STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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Mr. Chairman and Members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this oversight hearing of the Committee focused on the Department of Veterans Affairs (VA) and the health care needs of rural veterans. As an organization of 1.2 million service-disabled veterans, rural health is an extremely important topic for DAV, and we value the opportunity to discuss our views. Also, as requested by Senator Tester, a member of this Committee, we are incorporating in this statement the particular concerns of our DAV Department of Montana.

As a partner organization in the *Independent Budget* (IB) for Fiscal Year (FY) 2010, DAV believes that after serving their nation in uniform, veterans should not experience neglect of their health care needs by VA simply because they live in rural or remote areas far from major VA health care facilities. The delegates to our most recent National Convention, held in Denver, Colorado, August 22-25, 2009, again passed a longstanding resolution on improving health care for veterans living in rural or remote areas

In the IB, we have detailed pertinent findings dealing with rural health care, disparities in health, rural veterans in general, and the circumstances of newly returning rural service members from Operations Enduring and Iraqi Freedom (OEF/OIF). Unfortunately those conditions remain relatively unchanged:

- Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas. state offices of rural health identify access to mental health care and concerns for stress, depression, suicide, and anxiety disorders as major rural health concerns.[1]
- Inadequate access to care, limited availability of skilled care providers, and stigma in seeking mental health care are particularly pronounced among residents of rural areas.[2] The smaller, poorer, and more isolated a rural community is, the more difficult it is to ensure the availability of high quality health services.[3]
- Nearly 22 percent of our elderly live in rural areas; rural elderly represent a larger proportion of the rural population than the urban population. As the elderly population grows, so do the demands on the acute care and long-term-care systems. In rural areas, some 7.3 million people need long-term-care services, accounting for one in five of those who need long-term care.[4]

Given these general conditions of scarcity of resources it is not surprising or unusual, with respect to those serving in the U.S. military and to veterans, that—

- There are disparities and differences in health status between rural and urban veterans. According to the VA's Health Services Research and Development office, comparisons between rural and urban veterans show that rural veterans "have worse physical and mental health related to quality of life scores. Rural/Urban differences within some Veterans Integrated Service Networks (VISNs) and U.S. Census regions are substantial."
- More than 44 percent of military recruits, and those serving in Iraq and Afghanistan, come from rural areas.
- More than 44,000 service members have been evacuated from Iraq and Afghanistan as a result of wounds, injuries, or illness, and tens of thousands have reported readjustment or mental health challenges following deployment.
- Thirty-six percent of all rural veterans who turn to VA for their health care have a service-connected disability for which they receive VA compensation.
- Among all VA health care users, 40.1 percent (nearly 2 million) reside in rural areas, including 79,500 from "highly rural" areas as defined by VA.

Veterans Rural Health Resource Centers are Key Proponents of Improvements

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

The concept underlining their establishment was to support a strong ORH presence with field-based offices across the VA health care system. These offices are charged with engaging in local and regional rural health issues in order to develop potential solutions that could be applied nationally in the VA, including building partnerships and collaborative relationships – both of which are imperative in rural America. These satellite offices of ORH and their efforts, along with those of VISN rural health coordinators, can validate the importance of the work and extend the reach of ORH in VHA, to reinforce the idea that the ORH is moving VA forward using the direct input of the needs and capabilities of rural America, rather than trying to move forward alone from a Washington DC central office.

Currently, these Centers are under temporary charters, and recipient of centralized funding not exceeding five years. The nature of that arrangement has had unintended consequences on the Centers including problematic recruitment and retention of permanent staff to conduct their work. We have been informed that all staff appointments to the VRHRCs are consequently temporary or term appointments, rather than permanent career positions, because of reluctance on the part of the host VA medical centers to be placed in the position of needing to absorb these personnel costs when Central Office funding ends. If the concept of field-based

rural health satellite offices is to be successful and sustained, the Centers need permanency of funding and staff.

Further Beneficiary Travel Increases are Needed

In the FY 2009 appropriations act, Congress provided VA additional funding to increase the beneficiary travel mileage reimbursement allowance authorized under section 111 of title 38, United states Code, and intended to benefit certain service-connected and poor veterans as an access aid to VA health care. VA consequently announced payment of the higher rate, at 41.5 cents per mile. While we appreciate this development and applaud both Congress and the VA for raising the rate considerably, 41.5 cents per mile is still significantly below the actual cost of travel by private conveyance, and provides only limited relief to those who have no choice but to travel long distances by automobile for VA health care. This challenge is particularly acute in frontier states where private automobile travel is a major key to health care access.

Telehealth – A Major Opportunity

The DAV and our partners in the IB believe that the use of technology, including the World Wide Web, telecommunications, and telemetry, offer VA a great but still unfulfilled opportunity to improve rural veterans' access to VA care and services. The IB veterans service organizations (IBVSOs) understand that VA's intended strategic direction in rural care is of necessity to enhance noninstitutional care solutions. VA provides home-based primary care as well as other home-based programs and is using telemedicine and telemental health—but on a rudimentary basis in our judgment—to reach into veterans' homes and community clinics, including Indian Health Service facilities and Native American tribal clinics. Much greater benefit would accrue to veterans in highly rural, remote and frontier areas if VA were to install general telehealth capability directly into a veteran's home or into a local non-VA medical facility that a rural veteran might easily access, versus the need for rural veterans to drive to distant VA clinics for services that could be delivered in their homes or local communities. This enhanced cyber-access would be feasible into the home via a secured website and inexpensive computer-based video cameras, and into private or other public clinics via general telehealth equipment with a secured internet line or secure bridge.

Expansion of telehealth would allow VA to directly evaluate and follow veterans without their needing to personally travel great distances to VA medical centers. VA has reported it has begun to use internet resources to provide limited information to veterans in their own homes, including up-to-date research information, access to their personal health records, and online ability to refill prescription medications. These are positive steps, but we urge VA management to coordinate rural technology efforts among its offices responsible for telehealth, rural health, and Information Technology offices at the Department level, in order to continue and promote these advances, but also to overcome privacy, policy and security barriers that prevent telehealth from being more available in a highly rural veteran's home, or into already-established private rural clinics serving as VA's partners in rural areas.

The ORH: A Critical Mission

As described by VA, the mission of the ORH is to develop policies and identify and disseminate best practices and innovations to improve health care services to veterans who reside in rural areas. VA maintains that the office is accomplishing this by coordinating delivery of current services to ensure the needs of rural veterans are being considered. VA also attests that the ORH will conduct, coordinate, promote, and disseminate research on issues important to improving health care for rural veterans. With confirmation of these stated commitments and goals, the DAV concurs that the Veterans Health Administration (VHA) would be beginning to incorporate the unique needs of rural veterans as new VA health care programs are conceived and implemented; however, the ORH is a relatively new function within VA Central Office (VACO), and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals, we remain concerned about the organizational placement of the ORH within the VHA Office of Policy and Planning rather than placing it closer to the operational arm of the VA health care system, and closer to the decision points in VHA executive management. Having to traverse the multiple layers of the VHA's bureaucratic structure could frustrate, delay, or even cancel initiatives established by this staff office. We also note that executive direction within the office itself has been problematic, and that VA is experiencing difficulty in recruiting a permanent director of the office.

We continue to believe that rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VACO, perhaps at the Deputy Under Secretary level, with staff augmentation commensurate with these stated goals and plans. We understand that recently the grade level of the Director of ORH was elevated to the Senior Executive Service. We appreciate that change but grade levels of Washington-based executives do not necessarily translate to enhanced outcomes and better health for rural veterans.

Rural Health Coordination at the Grassroots

The VHA has established VA rural care designees in all its VISNs to serve as points of contact and liaisons with the ORH. While DAV appreciates that the VHA designated the liaison positions within the VISNs, we remain concerned that they serve these purposes only on a part-time basis, along with other duties as assigned. We believe rural veterans' needs, particularly those of the newest generation of war veterans, are sufficiently crucial and challenging that they deserve full-time attention and tailored programs. Therefore, in consideration of other recommendations dealing with rural veterans' needs put forward in this statement as well as in the IB, we urge VA to establish at least one full-time rural liaison position in each VISN and more if appropriate, with the possible exception of VISN 3 (urban New York City).

Outreach Still Needs Improvement

We note Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, approved on September 30, 2008, included $250 million for VA to establish and implement a new rural health outreach and delivery initiative. Congress intended these funds to build upon the successes of the ORH by enabling VA to expand

initiatives such as telemedicine and mobile clinics, and to open new clinics in underserved and rural areas.

Outreach Clinics are established to extend access to primary care and mental health services in rural and highly rural areas where there is not sufficient demand or it is otherwise not feasible to establish a full-time Community-Based Outpatient Clinic (CBOC) by establishing a part-time clinic. 10 Outreach Clinics were funded in fiscal year 2008 and 30 in fiscal year 2009. While the potential impact would affect over 997,000 rural and highly rural enrollees that reside within areas that VA serves, only 2,250 patients were seen by the end of fiscal year 2009.

Without question, section 213 of Public Law 109-461 could be a significant element in meeting the health care needs of veterans living in rural areas, especially those who have served in Afghanistan and Iraq. Among its features, the law requires VA to conduct an extensive outreach program for veterans who reside in rural and remote areas. In that connection, VA is required to collaborate with employers, state agencies, community health centers, rural health clinics, Critical Access Hospitals (as designated by Medicare), and local units of the National Guard to ensure that returning veterans and Guard/Reserve members, after completing their deployments, can have ready access to the VA health care and benefits they have earned by that service. Given this mandate is more than three years old, DAV urges VA's recently created National Outreach Office in the Office of Intergovernmental Affairs, Office of Public and Intergovernmental Affairs to move forward on this outreach effort—and that outreach under this authorization be closely coordinated with VA's ORH to avoid duplication and to maintain consonance with VA's overall policy on rural health care.

To be fully responsive to this mandate, VA should report to Congress the degree of its success in conducting effective outreach and the result of its efforts in public-private and intergovernmental coordination to help rural veterans. We note VA is required to develop a biennial plan on outreach activities and DAV has had the opportunity to review the December 1, 2008, VA biennial outreach activities report to Congress. Clearly VA is conducting numerous outreach activities to veterans of all eras and has a special emphasis on veterans of OEF/OIF. However, we note the report lacks an overarching strategic plan as well as any parameters or statistical evidence to determine whether outreach efforts, individually or collectively, are achieving the desired results. Strategic planning is essential for successful business operations and a full understanding of the veteran population is an important element in providing education and outreach.

Montana-Specific Concerns

Our DAV Montana past Department Commander furnished information responsive to Senator Tester's request. With respect to VA, the report indicates a local challenge in DAV's Transportation Network. VA's local processing time to qualify a DAV volunteer to drive for the Volunteer Transportation Network in Montana requires up to 50 days. As a result DAV Montana has lost potential volunteers, either because of their own extended travel requirements to facilities to try to qualify, or because of the lengthy time of processing their requests to volunteer. The report also indicated inconsistency within VA facilities between states; for example, the Ft. Harrison VA Medical Center (VAMC) requires a tuberculin test every year for

all its volunteer drivers; in other states VAMCs do not impose this requirement. Our Montana DAV believes these kinds of rules should be standardized for DAV volunteer drivers. The DAV National Organization concurs.

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

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

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

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

These DVOPs and LVERs were especially trained to aid veterans who were disabled or veterans who face a variety of barriers to employment, or have special needs preventing them from returning to the workforce. Through the federal authorization, Montana reported it once had sufficient available funds in these programs to work with the individuals and local employers to make sure these veterans received the help they needed either through local services or additional education to assist these individuals to return to the workforce. What they were also

able to accomplish was to identify any of those possible barriers to employment such as depression, TBI, PTSD and other special needs. These individuals had already networked throughout the community, county, state or other federal agencies to help these veterans with special needs.

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

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

Our Montana Department also reported that the Department of Transportation (DOT) offers no grant programs for veterans service organizations to support veterans' transportation to VA medical appointments. Similar to most of our Departments and many DAV Chapters, the Department of Montana DAV Volunteer Transportation Network depends on local fundraising, available grants, and DAV national funds to support this large program. In Montana during the most recent year, 31,184 volunteer hours were logged over 685,982 miles, with 16,880 individual veterans being transported to VA appointments, involving nearly 300 volunteers in VA clinics, and local area coordinators in the medical center in Ft. Harrison, but with only two paid VA employees (Hospital Services Coordinators). Given the over 5,000 members of the DAV residing in Montana, the transportation network is reduced from 44 active vans to 36, and currently Montana DAV has four inactive vans that are being retired due to high mileage and maintenance issues. Currently, Montana DAV deploys vans from 20 different locations throughout the state, and has identified four new locations in expansion planning, of which two vans will be based on Indian reservations.

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

Montana DAV raises this issue in hopes that Congress would require DOT to change its regulations for the acceptance of grant requests from veterans service organizations to apply for grants that are designed to help veterans obtain VA services and gain access to VA medical

appointments. The DAV National Organization takes no position on this request but passes it to the Committee as a matter of information. As this Committee is aware, the DAV National Organization does not accept federal grants, nor do we encourage subordinate entities to accept federal grants. In fact, we try to dissuade our Departments and chapters from applying for any federally appropriated dollars.

While Popular, Privatization is Not a Preferred Option

Section 216 of Public Law 110-329 requires the Secretary to allow veterans residing in Alaska and enrolled for VA health care to obtain needed care from medical facilities supported by the Indian Health service or tribal organizations if an existing VA facility or contracted service is unavailable. It also requires participating veterans and facilities to comply with all appropriate VA rules and regulations, and must be consistent with Capital Asset Realignment for Enhanced Services. In addition, Public Law 110-387, the Veterans' Mental Health and Other Care Improvements Act of 2008, directs the Secretary of Veterans Affairs to conduct a three-year pilot program under which a highly rural veteran who is enrolled in the system of patient enrollment of the VA and who resides within a designated area of a participating VISN may elect to receive covered health services through a non-VA health care provider at VA expense. The act defines a "highly rural veteran" as one who (1) resides more than 60 miles from the nearest VA facility providing primary care services, more than 120 miles from a VA facility providing acute hospital care, or more than 240 miles from a VA facility providing tertiary care (depending on which services a veteran needs); or (2) otherwise experiences such hardships or other difficulties in travel to the nearest appropriate VA facility that such travel is not in the best interest of the veteran. During the three-year demonstration period the act requires an annual program assessment report by the Secretary to the Committees on Veterans' Affairs, to include recommendations for continuing the program.

DAV's concerns regarding the use of non-VA purchased care are the unintended consequences for VA, unless carefully administered. Chief among these is the diminution of established quality, safety, and continuity of VA care for rural and highly rural veterans. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the specialized needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, polytrauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably impacted by the loss of veterans from those programs. Also, the VA's medical and prosthetic research program, designed to study and, hopefully, cure the ills of injury and disease consequent to military service, could lose focus and purpose were service-connected and other enrolled veterans no longer physically present in VA health care programs. Additionally, title 38, United states Code, section 1706(b)(1) requires VA to maintain the capacity of its specialized medical programs and not let that capacity fall below the level that existed at the time when Public Law 104-262 was enacted in 1996. Unfortunately some of that capacity has dwindled.

We believe VA must maintain a "critical mass" of capital, human, and technical resources to promote effective, high-quality care for veterans, especially those with sophisticated health problems such as blindness, amputations, spinal cord injury, or chronic mental health

problems. Putting additional budget pressures on this specialized system of services without making specific appropriations available for new rural VA health care programs may only exacerbate the problems currently encountered.

In light of the escalating costs of health care in the private sector, to its credit, VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected veterans might seek care in the private sector as a matter of personal convenience as a result of enactment of vouchering and privatization bills, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic health record, and bar code medication administration. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, ones that are either generally not available in private sector systems or only partially so, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

In general, current law places limits on VA's ability to contract for private health care services in instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract to obtain the services of scarce medical specialists in VA facilities. Beyond these limits, there is no general authority in the law (with the exception of the new demonstration project described above) to support broad-based contracting for the care of populations of veterans, whether rural or urban.

The DAV urges this Committee and the VA ORH to closely monitor and oversee the functions of the new rural pilot demonstration project from Public Law 110-387, especially to protect against any erosion or diminution of VA's specialized medical programs and to ensure participating rural and highly rural veterans receive health care quality that is comparable to that available within the VA health care system. Especially we ask VA in implementing this demonstration project to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state or other federal agencies) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, compared to similar measurements of a like group of rural veterans in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions' academic affiliates. We recommend the principles of our recommendations from the "Contract Care Coordination" section of the IB be used to guide VA's approaches in this demonstration and that it be closely monitored by VA's Rural Veterans Advisory Committee. Further, we believe the ORH should be designated the overall coordinator of this demonstration project, in collaboration with other pertinent VHA offices and local rural liaison staff in VHA's rural VISNs selected for this demonstration.

VA's Readjustment Counseling Vet Centers: Key Partners in Rural Care

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, DAV believes that these veterans, too, should have access to specialized services offered at VA's Vet Centers. Vet Centers are located in communities outside the larger VA medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of local veterans. These centers present the primary access points to VA programs and benefits for nearly 25 percent of veterans who receive care at the centers. This core group of veteran users primarily receives readjustment and psychological counseling related to their military experiences. Building on the strength of the Vet Centers program, VA should extend its current pilot program for mobile Vet Centers that could help reach veterans in rural and highly rural areas where there is no other VA presence.

VA Should Stimulate Rural Health Professions

Health workforce shortages and recruitment and retention of health care personnel (including clinicians) are a key challenge to rural veterans' access to VA care and to the quality of that care. The Future of Rural Health report recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deeper involvement in education in the health professions for future rural clinical providers seems appropriate in improving these situations in rural VA facilities as well as in the private sector. Through VA's existing partnerships with 103 schools of medicine, almost 28,000 medical residents and 16,000 medical students receive some of their training in VA facilities every year. In addition, more than 32,000 associated health sciences students from 1,000 schools, including future nurses, pharmacists, dentists, audiologists, social workers, psychologists, physical therapists, optometrists, respiratory therapists, physician assistants, and nurse practitioners, receive training in VA facilities.

We believe these relationships of VA facilities to health professions schools should be put to work in aiding rural VA facilities with their health personnel needs. Also, evidence shows that providers who train in rural areas are more likely to remain practicing in rural areas. The VHA Office of Academic Affiliations, in conjunction with ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. The VHA office of Workforce Recruitment and Retention should execute initiatives targeted at rural areas, in consultation with, and using available funds as appropriate from, the ORH. Different paths to these goals could be pursued, such as the leveraging of an existing model used by the Health Resources and Services Administration (HRSA) to distribute new generations of health care providers in rural areas. Alternatively, VHA could target entry level workers in rural health and facilitate their credentialing, allowing them to work for VA in their rural communities. Also, VA could offer a "virtual university" so future VA employees would not need to relocate from their current environments to more urban sources of education. While, as discussed above, VA has made some progress with telehealth in rural areas as a means to provide alternative VA care to veterans in rural America, it has not focused on training future clinicians on best practices in delivering care via telehealth. This initiative could be accomplished by use of the virtual university concept or through collaborations with established collegiate programs with rural health curricula. If properly staffed, the VRHRCs could serve as

key “connectors” for VA in such efforts.

Consistent with our HRSA suggestion above, VA should examine and establish creative ways to collaborate with ongoing efforts by other agencies to address the needs of health care for rural veterans. VA has executed agreements with the Department of Health and Human Services (HHS), including the Indian Health Service and the HHS Office of Rural Health (ORH) Policy, to collaborate in the delivery of health care in rural communities, but we believe there are numerous other opportunities for collaboration with Native American and Alaska Native tribal organizations, state public health agencies and facilities, and some private practitioners as well, to enhance access to services for veterans. The ORH should pursue these collaborations and coordinate VA’s role in participating in them.

The IB for FY 2009 had expressed the concern that rural veterans, veterans service organizations, and other experts needed a seat at the table to help VA consider important program and policy decisions such as those described in this statement, ones that would have positive effects on veterans who live in rural areas. The IBVSOs were disappointed that Public Law 109-461 failed to include authorization of a Rural Veterans Advisory Committee to help harness the knowledge and expertise of representatives from federal agencies, academic affiliates, veterans service organizations, and other rural health experts to recommend policies to meet the challenges of veterans’ rural health care. Nevertheless, we applaud the Secretary of Veterans Affairs for having responded to the spirit of our recommendation to use VA’s existing authority to establish such an advisory committee. That new federal advisory committee has been appointed, has held formative meetings and has begun to issue reports to the Secretary. We are pleased with the progress of the advisory committee and believe its voice is beginning to influence VA policy for rural veterans in a very positive direction.

Summary and Recommendations

DAV and our partner organizations in the IB believe VA is working in good faith to address its shortcomings in rural areas, but still faces major challenges. In the long term, its methods and plans offer rural and highly rural veterans potentially the best opportunities to obtain quality care to meet their specialized health care needs. However, we vigorously disagree with proposals to privatize, voucher, and contract out VA health care for rural veterans on a broad scale because such a development would be destructive to the integrity of the VA system, a system of immense value to sick and disabled veterans and to the organizations that represent them. Thus, we remain concerned about VA’s demonstration mandate to privatize services in selected rural VISNs and will continue to closely monitor those developments.

With these views in mind, DAV makes the following recommendations to the Committee and also to the VA, where applicable:

- VA must ensure that the distance veterans travel, as well as other hardships they face, be considered in VA’ s policies in determining the appropriate location and setting for providing direct VA health care services.

- VA must fully support the right of rural veterans to health care and insist that funding for

additional rural care and outreach be specifically appropriated for this purpose, and not be the cause of reduction in highly specialized urban and suburban VA medical programs needed for the care of sick and disabled veterans.

- The responsible offices in VHA and at the VA Departmental level, collaborating with the ORH, should seek and coordinate the implementation of novel methods and means of communication, including use of the World Wide Web and other forms of telecommunication and telemetry, to connect rural and highly rural veterans to VA health care facilities, providers, technologies, and therapies, including greater access to their personal health records, prescription medications, and primary and specialty appointments.

- We recommend a further increase in travel reimbursement allowance commensurate with the actual cost of contemporary motor travel. The existing gap in reimbursement has a disproportionate impact on veterans in rural and frontier states.

- The ORH should be organizationally elevated in VA's Central Office and be provided staff augmentation commensurate with its responsibilities and goals.

- The VHA should establish at least one full-time rural staff position in each VISN, and more if needed.

- VA should ensure that mandated outreach efforts in rural areas required by Public Law 109-461 be closely coordinated with the ORH. VA should be required to report to Congress the degree of its success in conducting effective outreach and the results of its efforts in public-private and intergovernmental coordination to help rural veterans.

- Additional mobile Vet Centers should be established where needed to provide outreach and readjustment counseling for veterans in highly rural and frontier areas.

- Through its affiliations with schools of the health professions, VA should develop a policy to help supply health professions clinical personnel to rural VA facilities and practitioners to rural areas in general.

- Recognizing that in some areas of particularly sparse veteran population and absence of VA facilities, the VA ORH and its satellite offices should sponsor and establish demonstration projects with available providers of mental health and other health care services for enrolled veterans, taking care to observe and protect VA's role as coordinator of care. The projects should be reviewed and guided by the Rural Veterans Advisory Committee. Funding should be made available by the ORH to conduct these demonstration and pilot projects, and VA should report the results of these projects to the Committees on Veterans' Affairs.

- Rural outreach workers in VA's rural CBOCs should receive funding and authority to enable them to purchase and provide transportation vouchers and other mechanisms to promote rural veterans' access to VA health care facilities that are distant from these

veterans' rural residences. This transportation program should be inaugurated as a pilot program in a small number of facilities. If successful as an effective access tool for rural and highly rural veterans who need access to VA care and services, it should be expanded accordingly.

- At highly rural VA CBOCs, VA should establish a staff function of rural outreach worker to collaborate with rural and frontier non-VA providers, to coordinate referral mechanisms to ease referrals by private providers to direct VA health care when available or VA-authorized care by other agencies when VA is unavailable and other providers are capable of meeting those needs.

Mr. Chairman, this concludes DAV's statement. I would be pleased to address questions from you or other Members of the Committee.

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[1] L. Gamm, L. Hutchison, et al., eds. *Rural Healthy People 2010: A Companion Document to Healthy People 2010, vol. 2*, College Station, Texas: Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003.
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[2] President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003

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

[4] L. Gamm, L. Hutchison, et al., eds., *Rural Healthy People 2010: A Companion Document to Healthy People 2010, vol. 3*, College Station, Texas: Texas A&M University System, Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center, 2003.