therapeutic care, such as cardiac rehabilitation for patients hospitalized due to ischemic heart disease. This disparity in health care access underscores the need for targeted interventions to address these challenges.

Beneficiary Travel Self-Service System. VA launched the Beneficiary Travel Self-Service System (BTSSS) in November 2019, allowing Veterans and their beneficiaries to submit reimbursement claims online. The program aims to address the financial and logistical challenges of long-distance travel for specialized medical care by reimbursing eligible Veterans for travel expenses like mileage, lodging, and meals. This program enhances access to medical appointments and reduces financial stress, allowing Veterans in rural areas to prioritize their health without financial barriers. VA is upgrading tools for Veterans through FY 2024 to simplify the reimbursement process. BTSSS allows for virtual assistance in claims processing, which was not possible with

the legacy processing tool. Additional paperless modalities were developed, including the Patient Check-in mobile application through va.gov and the integration of Vecna's express patient check-in kiosks, which are integrated directly with BTSSS. During the transition to BTSSS, claims processing time increased due to the need to manually scan paper claims.

VA's transportation program internal processing team assisted facilities with these challenges. VTP also provides ongoing training and guidance to effectively manage travel claims. Increased outreach and continued training opportunities assist Veterans and staff in submitting complete claims, allowing them to successfully move through the adjudication process, improving the time to payment of reimbursement. In response to Veteran feedback about the benefits of the kiosk system, we have also launched a working group that is taking a Veteran-centered design approach to improving the experience of travel claim submission while keeping Veterans' voices at the center.

Transportation Programs and Services. To further address Veterans' transportation issues, VA independently and collaboratively supports programs that assist Veterans in accessing their VA-authorized health care appointments. One such initiative, the Veterans Transportation Service, provides vehicles and funding to VA medical centers to transport Veterans and other VA beneficiaries to and from their appointments. In FY 2023, the program provided over 600,000 transports of Veterans to medical appointments, including 98,000 rural trips, serving nearly 15,000 individual Veterans. Additionally, ORH works with VTP to offer the Grants for Transportation of Veterans in Highly Rural Areas Program, providing grants for Veterans Service Organizations and state Veterans service agencies to improve transportation options for all Veterans, regardless of beneficiary travel eligibility. In FY 2023, nearly 19,000 trips were provided through the program, serving more than 5,000 unique Veterans. PPP The Volunteer Transportation Network is also an essential service for Veterans who lack transportation for VA medical appointments. It operates in collaboration with the Disabled American Veterans, which has donated 328 vehicles to 127 medical facilities since 2020.

Health Care Innovations

VA has been at the forefront of developing innovative care initiatives to address the unique health care needs of Veterans. VA's commitment extends beyond urban areas, recognizing the unique challenges faced by Veterans in rural communities and actively working to address those barriers. By leveraging technology, collaboration, and tailored programs, VA is committed to improving access to high-quality health care services, including ongoing efforts to enhance care delivery and promote wellness.

Innovative Care Initiatives. VA is committed to developing and enhancing cutting-edge methods to ensure that Veterans from all backgrounds and settings receive effective treatments more quickly. VA's strategic collaborations have made much of this work possible. One recent initiative, the TeleWound Practice program, aims to use telehealth technologies for improved care access and coordination for

Veterans. Evaluations of four VA facilities, facilitated by various VA initiatives, identified barriers and solutions for implementation. The data-driven approach will guide the Nationwide rollout of telehealth services, aiming to deliver high-quality, patient-centered care while reducing health care costs and improving efficiency. The initiative's success in the VA Shark Tank Competition highlights its potential to transform health care delivery for Veterans.

Additionally, the Diffusion of Excellence Initiative aims to promote Advance Care Planning through Group Visits (ACP-GV) to empower Veterans, especially those in underserved rural areas, to make informed health care decisions. Since October 2019, ACP-GV has reached 36,597 Veterans, including 8,954 Veterans in rural areas. Group visits provide education, discussion, and community support, fostering a sense of community, and peer support.

Several initiatives have also produced data-driven platforms, including the Medical Foster Home Rural Expansion evaluation, which involved creating interactive maps to identify Veterans in rural areas for placement, Home-Based Primary Care locations, and key resources. These tools helped identify community-based organizations, health care facilities, and local support systems to enhance care delivery. ORH-funded research also created a national map of county-level "hotspots" of Veteran suicide, enabling targeted suicide prevention strategies. The research emphasizes the importance of advanced data analysis techniques and geospatial mapping tools in mental health research, enabling a more targeted and localized approach to suicide prevention efforts.

Innovative Research Initiatives. Looking to further these initiatives, our rural health research priorities include exploring virtual care to improve access and prevent disruptions during public health crises, coordinating care between VA and community providers, and addressing recruitment and retention challenges in the rural health care workforce. Recent research has demonstrated significant improvements in the quality of care for Veterans in rural areas.[2] Additionally, web-based skills training and telehealth coaching for mental illness in Veterans living in rural areas has shown significant benefits across various symptoms and functional outcomes.

Several other research projects are currently underway, focusing on rural health. These include examining the social determinants of health among Veterans in rural areas, ending in FY25; expanding access to opioid use disorder treatment in rural settings, extended through FY25; and understanding the impact of rurality and social risk factors on barriers to care and surgical outcomes, through FY26. VA is also developing a manual to engage vulnerable Veterans in selecting and customizing strategies for implementing or redesigning health care services and implementing the ongoing Virtual Care Quality Enhancement Research Initiative Program to improve access to high-quality care for Veterans in rural areas who receive care at home and in

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[2] For instance, a study compared the satisfaction of rural and urban Veterans with VA outpatient care vs. community care. It found that rural Veterans rated their community care experiences as similar or better than those in specialty care.

community-based outpatient clinics. Planned research opportunities moving into the next several fiscal years also include reviewing the quality of care for presumptive conditions among Veterans living in rural areas with military toxic exposures, the impact of virtual care on the quality of mental health services for Veterans living in rural areas, and the risk and resilience factors among Veterans experiencing housing insecurity or homelessness.

Conclusion

Chairman Tester and Ranking Member Moran, thank you once more for the opportunity to discuss VA's efforts to best serve Veterans living in rural communities. Through our joint efforts, we are proud to have broadened our reach, delivering more care to a greater number of Veterans than ever before. All Veterans, but particularly those in rural areas, benefit from the robust working relationship between VA and Congress. We value your ongoing engagement as we embrace our shared responsibility to better serve those who have served.

Peter Kaboli, MD, MS
Executive Director, VA Office of Rural Health

Peter Kaboli, MD, MS was named Executive Director in 2024. He leads the Office of Rural Health's portfolio of partnerships with clinical program offices, research initiatives, and a strong innovation program of Rural Promising Practices and Enterprise-Wide Initiatives that are disseminated across VHA to increase access to care for hundreds of thousands of rural Veterans.

Dr. Kaboli also oversees the activities of five Veterans Rural Health Resource Centers (VRHRCs) in Iowa City, Iowa; Salt Lake City, Utah; White River Junction, Vermont; Gainesville, Florida; and Portland, Oregon. ORH's VRHRCs serve as hubs of rural health care research, innovation and dissemination. Dr. Kaboli ensures that ORH fulfils its legislative mandate as outlined in 38 USC § 7308 to conduct rural Veteran focused research, create innovative solutions to rural Veteran access challenges, and disseminate those solutions system-wide.

Dr. Kaboli is a Core Investigator with the Comprehensive Access and Delivery Research and Evaluation (CADRE) Center of Innovation; a Hospitalist at the Iowa City VA Healthcare System; and a Professor of Internal Medicine in the Division of General Internal Medicine at the University of Iowa Carver College of Medicine.

He earned his BS in Biology, MS in Epidemiology, and his MD, all from the University of Iowa. He completed his residency at LDS Hospital in Salt Lake City, UT in 1998 and General Medicine Fellowship and VA Quality Scholars Fellowship at the University of Iowa/Iowa City VAMC in 2000.

He has held leadership positions as Chief of Medicine, Iowa City VA Healthcare System; a Veterans Rural Health Resource Center Director; and Senior Scholar of the VA Quality Scholars Fellowship program.

Dr. Kaboli's research interests include health care access, rural health, inpatient medical care quality, development of valid methods for measuring medication appropriateness, and interventions to optimize medication delivery to vulnerable Veteran populations.

Department of Veterans Affairs

Senior Executive Biography

Ryan Heiman, MHSA, CPTA

Deputy Executive Director
VHA Member Services

As Deputy Executive Director, Mr. Heiman leads more than 2,200 Team Members in facilitating access to VA healthcare, and support services for Veterans and their families through four distinct business lines: Health Eligibility Center, Health Resource Center, Pharmacy Services, and Veterans Transportation Program. In Fiscal Year 2023, Member Services handled more than 5.6 million Veteran contacts via phone, e-mail, web chat, secure messaging, and correspondence requests; processed 360,000 new health care enrollment applications and issued 562,000 Veteran Health Identification Cards; and provided 600,000 transports of Veterans to medical appointments and facilitated nearly 450,000 claims for travel reimbursement.

Mr. Heiman previously served as the Chief Operations Officer for VHA Member Services since 2018 achieving many accomplishments surrounding modernizing VA Systems, enhancing access to services, and improving the team member experience.

Mr. Heiman is a proud graduate of the 2012 cohort of the Graduate in Healthcare Administration Training Program (GHATP). He earned his Green Belt in Lean Six Sigma from Georgetown University and Black Belt training through the United States Army Corp of Engineers.

Mr. Heiman holds a Master of Arts in Health Services and Administration from the University of Kansas, School of Medicine. Prior to his graduate degree, he earned a Bachelor of Science in Health Administration and an Associate of Science from Washburn University. He holds an active license as a Physical Therapist Assistant and has range of direct patient experience across inpatient, outpatient, cardiac, spinal and joint rehabilitation.

CAREER CHRONOLOGY:

Aug. 2018 – April 2023	Chief Operations Officer, Member Services
Dec. 2016 – July 2018	Executive Officer, Member Services
Oct. 2015 – Nov. 2016	Chief of Staff, Health Resource Center
May 2015 – Sept. 2015	Deputy Associate Director, Pharmacy Services
Apr. 2014 – Apr. 2015	Public Affairs Officer, Health Resource Center
Jan. 2013 – Mar. 2014	Project Manager, Health Resource Center
Aug. 2012 – Dec. 2012	Administrative Officer, Oklahoma City VA Radiation Oncology

EDUCATION:

2014	Lean Six Sigma Black Belt Training, United States Army Corp of Engineers
2012	Graduate Fellow (GHATP), Oklahoma City VA Medical Center
2012	Lean Six Sigma Green Belt, Georgetown University
2011	Master of Health Services and Administration, University of Kansas, School of Medicine
2009	Bachelor of Health Science, Washburn University
2008	Certified Physical Therapist Assistant, Kansas State Board of Healing Arts
2008	Associate of Science, Washburn University

Leonie Heyworth, M.D., M.P.H
Deputy Director for Clinical Services, Telehealth Services
Office of Connected Care
Veterans Health Administration
U.S. Department of Veterans Affairs

Dr. Leonie Heyworth is the deputy director for clinical services, Telehealth Services, at the Veterans Health Administration. In these roles, she combines her clinical and research experience to help expand telehealth services to the 6 million Veterans who rely on the U.S. Department of Veterans Affairs for health care. Dr. Heyworth is an expert on national telehealth programs and is passionate about her work in leading national initiatives and developing policies to help front-line VA staff deliver high-quality, accessible care to Veterans. She practices primary care at the Jennifer Moreno VA Medical Center in San Diego, California.

Dr. Heyworth's efforts have earned significant recognition, including a Government Innovation Rising Star Award in 2019 and VA's prestigious Robert L. Jesse Award for Excellence in Innovation in 2020. Dr. Heyworth was also featured on FCW's 2022 Federal 100 for her work in federal information technology.

Dr. Heyworth earned her doctorate in medicine at Harvard Medical School and completed her residency training at Brigham and Women's Hospital in Boston, Massachusetts. She is board-certified in internal medicine and is an associate professor at the University of California, San Diego.

[Long form]

Dr. Leonie Heyworth, M.D., MPH

Dr. Leonie Heyworth is the deputy director for clinical services, Telehealth Services, at the Veterans Health Administration. In this role, she combines her clinical and research experience to help expand telehealth services to the 6 million Veterans who rely on the U.S. Department of Veterans Affairs for health care. Heyworth is an expert on national telehealth programs and is passionate about her work in leading initiatives and developing policies to help front-line VA staff deliver high-quality, accessible care to Veterans.

Heyworth earned her doctorate in medicine from Harvard Medical School and completed a residency in internal medicine and primary care at Brigham and Women's Hospital. She completed her master's in public health with a concentration in clinical effectiveness at the Harvard School of Public Health in conjunction with a general medicine fellowship at Brigham and Women's Hospital and a VA advanced fellowship at the Center for Healthcare Organization and Implementation Research at the VA Boston Healthcare System. Dr. Heyworth currently practices primary care at the Jennifer Moreno VA Medical Center in San Diego. She is board-certified in internal medicine and is an associate professor at the University of California, San Diego.

Previously, she served as the National Synchronous Telehealth Lead for Telehealth Services, where she oversaw the massive expansion of video telehealth during the Covid-19 pandemic. Additionally, she has served as the acting National Telehealth Lead for primary care and the acting chief consultant for the

VHA Office of Primary Care. In these roles, she supported the expansion of TelePrimary Care and the expansion of video telehealth and mobile app use in primary care and clinical call centers.

Her leadership within the Office of Connected Care has been marked by numerous accomplishments. Notably, Dr. Heyworth received the 2019 Government Innovation Rising Star Award for her efforts in advancing telehealth. In 2020, she earned VA's prestigious Robert L. Jesse Award for Excellence in Innovation, a testament to her groundbreaking work. She was also featured on FCW's Federal 100 Award in 2021 and received a FORUM Health IT Innovation Award in 2022 for her work with VA Video Connect and ATLAS (Accessing Telehealth through Local Area Stations).

Dr. Heyworth continues to show a commitment to education in her role as an associate professor at the University of California, San Diego, where she trains medical residents.

Her scholarly interests include clinical innovation and systems improvement with multiple peer-reviewed publications. As a subject matter expert in her field, Dr. Heyworth has been published in numerous academic journal and publications including "Journal of Medical Internet Research," "Journal of General Internal Medicine," "Journal of Primary Care & Community Health," among others. Dr. Heyworth has also oversees the Virtual Consortium of Research, spearheading VA-led research projects in telehealth access, equity and effectiveness.

Beyond her professional accolades, Dr. Heyworth engages in community service. She serves on community boards and volunteers at the Stand Down medical tent at the VA San Diego Healthcare System. Her commitment to service aligns with her belief in the importance of community connections in health care.

Dr. Heyworth's professional journey has been marked by innovation, leadership, and a steadfast commitment to improving health care accessibility.

Department of Veterans Affairs

Senior Executive Biography

Kristopher "Wade" Vlosich, MBA

Director, Oklahoma City VA Health Care System
Veterans Health Administration

Mr. Wade Vlosich is responsible for the day-to-day management of a complex health care system that serves 47 Oklahoma counties and two counties in north central Texas with approximately 92,000 veterans enrolled. The OKCVAHCS consists of 192 operating beds and is a tertiary care facility. OKCVAHCS consists of 14 Outpatient Clinics, in addition to 3 Outpatient Clinic partnerships with the Department of Defense and a Friendship House/Compensated Work Therapy Transitional Residence. The Oklahoma City VAHCS includes outpatient clinics in Ada, Altus, Ardmore, Blackwell, Clinton, Enid, Lawton, Lawton North, Norman, North Oklahoma City, North May in Oklahoma City, South Clinic in Oklahoma City, Shawnee, Stillwater, Tinker AFB, Wichita Falls and Yukon. Education and Research are substantial programs that bring continual growth to the hospital.

Mr. Vlosich has served in several key leadership positions including the Medical Center Director at the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri. He has held leadership roles as Associate Medical Center Director at the South Texas VA Health Care System in San Antonio, Acting Associate Director and Assistant Medical Center Director at the Eastern Kansas VA Health Care System in Topeka and Leavenworth, Kansas, as well as the Acting Assistant Medical Center Director at the North Texas VA Health Care System in Dallas, Texas. A native of Amarillo, Texas, he earned a master's degree in business administration and health organization management and a bachelor's degree in psychology and business management from Texas Tech University. He began his VA career in 2004 as an administrative fellow to the Network Director at VISN 17 in Arlington, Texas. Vlosich has diplomat status with the American College of Healthcare Executives (ACHE). He is married and has three children.

CAREER CHRONOLOGY:

2016 – Present	Director, Oklahoma City VA Health Care System, OKC, OK
2013 – 2016	Medical Center Director, Harry S. Truman Memorial Veterans' Hospital, Columbia, MO
2010 – 2013	Associate Director, South Texas Veterans Health Care System, San Antonio, TX
2009 – 2010	Assistant Director, VA Eastern Kansas Health Care System, Topeka and Leavenworth, KS
2004 – 2009	Acting Assistant Director, VA North Texas Health Care System, Dallas, TX
2004	Administrative Fellow, VISN 17: VA Heart of Texas Health Care Network, Arlington, TX

EDUCATION:

2004 Master of Business Administration in Health Organization Management, Texas Tech University, Lubbock, TX
2002 Bachelor of Arts in Psychology, Texas Tech University, Lubbock, TX
2002 Bachelor of Business Administration in Management, Texas Tech University, Lubbock, TX

Great Plains Veterans Services Center

"Veterans helping Veterans for a better future"

May 13, 2024

The Honorable Jon Tester
311 Hart Senate Office Building
Washington DC 20510

The Honorable Jerry Moran
521 Dirksen Senate Office Building
Washington DC 20510

Dear Chairman Tester and Ranking Member Moran,

Thank you for the invitation to testify before the Senate Committee on Veterans' Affairs' hearing entitled, "Frontier Health Care: Ensuring Veterans' Access No Matter Where They Live." On behalf of the Native Veterans and rural Montana Veterans I serve, I am honored to provide the following written testimony.

American Indians have enriched our communities, strengthened our country, and made lasting contributions to the United States, including significant military service to defend our nation. They significantly have more members per capita than any other group serving our country. Like most Americans, American Indians also seek to live the "American Dream," unbothered by economic hardship. Unfortunately, for many of our Native Veterans, living in prosperity is just a dream. Despite their sacrifice and service to our nation, many Native Veterans return home to poor conditions, conditions one would expect to find in a third-world country, not a prosperous nation like the United States.

Tribal communities also suffer from chronically high unemployment rates (60%-85% at any given time) due mainly to our detachment from mainstream corporate America. Income and employment data for the reservations document a high level of economic distress, especially when compared to local, state, and national levels.

Living conditions on Indian reservations are deplorable. As a result, Veterans must often live in unstable conditions, with very little access to steady employment, reliable housing, or basic needs. In addition to the poor economic environment, reservation communities face the challenge of rampant drug and alcohol abuse. Those Veterans whom the Great Plains Veterans Services Center currently assist struggle to provide a stable quality of life for themselves and their families. Veterans living on Indian reservations have unequal access to benefits and services they have earned. Additionally, a lack of information on how to access and use those benefits can place Native Veterans in this area at a much higher risk

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for poverty, becoming economically disadvantaged, at risk of homelessness, and being in a state of societal depression.

Additionally, Veterans are more likely than the general population to commit suicide. According to the Montana DPHHS 2016 Suicide Mortality Review Team Report, 22% of suicides in Montana between January 01, 2014 and March 01, 2016 were Veterans. Amongst American Indians, 19% of suicides during the same period were Veterans. The resources and services the GPVSC can provide give the Veteran a means to manage their issues and provide some stability to an otherwise very unstable lifestyle and environment, saving a Veteran's life.

Due to all these conditions, Veterans receive very little priority and must compete with the general population to receive even minimum services. The Great Plains Veterans Services Center seeks to eliminate this disparity. Rather than rely on substandard and overtaxed tribal/local resources, the Great Plains Veterans Services Center utilizes different funding streams and strategies to bring resources to Veterans. Direct assistance resources are explicitly provided for low-and moderate-income Veterans, which are not available to the general population. By focusing strictly on Veterans and ensuring their quality-of-life needs are met, the Great Plains Veterans Services Center will become a model for the tribal communities to follow. Those Veterans whom the Great Plains Veterans Services Center assists will become an asset to their Tribe.

A big issue is the lack of knowledge Veterans, Native and non-Native, have on VA benefits. The VA has done a poor job of educating the Veteran population about ALL the services they have earned in their service to our nation. With the passage of the PACT Act, the VA has conducted a number of clinics to address this issue. However, more is definitely needed to ensure Veterans are knowledgeable about these services. By educating and reaching out to Native and rural Veterans, the VA can also help the greater Montana community. Ensuring Veterans have access to VA services will reduce the impact on local services that would otherwise go to other residents.

Another issue facing Native Veterans and rural Veterans is the lack of transportation to access services. While telehealth options exist for Veterans, access to telehealth technology is disparate. Often, Veterans must travel to their providers, which can be hundreds of miles away. Additionally, Veterans, especially elderly Veterans, do not have the means to make the drive.

In answer to the conditions facing Native communities, the Great Plains Veterans Services Center has stepped in to bridge the gap between

Great Plains Veterans Services Center

"Veterans helping Veterans for a better future"

federal resources and Native Veterans. Through funding from the VA, the GPVSC has provided transportation services to Native and rural Montana Veterans. In 2023, we supported 288 Veterans with transportation to their VA medical and VA-referred medical appointments. We have completed 451 trips and driven 162,819 miles. Our transportation service area covers 28 of 56 Montana counties and six of seven Indian reservations.

Additionally, the GPVSC has conducted outreach through the SSG Fox Suicide Prevention Grant Program. As part of the program, we assisted 741 Veterans with requesting discharge paperwork, direct assistance for groceries and other essential needs items, care and wellness packages, and referrals to other service providers.

The work the GPVSC has done is because of the funding made available through the VA. We hope that this continued support to local organizations will continue in order to help break down the barriers that Native Veterans and rural Montana Veterans encounter in trying to access services they have earned in their service to this great nation.

Sincerely,

Chauncey L Parker
Executive Director
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United States Government Accountability Office

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

For Release on Delivery
Expected at 3:30 p.m. ET
Wednesday, May 15, 2024

VA HEALTH CARE

Opportunities to Improve Access for Veterans Living in Rural Areas

Statement of Alyssa M. Hundrup, Director, Health Care

GAO-24-107559

Chairman Tester, Ranking Member Moran, and Members of the Committee:

Thank you for the opportunity to discuss our work on opportunities the Department of Veterans Affairs (VA) can take to improve access to health care for veterans living in rural areas. In fiscal year 2022, about one third of the 8.3 million veterans enrolled in the Veterans Health Administration lived in a rural area.[1] Comparatively, about one fifth of Americans lived in a rural area. VA projects veterans living in rural areas will continue to represent a significant portion of our nation's veterans.

Living in rural areas can create challenges accessing health care, including care provided by VA. Our past work and other research have demonstrated that long distances from health care facilities, limited access to broadband internet, and staffing shortages, among other factors, may affect rural veterans' access to care.[2] In turn, these challenges can lead to disparities in access and quality of health care compared with veterans who live in urban areas.

VA identified veterans living in rural areas as an underserved population in its *Fiscal Years 2022-28 Strategic Plan* and established a strategic objective to increase health care access for rural veterans.[3] Our past work highlighted various approaches VA has taken to improve this population's access to care, including funding rural health transportation initiatives and providing care through mobile medical units that can provide critical services to veterans living in remote areas. On the basis of this work, we have made several recommendations to VA to help ensure its approaches effectively address the access challenges these veterans face. In light of the passage of the Honoring our PACT Act of 2022 (PACT Act), which expands access to health care for certain veterans, it is even

[1]The Veterans Health Administration uses the Rural-Urban Commuting Areas system to define rurality. The Rural-Urban Commuting Areas system takes into account population density as well as how closely a community is linked socio-economically to larger urban centers. We use the term rural to include rural, highly rural, and insular island areas.

[2]For example, see GAO, *VA Mental Health: Additional Action Needed to Assess Rural Veterans' Access to Intensive Care*, GAO-23-105544 (Washington, D.C.: Feb. 9, 2023) and Colin Buzza et al., "Distance Is Relative: Unpacking a Principal Barrier in Rural Healthcare," *Journal of General Internal Medicine*, vol. 26, no. 648 Supplement 2 (2011).

[3]Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan* (Washington, D.C.: Apr. 18, 2022).

more imperative VA do all it can to ensure access for all veterans, including those in rural areas.[4]

My testimony today summarizes key findings from our recent work, including recommendations we have made to VA and steps the department has taken towards implementing them, related to

1. the Office of Rural Health's initiatives and research;
2. funding for intensive mental health care services for rural veterans; and
3. mobile medical unit operations and performance.

This statement is based on our recent work issued between February 2023 and December 2023 reviewing VA's approaches to improve access to care for veterans in rural areas, including our recommendations to improve these approaches.[5] Detailed information on the objectives, scope, and methodology of this work can be found in each issued report. For this statement, we reviewed VA documentation related to the status of efforts to implement our recommendations since the reports were issued.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

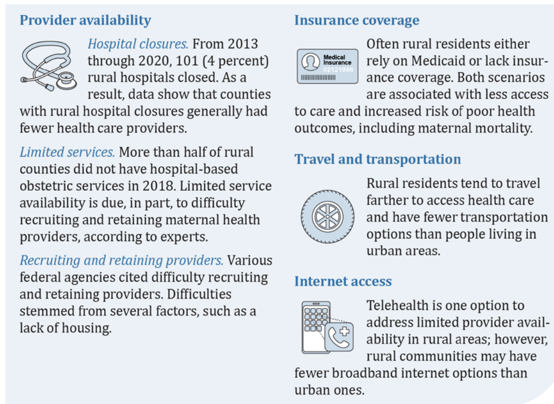
According to our prior work and research, rural communities often have fewer resources compared with urban communities, which can result in rural residents, including veterans, experiencing challenges in accessing

[4]The Honoring our PACT Act of 2022 expanded eligibility for health care benefits for specific categories of toxic-exposed veterans and veterans supporting certain overseas contingency operations. See Pub. L. No. 117-168, Tit. I, 136 Stat.1759, 1761 (2022).

[5]See GAO, *VA Health Care: Actions Needed to Improve Information Reported on Mobile Medical Units*, GAO-24-106331 (Washington, D.C.: Dec. 14, 2023); *VA Health Care: Office of Rural Health Would Benefit from Improved Communication and Developing Performance Goals*, GAO-23-105855 (Washington, D.C.: May 4, 2023); and GAO-23-105544.

health care.[6] In particular, rural communities tend to have fewer hospitals, health care providers, transportation options, and broadband access compared to urban communities.[7] We have previously reported on how increases in rural hospital closures, coupled with fewer providers, have negatively affected access to care for rural residents.[8] See figure 1.

Figure 1: Examples of Previously Reported Health Care Access Challenges Individuals Living in Rural Areas May Face



Source: GAO. | GAO-24-107559

Note: Information presented in this figure is taken from GAO, *Health Care Capsule: Accessing Health Care in Rural America*, GAO-23-106651 (Washington, D.C.: May, 2023).

[6]For example, see GAO, *Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas*, GAO-23-105515 (Washington, D.C.: Oct. 19, 2022) and Medicaid and CHIP Payment and Access Commission, *Medicaid and Rural Health* (Washington, D.C.: April 2021). Also see Hillary D. Lum et al., "Anywhere to Anywhere: Use of Telehealth to Increase Health Care Access for Older, Rural Veterans," *Public Policy & Aging Report*, vol. 30, no. 1 (2019): 12-18.

[7]*Health Care Capsule: Accessing Health Care in Rural America*, GAO-23-106651 (Washington, D.C.: May, 2023).

[8]GAO, *Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services*, GAO-21-93 (Washington, D.C.: Dec. 22, 2020).

Similarly, veterans living in rural areas can experience unique challenges in accessing health care. According to VA, compared with their urban counterparts, rural veterans tend to (1) experience higher levels of poverty, with 44 percent earning less than $35,000 annually, (2) be older, with more than 60 percent of rural veterans over the age of 65, and (3) experience worse health outcomes, including higher rates of cardiovascular deaths and suicide deaths.[9] Additionally, research shows that rural veterans experience higher rates of serious mental illness and higher risk for suicide than those in urban areas.[10] Our past work also identified that veterans living in rural areas may face unique barriers to accessing mental health care compared with urban veterans, and that rural veterans used some mental health programs at lower rates than urban veterans.[11]

Office of Rural Health Initiatives and Research

As described in our May 2023 report, the Office of Rural Health's mission is to improve the health and well-being of rural veterans through research, innovation, and the dissemination of best practices.[12] VA's strategic plan identified the Office of Rural Health as one of the main offices responsible for implementing several actions to increase rural veterans' access to care.[13] These actions include developing innovative models of care for rural veterans, and coordinating and disseminating research on issues that affect rural veterans. In addition to a central office, the Office of Rural Health oversees five resource centers, which are field-based satellite offices that serve as hubs of rural health research, innovation, and dissemination.

The Office of Rural Health funds (1) VA program office initiatives, which seek to expand existing health care services to rural veterans; and (2) research projects, in which VA researchers study, pilot, and disseminate research in areas, such as rural health disparities. For example, one

[9]Veterans Health Administration, Office of Health Equity, *National Veteran Health Equity Report 2021* (2022).

[10]See for example John F. McCarthy et al., "Suicide Among Patients in the Veterans Affairs Health System," *American Journal of Public Health,* vol. 102, no. S1 (2012): S111-S117 and Carlee J. Kreisel et al., "Reducing Rural Veteran Suicides: Navigating Geospatial and Community Contexts for Scaling up a National Veterans Affairs Program," *Suicide and Life Threatening Behavior*, vol. 51, no. 2 (2021): 344-351.

[11]See GAO-23-105544.

[12]GAO-23-105855. Department of Veterans Affairs, Veterans Health Administration, *ORH 2020-2024 Strategic Plan* (Washington, D.C.).

[13]Department of Veterans Affairs*, Fiscal Years 2022-28 Strategic Plan*.

initiative that the Office of Rural Health has funded includes the Veterans Transportation Service, which provides veterans transportation to VA facilities for medical treatment and care. (See figure 2.) Related to research, the five resource centers oversee a variety of research projects, such as various interventions like knee or cardiac rehabilitation that could be done through telephone or video visits.

Figure 2: Example of Department of Veterans Affairs Veterans Transportation Service Van in Alaska

Source: Department of Veterans Affairs. | GAO-24-107559

However, in our May 2023 report we found that each of the office's five resource centers—which are responsible for identifying research projects to fund—only communicated these funding opportunities to VA researchers informally, such as by word-of-mouth. As a result, some rural health researchers with relevant knowledge and experience may be unaware of the funding. Relying on professional connections and word-of-mouth to communicate the availability of funding potentially creates a disadvantage for the more recently established resource centers that have less developed connections across VA.

We recommended the Director of the Office of Rural Health develop a policy requiring resource centers to communicate their available research funding opportunities across VA. By developing such a policy, the office could reach a larger pool of applicants, which in turn would allow the office to ensure the research projects it selects and funds best align with its mission.

In our May 2023 report we also found the Office of Rural Health had not developed performance goals that define the level of performance the office aims to achieve during a particular year. For example, while the office collects data on the number of clinicians trained through its funded initiatives and research projects, it had not defined how many clinicians should be trained each year to achieve its strategic goal of reducing health care workforce disparities. In fiscal year 2021, around 31,000 clinicians received training, according to documentation. However, the office has not defined a performance goal to identify how many clinicians it should be training per year to meet its strategic workforce-related objectives and strategic goal. We recommended the Director of the Office of Rural Health develop performance goals, which would better position the office to assess its progress in improving the health and well-being of rural veterans.

VA concurred with our two recommendations and has taken steps to implement them. Regarding the first recommendation, as of March 2024, the Office of Rural Health stated that it is developing a communication plan and accompanying standard operating procedures to communicate available research funding opportunities throughout VA. The office anticipates implementing the plan and procedures in September 2024. Regarding the second recommendation, as of March 2024, the office has started the process of drafting its upcoming fiscal years 2025 through 2029 strategic plan. According to officials, the plan will include performance goals and activities necessary to achieve them. The office plans to finalize the strategic plan by the end of May 2024.

Funding for Intensive Mental Health Care Services for Rural Veterans

In our February 2023 report, we describe two outpatient intensive mental health programs.[14] These two programs are designed to provide intensive community mental health recovery services to veterans.[15] The Office of Rural Health makes available seed funding to establish these programs which the Office of Mental Health and Suicide Prevention selects and oversees their implementation. We found VA provided funding from fiscal year 2010 through fiscal year 2021 to facilities to help establish such programs. However, we found that more facilities applied for seed funding than VA had monies to fund. For example, in fiscal year 2022, based on available funding, the office provided funding to three of the 27 facilities that applied for funding that year to establish programs.

We also found the guidelines for selecting its outpatient intensive mental health care programs do not account for where veterans with serious mental illness live. According to VA officials, the guidelines for deciding which facilities to fund include consideration of the percentage of enrollees in a service radius who lived in a rural area, proposed staffing for the program, and other resources available for the program identified by the applicant, including the number of available vehicles to help with transporting veterans. VA officials said that application requires the rurality of veterans in the zip codes targeted to be served to be at least 50 percent. However, the guidelines do not ask officials to account for information on the population these programs are meant to serve—the locations of veterans with serious mental illness or locations with the highest concentration of such veterans potentially served by the programs.

Without considering information on the location of veterans with serious mental illness, VA is at risk of not directing its resources to where they are most needed, especially when the number of applicants for seed funding

[14]GAO-23-105544. In this report, we made three other recommendations, including that the Office of Mental Health and Suicide Prevention analyze utilization and performance data by rurality, which as of March 2024, VA has implemented. Specifically, it developed a dashboard to support intensive mental health care programs and help staff investigate potential differences in quality measures stratified by vulnerable demographic groups, such as rurality. VA also completed analyses by rurality of the patient utilization and performance data it uses to monitor access for its intensive mental health programs.

[15]The two programs are the Rural Access Network for Growth Enhancement and the Enhanced Rural Access Network for Growth Enhancement. These programs provide intensive case management services, including homeless outreach, to seriously mentally ill veterans in rural areas. Veterans with serious mental illness—mental, behavioral, or emotional disorders resulting in serious functional impairment—often need higher level of mental health care and are generally at greater risk for worse health outcomes, including the risk of suicide.

has well exceeded available funding. We recommended that VA update its guidelines to include data on the locations of veterans with serious mental illness. By incorporating such information, VA could better ensure that it is able to direct available seed funding to the areas with the greatest need.

VA concurred with our recommendation and, as of April 2024, has taken some steps to address this recommendation. For example, VA reported that it started requiring applicants for these programs to use a tool to indicate whether there are veterans within the proposed service area that have serious mental illness. We are encouraged by these steps and will continue to monitor VA's actions to fully implement this recommendation.

Mobile Medical Unit Operations and Performance

Mobile medical units are vehicles equipped to deliver clinical services, such as primary care appointments or audiology services, in self-contained environments away from parent facilities. See figure 3.

Figure 3: Example of a Department of Veterans Affairs Mobile Medical Unit in Texas

Source: Department of Veterans Affairs. | GAO-24-107559

In our December 2023 report, we found that mobile medical units offer benefits that help VA medical centers expand primary and specialty care services to veterans—in particular, veterans living in rural areas—who may otherwise experience barriers to care, according to selected medical center officials.[16] These officials said mobile medical units can help VA medical centers in several ways including addressing transportation challenges and mitigating local provider shortages. Officials from one medical center in our review added that many veterans who use the units

[16] GAO-24-106331.

are elderly, are hard-of-hearing, or have trouble seeing, making it difficult for them to travel long distances. By delivering services closer to home, mobile medical units help veterans save transportation time and avoid missing work or other responsibilities to receive medical care.

However, in our December 2023 report we found that VA's annual reports to Congress about the operations and performance of mobile medical units lacked quality information. For example, in its 2023 report, VA reported there were 52 active units, yet we found at least nine that did not meet VA's definition of an active unit.[17] Under VA's definition, the units must be mobile and providing clinical services, but we identified units that were not being used for their intended purpose, were not providing clinical services, or were immobile. We recommended that VA assess the reliability of data it reports on mobile medical units.

Additionally, our December 2023 report found that VA's reports did not include contextual information important to understanding the operations and performance of the units. For example, we found that one unit reported conducting fewer appointments than operational requirements called for, suggesting the unit was underperforming. However, we found when speaking to VA officials, that the unit was not yet fully operational and data were for test appointments that should not have been reported. We recommended that VA include additional information in its reports to Congress about their use.

Without quality information, VA has an incomplete picture of the overall operations and performance of its mobile medical units. This may limit VA and Congress's ability to make informed decisions about how best to use mobile medical units, potentially contributing to missed opportunities to efficiently and effectively leverage mobile medical units to increase access to care and improve outcomes for veterans living in rural areas.

VA concurred with our recommendation to assess the reliability of the data it reports and identified steps it plans to take to implement it. Specifically, VA reported it is initiating an integrated project team that will, among other things, work to ensure the reliability of the data management

[17]We assessed the operational status of a sample of 20 selected VA medical centers' mobile medical units. We did not collect additional information to assess the operational status of mobile medical units outside our selection. As such, we did not determine whether more than nine mobile medical units were incorrectly identified as active in the Veterans Health Administration's Site Tracking database in fiscal year 2022, or whether some active mobile medical units were missing from the database.

plan for its mobile medical units by August 2025. VA concurred in principle with our second recommendation to include contextual information on mobile medical unit operations and performance.VA reported it plans to work with Congress to understand its reporting needs and update its 2024 report accordingly.

In closing, fully ensuring the access to health care for veterans living in rural areas is an issue of vital importance given the unique challenges they often face accessing care. Recognizing this, VA has taken important steps to address barriers, such as through the various initiatives and research efforts supported by the Office of Rural Health. By implementing the recommendations I've highlighted today, VA will be better positioned to improve access to health care for veterans living in rural areas.

Going forward, we will continue to monitor VA's steps to implement our recommendations. We also continue to examine issues critical to improving rural veterans' access to care. For example, as of May 2024, we have work underway examining actions VA has taken to help address barriers to accessing telehealth services, and examining the extent to which health care services are available to veterans in territories and freely associated states of the United States.[18]

Chairman Tester, Ranking Member Moran, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Alyssa M. Hundrup at (202) 512-7114 or hundrupa@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony include Rebecca Rust Williamson (Assistant Director), Q. Akbar Husain (Analyst-in-Charge), Amy Leone, and Rob Dougherty. Other contributors include Jacquelyn Hamilton, Roxanna Sun, and Cathy Whitmore.

[18]GAO is completing this work in response to provisions included in the Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, § 153, 136 Stat. 4459, 5429 (2022) and the Honoring our PACT Act of 2022, Pub. L. No. 117-168, § 508, 136 Stat. 1759, 1790-91 (2022).

Related GAO Reports

VA Health Care: Office of Rural Health Efforts and Recommendations for Improvement, GAO-24-107245 (Washington, D.C.: Jan. 11, 2024).

VA Health Care: The Medically Underserved Facilities Initiative, GAO-24-106306 (Washington, D.C.: Dec. 21, 2023).

VA Health Care: Actions Needed to Improve Information Reported on Mobile Medical Units, GAO-24-106331 (Washington, D.C.: Dec. 14, 2023).

VA Health Care: Office of Rural Health Would Benefit from Improved Communication and Developing Performance Goals, GAO-23-105855 (Washington, D.C.: May 4, 2023).

Health Care Capsule: Accessing Health Care in Rural America, GAO-23-106651 (Washington, D.C.: May, 2023).

VA Mental Health: Additional Action Needed to Assess Rural Veterans' Access to Intensive Care, GAO-23-105544 (Washington, D.C.: Feb. 9, 2023).

Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services, GAO-21-93 (Washington, D.C.: Dec. 22, 2020).

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May 15, 2024

GAO Highlights

Highlights of GAO-24-107559, a testimony before the Committee on Veterans' Affairs, U.S. Senate

VA HEALTH CARE

Opportunities to Improve Access for Veterans Living in Rural Areas

Why GAO Did This Study

About one-third of the 8.3 million veterans enrolled in Veterans Health Administration services lived in a rural area in fiscal year 2022. Comparatively, about one-fifth of Americans lived in a rural area. VA projects rural veterans will continue to represent a significant proportion of the nation's veterans. According to VA, rural veterans experience worse health outcomes, including cardiovascular and suicide deaths, compared to veterans in urban areas.

VA identified veterans living in rural areas as an underserved population in its strategic plan and included a strategic objective to increase health care access for this population.

This statement describes GAO's recent work examining rural veterans' access to health care, including recommendations GAO made to VA on (1) the Office of Rural Health's initiatives and research; (2) funding for intensive mental health care services to rural veterans; and (3) mobile medical unit operations and performance.

This statement is based on three GAO reports issued between February and December 2023 (GAO-23-105855, GAO-23-105544, and GAO-24-106331). GAO also reviewed documents from VA related to steps the agency has taken to address the eight recommendations GAO made across these reports. VA concurred or concurred in principle with each of the eight recommendations and, as of March 2024, VA has implemented three of them.

View GAO-24-107559. For more information, contact Alyssa M. Hundrup at (202) 512-7114 or hundrupa@gao.gov.

What GAO Found

Veterans living in rural areas can experience unique challenges in accessing health care. For example, GAO's past work and other research have demonstrated that long distances from health care facilities, limited access to broadband internet, and staffing shortages, among other factors, may affect access to care for this population. GAO has made several recommendations to the Department of Veterans Affairs (VA) to help ensure its efforts effectively address the access challenges veterans living in rural areas face. VA agreed with these recommendations and reported steps taken towards implementing them.

- **Office of Rural Health.** This office provides funding to support (1) initiatives that expand existing services for veterans living in rural areas, and (2) research on interventions intended to address disparities in health care for this population. In May 2023, GAO found that the office does not communicate its research funding opportunities across VA. GAO also found that the office had not developed performance goals that define the level of performance the office aims to achieve during a particular year. GAO made two recommendations for the office to improve communication of rural health initiatives and develop performance goals. VA concurred and, as of March 2024, has taken steps to implement them, including developing a communication plan and drafting performance goals for its upcoming strategic plan.
- **Rural-focused mental health treatment programs.** The Office of Rural Health makes available seed funding to two outpatient intensive mental health programs. These two programs are designed to provide intensive community mental health recovery services to veterans living in rural areas. In February 2023, GAO found the guidelines for selecting its outpatient intensive mental health care programs for seed funding do not consider where veterans with serious mental illness live. GAO recommended that VA update these guidelines to include data on the locations of veterans with serious mental illness. VA concurred with the recommendation. As of April 2024, VA has taken steps to implement it, such as developing a tool to indicate whether there are veterans within the proposed service area that have serious mental illness.
- **Mobile medical units.** Mobile medical units are vehicles equipped to deliver primary and specialty care to veterans—in particular, veterans living in rural areas. In its December 2023 report GAO recommended that VA assess the reliability of the data it reports on mobile medical units and include additional information in its reports to Congress about their use. VA concurred with the first recommendation and plans to initiate such a project to ensure the reliability of the data management plan for its mobile medical units by August 2025. VA concurred in principle with the second recommendation. VA reported it plans to work with Congress to understand its reporting needs and update its 2024 report accordingly.

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STATEMENT OF
JON RETZER
DAV ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
MAY 15, 2024

Chairman Tester, Ranking Member Moran, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's hearing for the Senate Committee on Veterans' Affairs. As you know, DAV is a Congressionally chartered non-profit veterans service organization (VSO) comprised of over one million wartime service-disabled veterans. Our driving purpose is to empower veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the *Frontier, Health Care: Ensuring Veterans' Access No Matter Where They Live*, addressing the VA health care challenges for rural veterans under consideration today by the Committee.

CHALLENGES FOR RURAL VETERANS' HEALTH CARE

Veterans separating from military careers choose to live in rural communities for a variety of reasons, including proximity to family, friends, and the communities they grew up in. Although these veterans enjoy the benefits of rural living, they may face health care challenges due to the scarcity of medical resources in rural and remote areas; a problem that is intensified for those with combat-related injuries and illnesses.

There are 4.4 million veterans living in rural areas, 2.7 million of whom are enrolled in the Department of Veterans Affairs (VA) health care system. Approximately 58% of rural veterans have at least one service-connected condition and around 56% are 65 or older. As a result, rural veterans frequently have serious chronic medical conditions, such as diabetes, obesity, high blood pressure, and heart conditions. To address these complex conditions, care must be provided more frequently and consistently, often making it more expensive.

It is an unfortunate reality that rural and remote communities in this nation continue to struggle with health care inequity. In general, rural communities exhibit a number of distinct characteristics that make health care more challenging compared to other areas of the country, including:

- Greater geographic and distance barriers;
- Limited public transportation options;
- Fewer housing, education, and employment options;
- Difficulty of safely aging in place in rural America;
- Limited broadband internet;
- Income and wealth gaps;
- Higher uninsured rates or lack of insurance coverage;
- Fewer physician practices, hospitals, and other health delivery resources; and
- Hospital closings because of financial instability

To meet the needs of veterans who live in rural areas, VA must ensure that its overall health care strategy has properly balanced the needs of rural veterans, as well as strengthen special programs to fill in gaps for these veterans.

VA COMMUNITY CARE PROGRAMS

Probably the single most important VA health care program for veterans who live in rural and remote areas is its Veterans Community Care Program (VCCP). Despite an overall decline in the U.S. veteran population, the number of veterans using VA health care has increased over the past decade, resulting in an overall rising demand for care. To help ensure timely care for all eligible veterans, VA combines care from VA providers with non-VA providers from a Community Care Network (CCN) funded by the VA. Although the CCN is an important resource for millions of veterans who too often face access barriers or extended wait times for appointments, serious questions exist about its cost and quality. With recent expansions in veterans' eligibility for community care, accurate data is critical to policy and budget decisions to ensure that veterans receive the high-quality health care they deserve. Ensuring the proper balance of VA and non-VA options is critical for rural veterans.

VA has a smaller footprint in rural areas and veterans who live there face unique challenges to accessing timely and high-quality care and rely more heavily on the CCN to address their health needs. This increased reliance has come with increasing costs for these services. A recently released "Red Team" report titled, *The Urgent Need to Address VHA Community Care Spending and Access Strategies "Red Team" Executive Roundtable Report,* has raised serious concerns about VA's CCN program. This independent review was requested by the Veterans Health Administration (VHA) Under Secretary for Health, Dr. Shereef Elnahal and conducted by a panel of nationally renowned health care experts with experience in the VA, Department of Defense, and private sector health care systems. Of most concern, the Red Team unanimously concluded that VA needs to take urgent action to protect both VA's health care system, and its community care program. Specifically, the report concluded that:

> ...[VA] VHA has insufficient information to know whether referrals to community providers will result in the Veteran receiving either the soonest or the best care... [because] Private sector outpatient providers are not required to make access (e.g.,

> wait time) and quality of care data publicly available, nor are VCCP contracted providers required to report these data to VHA.
>
> Additionally, VCCP Community Care Network (CCN) providers are not required to demonstrate competency in diagnosing and treating the complex care needs of Veterans nor in understanding military culture, which is often critical to providing quality care for Veterans.
>
> [T]he VCCP generally does not provide Veterans with quality of care or accessibility data that would allow them to make truly informed choices about where they receive care.

Furthermore, the lack of care coordination between VA and CCN providers is a significant cause for concern for veterans who must rely on both avenues of care. Because rural veterans rely more heavily on the CCN, the documented problems with this system of community care are magnified for these veterans.

To improve the CCN, the Red Team offered a number of recommendations, including:

> VHA has a centralized model for clinical and administrative teams known as Referral Coordination Teams (RCTs) that discuss care options with veterans and empower them to make informed choices about where to receive care. However, RCTs are not implemented across the enterprise and where implemented, it is not in a standardized manner. VHA has the capacity to provide more care, but just having capacity is not enough. VHA should guide veterans to the "right" care based on quality and accessibility, whether that be in the VHA direct care system or the community.
>
> Given Emergency Care is the largest category of community care spending, continued focus in this area should be a top priority. Additional efforts the VCCP could take in this regard include:
>
>> Expand Tele-Emergency Care (Tele-EC) so that it is available systemwide. In addition to expanding Tele-EC in a consistent and standardized manner systemwide, a robust communication campaign should be undertaken to ensure all stakeholders (internal and external) are aware of the key attributes of the program and how to access it.

In addition, DAV continues to advocate to keep VA as the primary provider and coordinator of veterans' health care, regardless of where veterans live or how they access their care. We also continue to call on Congress and VA to mandate that CCN providers meet the same training, certification, and quality standards as VA providers to ensure that veterans have the best health outcomes possible. VA must require that all CCN providers complete VA's training courses in cultural competency, suicide prevention, lethal means safety counseling, and substance use disorders. VA has an

obligation to ensure that the quality of care provided to veterans through the CCN is at least equivalent to the care veterans receive at VA.

OFFICE OF RURAL HEALTH

In 2006, Congress established the VHA Office of Rural Health (ORH) to specifically respond to the needs of almost five million veterans living in rural areas. The ORH's primary responsibilities include conducting research, coordinating efforts, and promoting initiatives for these veterans. ORH is responsible for developing policies, best practices, and successful programs.

For over a decade, the ORH has pursued a four-part mission, which includes promoting the health and well-being of rural veterans; generating knowledge about their health; strengthening community health care infrastructure; and informing policy related to their care. To better serve rural veterans, the ORH developed the 2020-2024 Rural Veteran Strategic Plan, aimed at improving health care access in rural communities, which established the following goals:

- To build stronger federal and community care solutions and relationships to facilitate the exchange of rural-centered information and foster collaboration that supports the health and well-being of rural veterans.

- To reduce rural health care workforce disparities by expanding understanding of current rural health care workforce.

- To enhance rural veteran health research and innovation and develop new models of care for veterans living in rural communities.

In recent years, ORH has focused on increasing virtual access to providers; in FY 2022, ORH funded 32 telehealth initiatives to provide mental health, radiology, neurology, ophthalmology, and primary care locally to rural veterans. ORH also funded training initiatives to enhance the clinical skills of the rural workforce at 975 VA rural sites of care. To increase access, ORH funded transportation programs at 113 VA sites of care to assist rural veterans with transportation challenges caused by distance, geography, and lack of public transportation. Notwithstanding ORH's accomplishments, this office must address longstanding challenges in order to achieve its full potential.

In May 2023, the Government Accountability Office (GAO) issued a report (GAO-23-105855) that contained a number of recommendations to strengthen ORH. GAO recommended that the ORH improve communication and develop performance goals, specifically by requiring its five resource centers to share research funding opportunities across VA. Each of the resource centers identifies research projects to fund; however, GAO found the centers only communicate funding opportunities to VA researchers by word-of-mouth, rather than through a formal process.

GAO also recommended that ORH develop performance goals that reflect leading practices, such as being objective and measurable. The office's strategic goals for the years 2020 through 2024 included:

1. Promoting federal and CCN solutions for rural veterans;
2. Reducing rural health care workforce disparities; and
3. Enriching rural veteran health research and innovation.

However, GAO found that ORH had failed to develop performance goals to measure whether they were making progress towards these goals. For example, while the office tracks the number of clinicians trained, it hasn't defined an annual target to address health care workforce disparities as part of its strategic goal. By establishing measurable goals, ORH is more likely to receive and attention and resources that will allow them to enhance the health and well-being of rural veterans.

To better address gaps in coverage in rural and remote areas, we recommend that ORH develop and implement strategies to increase the use of mobile health clinics and telehealth options. Neither VA nor the CCN can be easily accessible in every area of the country, therefore we must optimize the use of mobile and virtual resources to provide care for those veterans who do not have better options. For virtual health care, ORH must ensure that adequate research is conducted to ensure the level of care meets the standards expected from in-person care.

VA TRANSPORTATION PROGRAMS

One of the greatest, and most obvious, obstacles to health care for rural veterans is travel and transportation. VA recognizes the need to help veterans, particularly rural veterans, overcome access challenges due to distance from medical facilities, and has established a network of transportation options. The Veterans Transportation Service provides safe and reliable transportation to veterans who require assistance traveling to and from VA health care facilities and authorized non-VA health care appointments, particularly those living in rural and remote areas. This program offers these services at little or no cost to eligible veterans.

The Highly Rural Transportation Grants program provides grants to VSOs and state veteran service agencies to provide transportation services to veterans seeking VA and non-VA approved care in highly rural areas.

VA's beneficiary travel (BT) program reimburses eligible veterans for costs incurred while traveling to and from VA health care facilities. Veterans who have service-connected conditions, including those rated at least 30%, can qualify for reimbursement for mileage, tolls, meals, lodging, and other expenses related to seeking care. The BT program may offer pre-approved transportation options and coordinate special mode transportation if requested by the VA. Veterans might also qualify for common carrier transportation (like buses, taxis, airlines, or trains) under specific circumstances.

One of the main shortcomings of the BT program is the inadequate mileage reimbursement rates VA uses. In 2010, Congress passed legislation setting the mileage reimbursement rate at a minimum of $0.41 per mile. This rate was like what federal employees were being reimbursed for work-related travel. The law gave the VA Secretary the authority to adjust rates in the future based on the mileage rate for federal employees using private vehicles for official business, as determined by the GSA Administrator. In recent years, the VA travel mileage reimbursement rate has not kept up with the rising gas prices and costs of auto maintenance and insurance. These costs have increased significantly since the enactment of this law. Meanwhile, the GSA rate has increased over time to $0.655 per mile. Unfortunately, with gas prices continuing to rise, the current mileage rates for beneficiary travel do not always cover the actual expenses for gas and the associated costs of using a personal vehicle, as such expenses may serve as a barrier to care.

DAV TRANSPORTATION PROGRAM

In addition to VA options, DAV also operates a significant transportation program to help veterans get to their medical appointments. The DAV Transportation Network is the largest program of its kind for veterans in the nation. This unique initiative provides free transportation to and from VA health care facilities to veterans who otherwise might not be able to obtain needed care and services. The program is operated by 149 hospital service coordinators and more than 3,200 volunteer drivers at VA medical centers across the country. During FY 2023, DAV volunteers donated over 575,000 hours of their time transporting veterans to their VA medical appointments. Since 1987, we have deployed DAV vehicles in every state and nearly every congressional district to serve our nation's ill and injured veterans, many of whom are your constituents.

To facilitate these rides, DAV has donated 3,763 vehicles to VA. Additionally, Ford Motor Company has donated 264 vehicles, to support this critical transportation program, amounting to a combined cost of over $96.9 million since the program began transporting veterans to their medical appointments.

DAV relies on volunteer drivers; however, we continue to have difficulties getting volunteer drivers approved through VA's screening and onboarding process in a timely manner. Part of the problem is that different VA medical facilities use different processes, and the long delays can discourage volunteers who want to participate in the program. VA must develop national policies – and aggressively implement them consistently across the country – to streamline and standardize the process for becoming a volunteer.

VA STAFFING CHALLENGES

In addition to transportation, the primary major challenge to providing timely health care to rural veterans is clinical staffing, which is also a national problem for both VA and every other health care system. Staffing shortages in health care in 2024 are

increasing because of demand for health care services and an increasing number of health care professionals leaving the industry. Factors contributing to this include the aging population, burnout among health care workers, and the evolving expectations of work-life balance in the health care sector. The time-to-fill for health care positions is longer than in other industries, exacerbating the shortage.

In 2023, a report by the Health Resources and Services Administration revealed that 65% of rural areas experienced a shortage of primary care physicians. Rural areas in the United States are home to over 15% of Americans, which is about 46 million people. Unfortunately, only 10% of doctors choose to practice in these communities, and many of them are primary care and family physicians. As the demand for health care services has risen, an increasing number of health care professionals are exiting the industry. Workforce challenges may pose the greatest threat to VA and community healthcare.

In the VA health care system, positions that are typically hard to fill include roles such as registered nurses, nurse practitioners, general practitioners, physical therapists, and psychiatrists. Staffing challenges are prevalent in specialty areas like geriatrics, rheumatology, and various surgical specializations. Neglecting a strategic approach to talent management, particularly focusing on retention during the hiring process, has challenged the VA health systems in the retention of employees.

VA's Office of Academic Affiliations oversees the training of future health professionals for VA and the nation. Nearly 70% of all U.S. physicians have trained at VA, and over 118,000 clinicians train at VA each year. Health care recruitment today is fiercely competitive, presenting a significant challenge for VA's recruiters and sourcing professionals to stay competitive.

VA needs to adopt a more proactive strategy in sourcing top talent to reduce the time to fill positions without compromising care quality. By streamlining recruitment processes and workflows and updating an aged and outdated HR system, VA can improve their time-to-fill metrics, even for the most challenging positions.

CHALLENGES FOR NATIVE AMERICANS' HEALTH CARE

Native American Indian and Alaskan veterans also face many of these same challenges that rural Americans face, as well as other factors that are unique to this specific population. Many of these conditions are connected, but it is important to note that they are the symptoms of systemic disparities in health care for Native Americans.

- Native American life expectancy is 5.5 years less than the overall United States population: 73 years to 78.5 years, respectively.

- Native American communities have a high prevalence and risk factors for mental health issues and suicide. In 2019, the Department of Health and Human Services discovered that suicide ranked as the second leading cause of death

among Native Americans aged 10 to 34, with rates approximately 20% higher than non-Hispanic white individuals.

- In 2021, the unadjusted suicide rate was 46.3 per 100,000 for American Indian or Alaska Native Veterans. In 2021, among the U.S. adult general population, including veteran and non-veteran adults, the highest unadjusted suicide rates were observed among American Indian or Alaska Native individuals. (2023 National Suicide Prevention Annual Report)

- In 2018, the National Survey on Drug Use and Health (NSDUH) found that 10% of Native American individuals have a substance use disorder. Around 25% admitted to binge drinking in the past month. Notably, Native American participants reported the highest incidence of drug abuse within the same timeframe when compared to other ethnic groups.

- A staggering 23% of Native Americans report experiencing discrimination in a health care setting. Nearly 15% note avoiding seeking health care, as they anticipate discrimination. A notable number have also reported experiencing violence or being threatened during a health care visit as well.

VA needs to increase research to better understand the unique needs and obstacles faced by Native American veterans seeking health care, and work to increase awareness of these special challenges throughout its health care system.

Mr. Chairman, to provide true health equity to all veterans, including rural veterans and Native American veterans, VA must develop and implement specific strategies to address the unique obstacles to health care faced by these veterans. The responsibility towards those who serve our nation and the promises made to them must be upheld as a sacred duty by both Congress and the VA, regardless of where a veteran chooses to live.

This concludes my testimony on behalf of DAV. I am pleased to answer questions you or members of the Committee may have.

Questions for the Record

Senate Veterans' Affairs Committee
May 15, 2024 Hearing
Frontier Health Care: Ensuring Veterans' Access No Matter Where They Live
Due-outs for Sens. Tillis

1) **Senator Tillis:** I have got about a 31,000 number backlog -- gives you an idea of how big our veterans population is -- for expense reimbursement for travel. Tell me how I can make them feel better about getting timely reimbursement for travel to VA facilities. State-specific travel reimbursement claims backlog (North Carolina)

   VA Response: As of June 12, 2024, Veterans Integrated Service Network (VISN) 6, inclusive of North Carolina VA Medical Centers (VAMCs), have a total inventory of 17,550 claims, which is 6.3 days of inventory, well under the VISN's 10-day inventory goal. VA is committed to ensuring Veterans receive timely benefits for travel reimbursements, as we take steps to ensure we are paying eligible Veterans accurately. In addition to continually improving the BTSSS application, VISN 6 (to include North Carolina VAMC) is working on aligning centralized claims processing support to ensure the most efficient way forward in processing claims, which require manual intervention.

2) **Senator Tillis:** Are there authorities right now that are only temporary, or have we permanently authorized the use of telehealth for any sort of provisioning of health care in the VA?

   VA Response: VA relies on telehealth to distribute health care services within and between States to enhance the accessibility of care, to resolve access gaps in underserved communities, and to match unique Veteran clinical needs with rare provider expertise anywhere in the country. VA providers are concerned with the lack of clarity in the law regarding their requirement to follow State laws to prescribe controlled substances via telemedicine. While 38 U.S.C. § 1730C authorizes VA health care professionals to provide health care via telemedicine across State lines, there is a requirement to follow the Controlled Substances Act (CSA) in 38 U.S.C. 1730C(e). While the Controlled Substance Act (CSA) does not explicitly require health care professionals to follow their State law, DEA's regulations implementing the CSA do. This can be very complicated for providers who, for example, are licensed in one State, treating Veterans in another State, and writing prescriptions that are filled in a third State. Each of these States could have differing requirements that can be challenging to follow.

   The ambiguous, uncertain, and frequently changing legal landscape for VA health care professionals is an existing and persistent concern, particularly for health care professionals serving Veterans across States or in multiple States.
   To address State law ambiguity, uncertainty, and barriers, VA developed a legislative proposal as part of the fiscal years (FY) 2024 and 2025 budget requests. In the FY 2025 budget request, this proposal, titled "Maintaining Consistent Access to Critical Treatments Through Telehealth," would amend 38 U.S.C. § 1730C to authorize covered health care professionals to practice

their health care profession through telemedicine and prescribe controlled substances in their authorized role notwithstanding any provision of State law regarding the prescribing of controlled substances. Covered health care professionals dispensing controlled substances would be subject to the provisions of the CSA and its implementing regulations except where State law is incorporated. Covered health care professionals would follow national telemedicine prescribing standards, as outlined in Federal law and regulations, and supplemented by VA policy. In areas where a national standard hasn't been defined, covered health care professionals would follow standards in their State of licensure. This proposal was developed in collaboration with the Department of Justice and is included in the President's budget. ***IMPORTANT NOTE***: The proposal would not authorize a VA health care professional to prescribe controlled substances beyond what is authorized under their State license(s), registration, certification, and DEA registration(s). For example, the proposed legislation would not authorize an Advanced Registered Nurse Practitioner (ARNP) to prescribe Schedule II controlled substances if that ARNP's State license prohibits them from prescribing such medications.

Without supportive legal clarity about the applicability of State law to VA practice, VA health care professionals might be required to:
- Know and operationalize multiple, potentially conflicting, practice standards,
- Provide similar Veterans with different services,
- Modify the treatment of a single Veteran based on the location of the Veteran or provider at the time of a visit, and/or,
- Be prohibited from prescribing medically appropriate treatment at all.

The variation across States and the lack of clarity on the applicability of State law means that Veterans may suddenly lose access to their medications if a VA health care professional licensed in one State is replaced by a VA health care professional licensed in a different State as part of VA's national practice.

Alternatively, clearly authorizing VA health care professionals to follow a single, understandable Federal framework for prescribing controlled substances via telehealth would enable VA to maximally leverage telehealth to expand access, reach vulnerable Veterans in rural communities, and deliver equitable services to all Veterans irrespective of their location in the country.

ANSWERS TO QUESTIONS FOR THE RECORD
DR. PETER KABOLI, EXECUTIVE DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION (VHA), AND
RYAN HEIMAN, DEPUTY EXECUTIVE DIRECTOR, VHA MEMBER SERVICES, VHA
FROM THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

"FRONTIER HEALTH CARE: ENSURING VETERANS' ACCESS NO MATTER WHERE THEY LIVE"

May 15, 2024

Questions for the Record from Senator Mike Rounds:

Question 1: In your professional opinion what are rural hospitals lacking in regard to specialty care? How does a lack of resources impact facility budgets? What are the most critical yet under resourced operations in rural healthcare? How, specifically, during the authorizations and appropriations processes, can Congress assist to make sure that you have those resources?

VA Response: Rural VHA hospitals struggle to provide specialty care due to a range of issues, including, but not limited to, difficulty hiring specialists (either because of insufficient patient volume or professional isolation based on smaller staffs); infrastructure and technology gaps (which may be because it is not cost effective to staff specialists in small volume settings); and national workforce shortages for specialists.

To address these issues, VHA has leveraged new statutory authorities such as those in the Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 to add to the array of tools and incentives available to recruit clinicians into VHA. This included the Contract Buy Out Program (CBOP) specifically for buying out contracts for physicians/ providers in exchange for a 4-year service commitment at a rural facility as well as other flexibilities available to all facilities (i.e., increase in 3R incentive limits, the new critical skills incentive, elimination of the strict Veteran preference for housekeeping aids, and others). The Office of Rural Health (ORH) worked with the Office of Workforce Management and Consulting (WMC) to develop a Rural Recruitment and Retention plan, which was published at the end of fiscal year (FY) 2023. This plan outlined key rural-specific initiatives and programs to address provider gaps, as well as the top 10 rural recruitment and retention strategies. The plan also includes contact information for personnel to assist rural hiring managers and supervisors. While numerous factors were at play in FY 2024, including budget constraints, rural facilities did take advantage of the new CBOP and were able to onboard 11 providers using that program, with 3 more in progress. In addition, rural facilities experienced a higher combined growth rate in FY 2024 (2.3%) than non-rural facilities (2.1%).

Two of the most critical "operations" for rural health care that require resources and potential legislative action include transportation and telehealth. For transportation, a significant limitation is the expiring authority under 38 U.S.C. § 111A, which authorizes the Veterans Transportation Service (VTS). Because of the expiration date in

section 111A(a)(2) and resulting need for continued re-authorization of VTS' authority, VA is limited in developing long-term plans to further support and expand the services it can provide through VTS.

The second critical operation for expanding rural specialty care is telehealth. The Clinical Resource Hubs and Tele-Critical Care programs are two examples of telehealth programs that support primary care, mental health care, pharmacy services, and other specialty care for rural Veterans. Funding the annual President's Budget request for these programs will help VA meet the specialty care telehealth needs of rural VHA hospitals and Veterans. Additionally, VA strongly recommends Congress enact the authority recommended in the President's Budget request for FY 2025 that would amend 38 U.S.C. § 1730C to clarify that covered health care professionals may practice their health care profession through telemedicine and prescribe controlled substances in their authorized role to provide health care under title 38 notwithstanding any provision of state law regarding the licensure of health care professionals or the prescribing of controlled substances. Under this proposal, covered health care professionals dispensing controlled substances would be subject to the provisions of the Controlled Substances Act (21 U.S.C. § 801 *et seq.*) and its implementing regulations except where state law is incorporated.

Question 2: Specialty care initiatives like Precision Oncology are provided via the hub-and-spoke model. What can be done to help rural veterans get the care they need especially when it comes to cancer? Would expanding partnerships with local high-performing health care systems to deliver this or other types of care help?

VA Response: In order to ensure rural Veterans receive the oncology care they need; Congress should continue to fund the President's Budget for Precision Oncology because it is expanding the use of TeleOncology and growing the ability to provide cancer care services through the Cancer Care Close to Me initiative to rural Veterans. VA National TeleOncology (NTO) community partners, local health care systems, and VA are discussing a partnership with the Department of Defense's Defense Health Agency to expand access to care which may include development of a new resource sharing agreement. NTO also partners with National Cancer Institute (NCI)-designated cancer centers by hiring staff from these institutions to provide subspecialized expert care. VA NTO hasn't been able to find feasible mechanisms to partner with community providers or healthcare systems. VA's National Oncology Program (NOP) expands TeleOncology access to Veterans Nationwide through NTO. NTO provides cancer care virtually through telecommunication technology, connecting patients and providers across great distances. In addition, NTO delivers cancer screenings, diagnostics, and treatment for Veterans via telemedicine. On average, 43% of patients served by NTO reside in rural or highly rural areas.

NTO provides subspecialized cancer care with an interdisciplinary team of oncology certified Advanced Practice Providers (APP), clinical pharmacist practitioners, and registered nurse (RN) care coordinators. All NTO oncologists are associated with NCI-designated centers including UPMC Hillman Cancer Center, Duke Cancer Center, Yale Cancer Center, University of Kentucky Markey Cancer Center, and the Huntsman Cancer Center. NTO oncologists are sub-specialized cancer care providers. Disease-specific teams include benign hematology, malignant hematology, breast, genitourinary, gastrointestinal, thoracic/head and neck, and rare cancers. The rare cancer team has sub-specialists for skin (e.g., melanoma and Merkel cell), central nervous system, gynecologic, and sarcoma.

VA uses a "hub-and-spoke" model for TeleOncology, with the virtual hub at the Durham VA Medical Center (VAMC). VA cancer specialists around the country work through NTO from their local VAMC providing care virtually to Veterans. Patients can connect with providers in two ways: they can travel to a spoke site to communicate through clinical video telehealth or connect from home using an internet-connected device with VA Video Connect. Currently, NTO is partnered with 107 VA health care systems to deliver both synchronous and asynchronous virtual care to the local VAMC and community-based outpatient clinics (CBOC).

NTO also offers services such as National Virtual Tumor Boards, Clinical Cancer Genetics Service, Clinical Cancer Research Service including Decentralized Clinical Trials, and the Breast and Gynecologic System of Excellence.

Precision Oncology services are delivered across the nation by the National Precision Oncology Program by providing molecular testing and consultative services.

These collaborations within VHA and with academic-affiliated cancer centers can facilitate the sharing of resources, expertise, and technology between larger VAMCs and rural health care facilities, ensuring that Veterans receive timely and comprehensive cancer care without the need for extensive travel.

In an effort to further expand oncology care to rural locations, NOP is expanding the Close to Me (CTM) Cancer Care Delivery Models at 22 additional VA health care systems starting in FY 2025. With this expansion, CTM will be available across all 18 Veterans Integrated Service Networks (VISN). This expansion builds on the success of the original CTM model by adding an APP to the current care team of infusion RNs, who are deployed to CBOCs to administer chemotherapy infusions under remote supervision. When APPs establish clinics at CBOCs, those sites provide a VA option for oncology care to Veterans living within a 60-minute average drive time of that CBOC. Supervising oncologists can be accessed via telehealth modalities provided by either the local VAMC or the NTO Service.

Additionally, collaborations within VHA and with academic-affiliated cancer centers, as described herein, can support knowledge exchange, training programs, and telemedicine initiatives that further enhance the capacity of rural health care providers to deliver high-quality specialty care services. By fostering collaboration and coordination among health care systems, VA can help address the unique health care needs of rural Veterans, including access to advanced cancer care.

Question 3: In your professional opinion, what are rural hospitals lacking in regard to specialty care? How does the lack of these resources impact facility budgets? What are most critical, yet under-resourced, operations in rural healthcare? How, specifically, within the authorization and appropriations processes, can Congress assist to make sure that you have those resources?

VA Response: See response to Question 1 above.

Questions for the Record from Senator Tommy Tuberville:

Question 1: Dr. Kaboli, several veterans have reached out to my office regarding delays in travel reimbursement for their community care appointments, as well as conflicting guidance on what evidence is needed to submit a travel reimbursement for such appointments. Specifically, these veterans are told by the VA to get a "proof of visit" from their community care providers, which appears to be duplicative of the evidence of the visit displayed in the system. These veterans live in low-income, rural areas of Alabama, and they cannot afford to wait on the VA to reimburse them months later. What efforts is the VA making to ensure the veteran can easily submit their reimbursements?

VA Response: VA is committed to expanding tools that empower Veterans to use self-service options as part of their VA health care experience and is focused on streamlining the process to apply for Beneficiary Travel (BT) reimbursement. While those efforts remain underway, we note that 38 C.F.R. § 70.20(e) requires VA to notify the claimant should additional information be needed to adjudicate the claim. For some Veterans, this additional information may include proof that care/services were received from a non-VA provider. VA may process claims more quickly if this proof is included with the claim. This proof supports VA's obligation to deter fraud, waste, and abuse through improper payments, as further directed under the provisions of the Payment Integrity Information Act of 2019 (P.L. 116-117). In response to Veteran feedback, VA is reviewing opportunities to further decrease the burden on Veterans in the claim submission process.

Question 2: Another veteran, who reached out to my office, says that she has had seven claims pending in the travel reimbursement system for almost six months, and that when she tries to update her bank details, she gets an error message. How can a veteran get in touch with someone at the VA quickly, if they notice a delay in receiving their reimbursement?

VA Response: Veterans, caregivers, and other beneficiaries can reach out to the BT Office at their local VAMC for assistance with BT claim submission and status. BT facility points of contact can be found on va.gov at https://www.va.gov/HEALTHBENEFITS/vtp/beneficiary_travel_pocs.asp

Question 3: A February 2023 Government Accountability Office study found that the VA guidelines for selecting its outpatient intensive mental health care programs for seed funding do not consider where veterans with serious mental illness live. Understanding which veterans, whether rural or urban, utilize the residential treatment program will help determine how to strategically place them throughout the country. In Alabama, both the VA and outside organizations are working to improve the availability of in-patient residential treatment programs to help veterans experiencing substance abuse. I understand the VA concurred with the GAO's recommendation. How does the VA currently determine where they should establish residential treatment programs or where they should leverage community resources, and will there be changes in these determinations moving forward?

<u>VA Response</u>: As an integrated health care system, VA offers a comprehensive continuum of services for the treatment of mental health (MH) and substance use disorders (SUD) that ranges from general outpatient services through acute inpatient mental health care and includes both intensive outpatient treatment programs and Mental Health Residential Rehabilitation Treatment Programs (MH RRTP). MH RRTPs reflect the level of care between intensive outpatient mental health services and acute inpatient mental health treatment. This level of care is analogous to “inpatient residential” treatment in the community and reflects the level of care where VA traditionally provides “inpatient” treatment for SUD and posttraumatic stress disorder. MH RRTPs often serve to meet the needs of rural Veterans who require intensive outpatient services in person but who live at a significant distance from such programs.

VHA has a national planning strategy that informs decisions about the need for MH RRTP services to include residential treatment programs for Veterans experiencing substance use concerns. The formal market assessment process for VHA relies on data from multiple sources to include the Enrollee Health Care Projection Model and the MH RRTP Demographics and Diagnosis-Based Demand Model. Given MH RRTPs are considered regional resources, decisions are made regarding the need for additional residential treatment programs considering the broader range of available national, regional, and VISN resources. Planning considers the full range of available resources including available mental health treatment options (outpatient and residential) as well as supported housing resources in the region. Planning also considers current wait times in the context of access requirements defined by VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 15, 2019. Currently, priority admission for residential treatment is expected to occur within 72 hours of identified need, and routine admissions are expected to occur within 30 days of screening. In the event a program is unable to admit a Veteran within those defined time frames, programs are expected to offer the Veteran referral to an alternate program either within VA or in the community.

The Support The Resiliency of Our Nation’s Great (STRONG) Veterans Act of 2022 required VA to conduct a study on Veterans' access to care under VA’s MH RRTPs to determine the following:

- If there are enough inpatient mental health offerings for Veterans in rural and remote communities;
- If there are enough beds based on demand and drive time from a Veteran’s home;
- If provider shortages are leading to unused beds; and
- If there are diagnosis-specific or sex-specific barriers to use.

The study was completed in December 2023, and findings were presented to the House and Senate on September 3, 2024.

The Office of Mental Health Services currently has an active initiative underway focused on MH RRTP access and will be incorporating recommendations from the study into broader efforts. VA is committed to ensuring Veterans can receive residential treatment for mental health and substance use concerns when needed. Currently, VA supports more than 200 MH RRTP beds within Alabama, located in Tuskegee and Tuscaloosa, and provides additional access within the broader region with programs in neighboring states.

Questions for the Record from Senator Angus King:

Question 1: One of the biggest issues I've heard about with the Beneficiary Travel Self-Service System (BTSSS) is that, since it is a web-based application, it can be difficult for veterans without internet access or those who are less tech-savvy to submit their claims. I understand that VA Maine is working to get additional kiosks that will still use the BTSSS software, and those kiosks will be available at CBOCs so veterans can submit their claims there. However, the timeline for the arrival of those kiosks remains unclear. Can you provide an update on the status of the contract to get more kiosks to Maine? What sort of timeline are we looking at for their arrival at Maine facilities?

VA Response: Currently, 38 facilities have either local or VISN contracts that provide kiosks and support. The VetLink kiosks are now integrated with BTSSS and support paperless claims processing. VISN 1 (New England Healthcare System) has a current VetLink contract and has confirmed that kiosks are currently set up and active at all VA Maine CBOCs and at the Togus VA Medical Center.

VA is examining opportunities to reduce the burden on Veterans when they apply for travel reimbursement. For example, VA is examining the potential efficiencies observed in the Veterans Benefits Administration's Centralized Mail Portal as an opportunity to streamline the intake of travel reimbursement applications submitted by paper form, which would digitize the claim and feed it directly into BTSSS. This may reduce the time it takes to scan and enter claims by VA staff locally and allow for a faster timeline for approval.

Department of Veteran Affairs
December 2024

Senator King
Questions for the Record
Senate Veterans' Affairs Committee
"Frontier Health Care: Ensuring Veterans' Access No Matter Where They Live"
May 15, 2024

Questions for Mr. Chauncey Parker

1. Thank you for the work you do to support our tribes and for your important testimony. In your written testimony, you provide a very stark depiction of the current reality for Native Veterans, which—unfortunately—reminds me of the recent words of another Native Veteran, Charles Shay. Mr. Shay is a member of the Penobscot Nation, who grew up on Indian Island in Maine, and he was a 19-year-old medic on the shores of Normandy 80 years ago. He saved many lives in Normandy, was taken prisoner in March 1945, and liberated a few weeks later. After the war, he came home to Maine, then re-enlisted, because, as he said recently, **"...there was just no chance for young American Indian boys to gain proper labor and earn a good job."**

   Here we are, 80 years later, and you are describing exactly the same thing: you stated in your testimony that tribal communities suffer from unemployment rates of 60 to 85%; "deplorable" and unstable living conditions; challenges of "rampant drug and alcohol abuse." You rightly point out that our Native communities have more members, per capita, that serve in the military and yet, too many of those Native Veterans return home to these conditions that are hard to break out of.

   I know there's no simple fix here—no one thing that will magically solve all of these problems. But organizations like the Great Plains Veterans Services Center are helping to make sure that Native Veterans are able to access the programs and benefits we owe them—that they have earned—and hopefully help break this cycle and eliminate these disparities.

   a. **Can you give us five ideas on how VA how could improve its services and support programs for Native Veterans? Particularly, in what ways can they help Native Veterans come home and find fulfilling, stable jobs outside of the military?**

Responses were unavailable at the time of publication.
Contact U.S. Senate Committee on Veterans' Affairs for additional information.

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Senate Veterans' Affairs Committee Hearing
May 15, 2024
"Frontier Health Care: Ensuring Veterans' Access No Matter Where They Live"
Follow-up Questions for the Record (from Senator King)

Questions for Mr. Jon Retzer, Assistant National Legislative Director, DAV *(Disabled American Veterans)*

1. In your written and oral testimony, you discussed the importance of community care and recently released VA reports focused on the need to improve coordination between the VA and the Community Care Network (CCN). This is an issue I am also worried about—many veterans in Maine, especially those in rural areas, rely on community care for a number of reasons, but I have concerns about the coordination of care between VA and the CCN. I recently joined Chairman Tester and Senator Brown on a letter to Secretary McDonough about the lack of oversight of the CCN from the VA. A recent OIG report discussed how staff at many facilities—including Togus in Maine—have come up with their own workarounds to deal with the inadequacies in the existing system.

    a. Can you give me five suggestions that DAV would like to see to improve community care?

Response: To meet the health care needs of all veterans, VA must ensure that its overall health care strategy is properly balanced and strengthened to meet the rising demand for care. Whenever possible we want VA provide direct care to veterans—to do so, VHA must improve and increase its physical and technological infrastructure, address staffing shortages, improve partnerships and training standards of community care network providers and improve transportation options and reimbursements for travel.

To optimize the Community Care Network (CCN) when VA direct care or VA telehealth services cannot be scheduled timely or provided care coordination to non-private sector partners and/or the CCN is necessary.

- VA needs to ensure that it strengthens the relationships for access and coordination of care with core/natural partners/first tier partners, such as Department of Defense, Medical Academic Affiliates, Indian Health Service and

other non-private sector providers. Then, if the first tier is exhausted, to look to coordinate care with CCN to fill needed gaps.

- To ensure quality of health care and competency of veteran-focused care, all medical providers outside of the VA direct health care system must be required to complete the same (or equivalent) training and meet required clinical standards as VA providers.

- VA must improve its care coordination internally and externally by creating an interoperable scheduling system that can connect VA directly to all partners outside of the VA direct health care system, specifically—a system that provides the ability to share availability of services that VA can schedule on behalf of veterans when they are on the telephone or in person. VA needs to expand the use of current systems like External Provider Scheduling (EPS) process used by the WellHive digital platform to enable VA schedulers to view and make appointments directly into in-network community provider scheduling grids. This eliminates many of the steps taken (that often cause care delays) between the VA scheduler, community provider, and veteran; saves time in the overall scheduling process; and improves access for veterans to the soonest and best care. EPS can also capture data on timeliness and quantity of time spent in providing care and measure the quality and control of appointments.

- For veterans to optimize and receive the highest quality of health care in the CCN, VA must conduct outreach to evaluate quality providers and satisfaction of care rates and ensure this data is available for veterans to make informed decisions on which providers will meet their medical needs and what qualification and training they have that is equal to the standard of care provided by VA providers.

- Rural veterans need options to care and information about the quality of care to determine what is in their best medical interest. VA should always offer direct health care services when available or VA telehealth care if appropriate and desired by the veteran. VA must optimize all of its resources to include mobile medicine and mobile Vet Centers. However, when VA cannot provide timely services, it must then coordinate care through the CCN.

2. As we discussed in the hearing, transportation for rural veterans is critical. DAV has discussed the problems their volunteers face with the inconsistent VA screening processes and requirements.

    a. Can you provide data about how many DAV volunteers start the screening process? And how many actually end up making it through the screening process and end up being volunteer drivers? Additionally, any data you have

> for reasons that those who don't make it through the screening process would be helpful as well—are volunteers being kicked out of the process because of medical conditions, or their driving records, or are they just being forced to wait too long so they find another way to give back to their fellow veterans?

Response: One of the greatest, and most obvious, obstacles to health care for rural veterans is travel distances and lack of transportation. To fill a gap in transportation needs, DAV's transportation network, the largest program of its kind for veterans in the nation provides millions of rides to VA medical appointments each year at no cost. DAV relies on volunteer drivers; however, we continue to have difficulties getting volunteer drivers approved through VA's health and background screening and onboarding process in a timely manner.

DAV does not have specific data on how many DAV volunteers started the screening process and subsequently dropped out; however, we currently have 3,282 volunteer drivers at VA medical centers across the country who have made it through the screening process. In 2019, DAV had 9,203 volunteer drivers; however, when the world was impacted by the COVID pandemic, our numbers significantly decreased—with 7,684 volunteer drivers in 2020; 4,409 volunteer drivers in 2021; and 3,905 volunteer drivers in 2022.

Now that the pandemic restrictions have been lifted, volunteers want to return to assisting injured and ill veterans to get to much-needed medical appointments; however, the delay in getting the VA screening process timely for both medical exams and background checks has detoured some of those volunteers.

Unfortunately, we do not have data on specific reasons the individuals did not make it through the screening process or stopped attempting to become a volunteer driver; however, prospective volunteers continually share with us their frustration with the VA's untimely process, which creates long delays for certification and onboarding in certain locations.

This concludes our responses and we thank you for the opportunity to offer our feedback and recommendations on the additional questions you sent to DAV. If you need clarification on any points we have made, do not hesitate to have your staff reach out to me.

Statements for the Record

Frontier Health Care: Ensuring Veterans' Access No Matter Where They Live

Statement for the Record

by Jaelynn Williams, CEO of Air Methods Corporation

May 13, 2024

On behalf of Air Methods, one of the leading emergency air medical providers in the country, I would like to submit a statement for the record to the Senate Veterans Affairs Committee for the hearing "Frontier Health Care: Ensuring Veterans' Access No Matter Where They Live." Air Methods provides emergency air medical services in 48 states. We currently operate 267 bases and over 400 air medical aircraft, staffed by approximately 5,000 medics, nurses, pilots, mechanics, and patient advocates, of which approximately 30% are Veterans. We proudly serve Veteran patients experiencing medical emergencies around the country, mostly in rural and highly rural locations.

Rural America is facing a growing health care crisis. More than 46 million Americans, or 15 percent of the U.S. population, live in rural areas as defined by the U.S. Census Bureau. About 4.8 million of those Americans are Veterans, which is 25% of our nation's Veterans. Americans living in rural communities face numerous health challenges and disparities compared with their urban counterparts. Geographic distances, limited resources, rising infrastructure costs, and physician shortages often impede the delivery of timely and comprehensive care. More than one hundred rural hospitals have closed in the past decade, and hundreds of others are at risk. In most cases, the closure of these hospitals has resulted in the loss of the emergency department, and residents of the community must now travel much farther when they have a life-threatening event. Over the past few years, as the health care industry has faced labor shortages and continued resource challenges, we have seen a dramatic increase in demand for our services in rural America.

It is no exaggeration to say that air ambulance transport has become a lifeline to trauma care for millions of Veterans, who can easily find themselves a long way from a medically appropriate trauma center when time is of the essence. Additionally, many rural hospitals are often unable to provide the necessary care due to the severity of the injury or illness, and the Veteran must be transferred to a higher level of care. Because of the sheer distance to that higher-level facility, such as a stroke center, cardiovascular center, trauma center, or neurosurgery center, Veterans must be transported by air ambulances in order to receive the medically necessary specialty care in a timely way. Notably, the clinical care that can be provided to the patient on the air ambulance typically far exceeds the care that could be provided by a ground ambulance transport.

In 2023, our crews transported more than 1,500 Veterans who were experiencing life threatening conditions that range from head trauma, stroke, and cardiac events to self-harm and attempted suicide. Of these transports, 68% were in rural America and more than 95% were picked up from non-VA smaller facilities and dropped off at non-VA higher level tertiary centers. For example, last year we

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transported a Veteran from Susan B. Allen Memorial Hospital in El Dorado, Kansas to Hays Medical Center in Hays, Kansas. We transported another Veteran from Barret Hospital in Dillon, Montana to Eastern Regional Medical Center in Idaho Falls, Idaho. In all cases, the decision to transport the Veteran to the closet, most appropriate facility for care is made by the attending physician or the first responder. Air medical crews never self-dispatch, and when they transport a patient, they do not know, and they do not ask, what type of insurance coverage the patient has.

Unfortunately, the emergency air ambulance industry is facing significant challenges when it comes to reimbursement for our services. In particular, the U.S. Department of Veterans Affairs (VA) has finalized a proposed rule that will put access to these emergency services at risk for Veterans. The rule would slash reimbursement rates for air and ground emergency transport services starting in February 2025. VA plans to cut the reimbursement rate down to the Medicare rate, which has not been updated in more than 20 years and reimburses providers at less than 50% of the cost of transporting a patient. This reimbursement cut will cause emergency transportation providers to severely reduce services or close bases, exacerbating access to care issues in rural areas.

Secretary McDonough has stated that air providers can negotiate with VA for payment rates that better reflect actual costs, since the Medicare rate is not adequate. However, the latest contract proposal from the Department is unworkable and would leave most Veterans uncovered as it does not recognize how Veterans receive emergency air transport services. Moreover, in 2023, VA only had 11 contracts in place between air ambulance and specific VA facilities. Compared to the approximately 9,000 Veterans that were transported by air in 2022 according to the VA, these 11 contracts accounted for only 101 Veterans, or 1.1%. It is unclear how VA plans to contract with all the emergency air providers necessary to ensure that all Veterans will continue to be covered and have access to critical care.

As such, we are eager to sit down with VA to develop a workable contracting solution that both recognizes the emergent nature of air medical services and allows contracting at a reasonable fair market rate, thus preserving access to millions of Veterans. In the commercial space, we have succeeded in achieving in-network agreements with over 80 percent of the health insurance marketplace at rates that reflect market dynamics and ensure continued access to emergency care.

Fortunately, bipartisan legislation has been introduced by Senators Jon Tester, Jerry Moran, Patty Murray, and John Boozman to protect rural Veterans' access to quality, lifesaving emergency medical care and transport. The *VA Emergency Transportation Access Act (S. 2757/HR 5530)* would bar VA from reducing reimbursement rates for ground and air ambulances unless VA meets certain requirements that ensure rate changes will not reduce Veterans' access to this essential service. Specifically, the bill would require that VA complete the following requirements before pursuing a rate change:

- Conduct a thorough review of the impact a change in rates would have on Veterans' access to care.
- Consult industry experts, CMS, appropriate VA subject matter experts, and Veteran Service Organizations (VSOs) when conducting the review.
- Develop a formal process of updating the rates that protects or expands Veterans' current access to emergency transportation; and

- Ensure the new rates reflect the actual costs of transportation.

This legislation is supported by numerous VSOs including Paralyzed Veterans of America, Disabled American Veterans, The American Legion, Jewish War Veterans, Veterans of Foreign Wars, and Wounded Warrior Project. In addition, industry emergency medical service providers nationwide support the legislation.

In conclusion, air medical services are often the difference between life and death for rural Americans, including the men and women who bravely served our country. We urge Congress to pass the *VA Emergency Transportation Access Act* and ensure that Veterans living in rural America are not left behind and have access to life-saving care.

American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

Dru Riddle, PhD, DNP, CRNA, FAAN, President
American Association of Nurse Anesthesiology

Senate Veterans Affairs Committee
412 Russell Senate Office Building
Washington, D.C. 20510

May 15, 2024

Background on AANA and CRNAs

Chairman Tester, Ranking Member Moran, and Members of the Committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthesiology (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 61,000 CRNAs and student nurse anesthetists representing over 85 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who provide anesthesia, as well as acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

AANA applauds the Committee's decision to hold this hearing, as it is of the utmost importance that our nation's healthcare systems meet our veterans where they live. This hearing is an important opportunity to address myriad barriers to care that veterans face throughout the country, especially in rural areas where staff shortages and long wait times have robbed our veterans of the care they deserve. To better provide the care we have promised our veterans, the VA must remove costly, unnecessary barriers to care and mobilize resources already available to them. The VA could see considerable cost savings and improved wait times, all without sacrificing healthcare quality, if they allow CRNAs full practice authority at all VA facilities.

CRNAs are highly trained and skilled anesthesia providers who have full practice authority in the Army, the Navy, and the Air Force, as well as the Indian Health Service. CRNAs are the primary provider of anesthesia on the battlefield, including in forward surgical hospitals. Despite claims by the group Physicians for Patient Protection and their allies in the medical community, CRNAs are not the primary provider of anesthesia in forward surgical units because they are 'more expendable' than their physician colleagues, but because of their high level of education and skill to provide anesthesia in the most difficult circumstances possible. While CRNAs do not currently have full practice authority at the VA, they remain critical members of the anesthesia care team and their exclusion from full practice authority remains a deficiency, not a feature, of the VA's healthcare delivery systems.

CRNAs possess all the necessary skills and training to be granted full practice authority at the VA. Should CRNAs be allowed to practice autonomously at the VA, the Department will enjoy considerable cost savings and our veterans would be afforded increased access to the healthcare our nation has promised them, all without compromising the quality of care delivered. For these reasons, the VA should develop National Standards of Practice (NSP) that allow CRNAs and other providers to work to the top of their education and training.

Rural Healthcare: How CRNAs Can Fill the Gaps

Nearly one quarter—4.4 million—of our nation's veterans reside in rural communities once they return from active duty. While these communities are attractive for a variety of reasons—more space, more privacy, lower cost of living, and proximity to loved ones—rural communities also tend to have higher rates of poverty, more elderly residents, poorer overall levels of health, and

have fewer physician practices, hospitals, and other health care facilities. Factors which complicate the delivery of healthcare in these settings, especially for our nation's veterans. Additionally, rural veterans enroll in the VA healthcare system at significantly higher rates than veterans who live in urban settings (61% to 41%, respectively). Over half of rural veterans (58%) have at least one service-connected condition; nearly half (44%) of rural veterans make less than $35,000 per year; and over one quarter (27%) have no internet access at home. Rural veterans are also significantly older than urban veterans, with over half (55%) over the age of 65, and the population of older veterans is more medically complex than their younger counterparts. While these barriers are substantial, healthcare delivery in rural areas sees many of the same barriers as healthcare delivery across the United States. Ongoing provider shortages are felt even more acutely in rural areas, which are even worse for an aging, medically complex population of rural veterans.

These disparities are critical when it comes to the anesthesia workforce. As the VA has not extended full practice authority to CRNAs, they are dependent on a steady stream of physician anesthesiologists to unnecessarily supervise CRNAs when they administer anesthesia. In rural areas, this can have a disastrous impact on a veteran's ability to access healthcare in a timely manner and delayed delivery of healthcare can lead to dangerous, even deadly, complications. According to the *Journal of Rural Health,* 81.2% of rural counties lack a physician anesthesiologist.[1] This leaves 4.4 million veterans in a precarious situation. Even urban VA facilities, such as in Denver, have seen anesthesiologist shortages result in dozens of canceled or delayed surgeries.[2] Delays and cancellations of critical healthcare services for our veterans is unacceptable. VA's data shows that full practice authority for other APRNs has increased access to care and decreased wait times, and VA should provide that same authority to CRNAs.[3]

Luckily, the VA has access to a ready-made solution to many of these barriers: **extend full practice authority to CRNAs within the VA system.** While physician anesthesiologists are a rarity in rural communities, the same cannot be said of CRNAs who are much more prevalent in rural communities. Unlike our physician peers, who are more likely to care for higher-income populations, CRNAs are disproportionately the anesthesia provider for rural and low-income communities.[4] Given the reality that healthcare outcomes are identical between physician anesthesiologists and CRNAs, as well as the potential cost-savings, the VA can mobilize a robust, well-trained workforce to fill gaps in communities across the country. Our veterans deserve the highest quality healthcare we can provide them. That means safe, timely, and in their

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[1] "The Surgical and Anesthesia Workforce and Provision of Surgical Services in Rural Communities: A Mixed-Methods Examination" (Cohen, et. al., 2020). https://doi.org/10.1111/jrh.12417

[2] "Dozens of surgeries at Denver VA hospital put off because of doctor shortage" (Migoya, 2017). https://www.denverpost.com/2017/10/12/dozens-surgeries-denver-va-hospital-put-off-because-doctor-shortage/

[3] Rugs, D., Toyinbo, P., Barrett, B., Melillo, C., Chavez, M., Cowan, L., Jensen, P. K., Engstrom, C., Battaglia, C., Thorne-Odem, S., Sullivan, S. C., & Powell-Cope, G. (2021). A preliminary evaluation of full practice authority of advance practice registered nurses in the Veterans Health Administration. Nursing outlook, 69(2), 147–158. https://doi.org/10.1016/j.outlook.2020.11.005

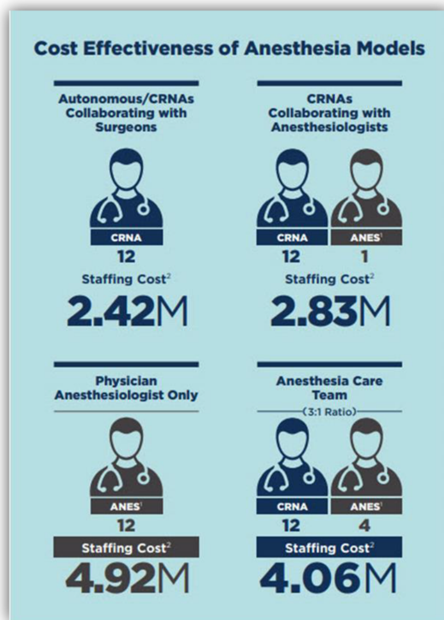
[4] "Geographical Imbalance of Anesthesia Providers and its Impact On the Uninsured and Vulnerable Populations" (Liao, et. al. 2015). https://pubmed.ncbi.nlm.nih.gov/26625579/

communities. CRNAs are ready to serve those who have served our nation, we are waiting for the VA to let us.

CRNA Supervision: At What Cost?

In late September 2022, Temple University published a study that had been commissioned by the Office of Nursing Services at the VA. The study, "Certified Registered Nurse Anesthetist Scope of Practice Laws," found that policy decisions on CRNA standards should be guided by currently available data.[5] After analyzing the available data, the study arrives at the conclusion that "removing restrictions and allowing more CRNAs to practice autonomously is documented to have no negative impact on patient outcomes, may potentially provide a cost-effective solution to physician shortages, and may increase access to care."

Currently, CRNAs do not have full practice authority at all VA facilities and are subject to restrictive supervision requirements that are not in line with most state laws. Outside of the VA, only seven states have rules in their Nurse Practice Acts or the State Boards of Nursing that require physician supervision of CRNA services. Twenty-four states have already opted out of Medicare's supervision requirement for CRNAs as well. Only one state requires the involvement of a physician anesthesiologist when a CRNA is providing care, and only at ambulatory surgical centers. Every branch of the military allows for CRNAs to practice autonomously. Supervision has no proven benefits to patients but has proven costs and detriments.



Comparing various methods of anesthesia delivery, an autonomous CRNA collaborating with a surgeon is the most cost-effective model for anesthesia delivery. Current trends in the QZ modifier, which is utilized when a CRNA is billing for anesthesia without supervision, have shown a steady increase in the utilization of this billing modifier, implying an increase in CRNA autonomous practice. The anesthesia care team model, of 1:3 supervision is one of the most expensive anesthesia delivery models possible. Allowing

[5] "Certified Registered Nurse Anesthetist Scope of Practice Laws" (DeAnna Baumle, JD, MSW, 2022). https://www.va.gov/STANDARDSOFPRACTICE/docs/CRNA_PolicyBrief_Temple.pdf

for autonomous practice by CRNAs allows facilities the flexibility to choose a model that meets their needs and helps to keep costs down. Unfortunately, the VA is known for significant waste in their anesthesia delivery models, including the utilization of the highest cost 1:1 supervision model, and employing millions of dollars in outside anesthesia contracts. Veterans and taxpayers deserve better than VA's inefficient anesthesia delivery models.

CRNA Safety and Outcomes

In 2016, the VA moved forward with implementing full practice authority for Nurse Practitioners, Nurse-Midwives, and Clinical Nurse Specialists. In the final APRN rule, the VA declined to provide CRNAs with full practice authority because of a perceived lack of anesthesia shortages. In the final rule however, **the VA explicitly stated that CRNAs are fully capable of practicing independently.**

The evidence is overwhelming that CRNA independent practice is just as safe as the anesthesia care provided under supervision or by our physician anesthesiologists colleagues. In the above-mentioned study that the VA commissioned from Temple University, it was found that "studies have found that CRNAs who had an expanded scope of practice did not have worse patient outcomes, complications, or mortality when compared to anesthesiologists."[6] A peer reviewed study published in the Journal of Medicare Care in 2016 looked at anesthesia related complications for CRNA only, anesthesiologist only, and a team-based approach and found there were no differences in complication rates based on delivery model.[7] This corroborates an earlier peer reviewed study published in Health Affairs in 2010 that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs were no different than outcomes in states that maintained supervision.[8] A comprehensive review completed by the Cochrane Library in 2014 further reinforced these finding, when it reviewed the literature on anesthesia staffing and found that there could be no definitive statement can be made about the superiority of anesthesia delivery models.

Some low-quality studies have purported to claim that CRNAs providing anesthesia without supervision negatively affects outcomes. A 25-year-old study that was not published in an outside peer-reviewed Journal, but rather in the Journal run by the American Society of Anesthesiologists, has major methodological issues that lead the Centers for Medicare and Medicaid to dismiss the study as too flawed to be used, stating, "One cannot use this analysis (Silber) to make conclusions about CRNA performance with or without physician supervision." This study looked at outcomes for 30-days post operative period, which is well outside the 48-hour period for anesthesia related complications.

The VA agreed that CRNAs can practice independently within the VA without harming patient access to care. In the 2016 APRN Final Rule issued by the VA, the rule stated, "'over

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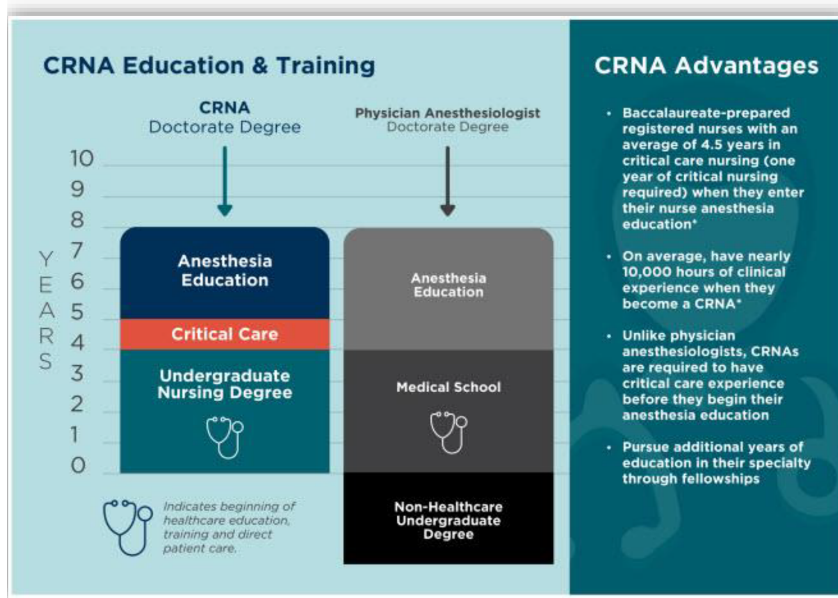
[6] Baumle, op. cit.

[7] "Scope of Practice Laws and Anesthesia Complications" (Negrusa, Hogan, Warner, Schroeder, and Pang, 2016). https://journals.lww.com/lww-medicalcare/abstract/2016/10000/scope_of_practice_laws_and_anesthesia.4.aspx

[8] "No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians" (Dulisse and Cromwell, 2010). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff

900 CRNAs provide every type of anesthesia care, as well as chronic pain management services, for our Veterans in the VHA. The safety of CRNA services has long been recognized by the VHA and underscored by peer-reviewed scientific studies, including a major study published in Health Affairs which found that anesthesia care by CRNAs was equally safe with or without physician supervision.' VA agrees with these comments."[9] Additionally, the VA agreed in their materials published with this rule that "anesthesia care by CRNAs was equally safe with or without physician supervision."[10] Only the ASA and the American Medical Association (AMA) continue to push a false narrative that CRNA care is unsafe to protect their turf.



Department of Veterans Affairs (VA) National Standards of Practice

In December 2020, the VA announced their intention to develop National Standards of Practice for more than fifty different providers currently working within the VA. These standards are an important part of ensuring continuity of care across the VA and ensuring that veterans at every VA facility receive the highest quality care. It is also an important part of ensuring the VA's Electronic Health Record (EHR) system works across the entire enterprise. The National

[9] "Advanced Practice Registered Nurses" (A rule by the Veterans Affairs Department, 2016). https://www.federalregister.gov/documents/2016/12/14/2016-29950/advanced-practice-registered-nurses

[10] Department of Veterans Affairs, op. cit.

Standards of Practice offer the VA an opportunity to address CRNA full practice authority, which could allow the VA to save money and increase access to care without sacrificing quality.

The VA's efforts to develop National Standards of Practice should be an evidence-based decision-making process that takes into account clinical competency and scientific evidence. This will allow providers to work to their full education and training. AANA was disappointed by the American Medical Association and the American Society of Anesthesiologists efforts to stop the establishment of practice standards for CRNAs and other providers, as they have a vested economic interest in restricting our practice. These organizations strongly oppose efforts to establish autonomous practice standards for CRNAs and have consistently and blatantly misrepresented CRNA education, competency, and safety. We should not be injecting politics into this process. Our veterans and taxpayers deserve better.

The ASA, AMA, and other physician groups have consistently complained about the process for the development of NSPs within the VA. The VA, however, has been deliberate and open throughout the process. The VA has hosted multiple listening sessions to ensure that all stakeholders have their say. To increase transparency, the VA has a website set up specifically on NSPs, including posting of any NSPs that have been developed and allowing for a sixty-day comment period on every set of standards. Additionally, VA personnel have attended meetings hosted by the American Society of Anesthesiologists to discuss the NSP process with their members, and physician anesthesiologists within the VA are part of the NSP process for CRNAs. Efforts to claim they are being shut out of the process is entirely disingenuous, and part of a larger campaign of fear mongering and misinformation in order to protect physician paychecks at the expense of taxpayers and veterans.

While the VA process has been slower than is ideal, it has been thorough, thoughtful, and transparent. The mission is important, and we believe all standards should be judged individually based on how they address safety, veteran access to care, effects on wait times, and cost-effectiveness. Alternately to the VA, the ASA has engaged in the process in a way that abuses important VA safety systems to the detriment of veterans, spams the VA regulatory system with anti-CRNA comments on unrelated regulations, and fearmongers with outrageous and inaccurate statements about the intentions of the VA NSP project. The ASA has abused the VA's 'Stop the Line' system for pointing out safety violations to complain about the NSP process. There has also been a complete misrepresentation of intent of the NSP project, with false claims that the VA is seeking to replace all physician anesthesiologists with nurse anesthesiologists. This is not the case, and the AANA does not support eliminating physician anesthesiologists from the VA, but strongly believe that it is in the best interest of our veterans to have physician anesthesiologists providing direct care to veterans, instead of unnecessary supervision of CRNAs. Our veterans deserve better.

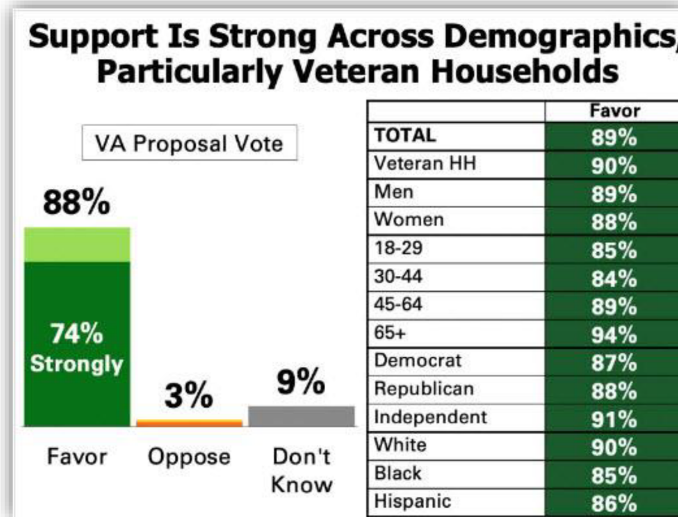
Independent Recommendations

The development of national standards of practice within the VA is meant to provide critical consistency across the VA and improve veteran's experience. Unfortunately, the AMA, ASA, and others in organized medicine have used the development of NSPs as a rallying cry to limit the ability of other providers to practice to the full extent of their education and training and

turned the process into an unnecessary and highly political turf battle, that does not serve the interest of our nation's veterans, who deserve better.

Outside of the sphere of healthcare providers, there are numerous independent groups who have weighed in supporting the removal of restrictions on CRNAs and other APRNs. Most critically, veterans themselves overwhelmingly support the VA allowing direct access to CRNA services. A 2022 survey found that an overwhelming 88% majority support this change, and nearly three-quarters (74%) strongly support it. This wide support extends across party, age, gender, race, and all other key demographics, but is especially strong among veterans and their families. Among veteran households 90% are in favor.

Across the ideological spectrum, groups have weighed in with support for removing barriers to care for APRNs, to increase access to care and to reduce costs. Among the groups that have supported the removal of restrictions are the Bipartisan Policy Center, Americans for Prosperity, The Brookings Institute, the Trump Administration, the National Rural Health Association, AARP, and LeadingAge. Full practice authority for CRNAs is also supported by the VA's own Independent Assessment and the Bipartisan Commission on Care. Multiple veterans service organizations have also weighed in supporting the development of NSPs and allowing providers to work to the top of their education and training.



	Favor
TOTAL	89%
Veteran HH	90%
Men	89%
Women	88%
18-29	85%
30-44	84%
45-64	89%
65+	94%
Democrat	87%
Republican	88%
Independent	91%
White	90%
Black	85%
Hispanic	86%

Veterans Need Care Now survey shows staunch support for CRNA autonomous practice in the VA

Conclusion

Our veterans deserve timely, high-quality health care no matter where they live. In rural settings, where healthcare delivery is already complex, CRNAs can fill critical gaps in the existing care matrix and help our nation deliver on its promise to those who have served. To fully remove barriers to care, it is imperative that the VA extend full practice authority to CRNAs at VA facilities. CRNAs have an unimpeachable track record in patient safety, already live in the communities where it is hardest to access care, and cost less than our physician peers. CRNAs are ready to serve our nation's veterans, if the VA lets us.