CARING FOR VETERANS IN RURAL AREAS

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THURSDAY, FEBRUARY 26, 2009

United States Senate,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to notice, at 10:06 a.m., in room SR-418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Tester, Begich, Burris, Burr, and Johanns.

OPENING STATEMENT OF CHAIRMAN AKAKA

Chairman Akaka. This hearing on Caring for Veterans in Rural Areas will come to order.

Good morning and aloha to all of you, and I want to extend my warmest welcome to our Committee members, and it is good to see Senator Tester here early, and also to welcome our witnesses visiting the Nation's capital from small communities as close as southern Virginia and as far away as Montana. Today's hearing brings together small communities with VA to discuss the health care problems our newest veterans face when they return to homes in rural areas.

Many of our veterans live in small towns and communities. This includes a large number of Guard members

and Reservists, who have been such a big part of the wars in Iraq and Afghanistan. Members of the Guard and Reserve face challenges different from their active-duty counterparts, who return to military bases with the support of their unit and programs geared toward re-acclimating them to life outside of the combat zone.

When a Guardsman or Reservist returns home, he or she can be isolated from their unit and must reintegrate without a strong VA or DOD presence or support system. Frequently, these servicemembers live up to, and beyond, 50 miles from their home base.

When health care is needed, a rural community may not have providers who offer mental health services like group counseling or therapy. The doctors may not be familiar with treating combat-related disorders.

Nevertheless, we have an obligation to care for all our veterans in need, regardless of location. We must ensure that adequate resources are available in our small communities, and that VA engages fully with local health care providers. Every resource must be united in the effort to care for our wounded warriors, be it a community hospital or VA clinic. When there is no VA presence available, this may mean paying community providers for the reasonable costs of care.

As a Committee, we will be focusing much effort on

improving veterans' health care in rural areas, and I welcome any new approaches to meet this goal.

I also want to tell you that I just had a conversation with Secretary Shinseki before coming into the room. We discussed the proposed VA budget. I must say that with the little detail we do have, it is positive. I can tell you that there will be an increase in the veterans' budget that will be proposed by the President to the VA and to Secretary Shinseki. And let me say that it is a step in the right direction. It is an increase. We are looking at about 15 percent, but it is a step in the direction of the needed resources.

The President's budget and its discretionary authority includes health care by $5 billion over last year's budget, so that is a good step. And I am looking forward to seeing more of the President's proposal in the days and weeks to come. And we do, of course, have VA's budget hearing scheduled for March 10th.

So let me call on Senator Tester for his opening statement.

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. Thank you, Chairman Akaka. I appreciate your holding this hearing today, and I want to thank the distinguished witnesses who are here today to discuss health care and the challenges faced by veterans

living in rural communities.

I also want to recognize Matthew Kuntz. Matthew is an attorney from Helena, Montana. Matthew gave up his practice as an attorney to serve as Executive Director of the National Alliance on Mental Illness, NAMI, in Montana, and this happened after his step-brother committed suicide. I have been very, very fortunate over the last couple of years to get to know Matt, and I believe he adds a very important voice to this story.

Matt's brother was an Iraqi war veteran suffering from combat-related PTSD, and I want to thank him personally for his leadership and his advocacy on this issue. His outreach has been a lifeline for Montana veterans and their families. We appreciate your courage, Matt, and the perspective that you will bring to this Committee today.

This is not an easy topic, but we must continue to address combat-related mental illness and the devastating effects that it can have on veterans, because if it is not properly identified and expeditiously treated, the problems do not get better. They get worse.

Again, I want to thank you for coming and thank you for bringing awareness from a Montana perspective.

Montana has a large population of Native American veterans. This is a special group of veterans that is disproportionately affected by service-connected health

conditions. Their access to primary and mental health care is further limited by distance, it is underfunded and often inadequate community health care services through the IHS. We need to do better there.

Next week, I intend to reintroduce the Rural Veterans Health Improvement Act. I will work with my colleagues and the Chairman on this Committee to be sure that this bill includes a section on improving the VA's work with IHS, because I think we all know that the relationship as it stands is not working properly. We did not have anything on the VA-IHS relationship last time, but I believe we need to address it.

Veterans who reside in frontier communities like Montana are at greater risk of adverse health outcomes. They cannot wait weeks for a VA appointment in a city hundreds of miles away with a doctor that they have never seen or who has no knowledge of their medical history. In many instances, the primary care setting, whether it is in the CBOCs or some kind of private provider in the local community, becomes the de facto mental health care delivery system for these individuals.

More than 40 percent of the patients with mental health concerns initially seek care in the primary care setting, and I believe we have to take a look at this because the primary care setting provides a valuable opportunity to

improve access to mental health services.

I believe there is a greater opportunity for the VA to collaborate and support primary care settings in the local communities. If the VA cannot provide timely, targeted access for veterans in rural areas, whether for mental health or for physical injuries suffered in service to our Nation, then they must expand and build upon resources in the local community with an eye toward improving access, communications, and follow-up.

Again, I appreciate, Mr. Chairman, your calling this hearing, and I appreciate the opportunity to hear from the witnesses as we progress today. Thank you.

Chairman Akaka. Thank you very much, Senator Tester. I want to mention that you are regarded as a leader here on rural health, so we are so glad to have you as a member of this Committee.

Let me call on Senator Burr for his opening statement.

OPENING STATEMENT OF SENATOR BURR

Senator Burr. Aloha, Mr. Chairman.

Chairman Akaka. Aloha.

Senator Burr. And I think it is evident to all of us that Senator Tester got his cut while he was gone. He desperately needed it at the last hearing. I just want to point that out.

[Laughter.]

Senator Burr. Mr. Chairman, I want to thank you for this hearing and good morning to our witnesses.

About one-third of all veterans enrolled for VA health care live in rural communities as defined by the Census Bureau. Many of us can point to large portions of our States that have limited access to health care, and North Carolina is no exception to that. I am convinced we must tackle this problem, and I am eager to hear what the witnesses from VA are doing to solve it.

I am pleased that in recent years the VA has continued to expand its presence of outpatient clinics in rural communities. VA has opened over 100 new community-based outpatient clinics in the past 5 years. I have had the pleasure of attending several VA clinic openings in North Carolina over the last couple of years. We have four more that will open within the next 2 years. These clinics will cut down on lengthy travel times and hopefully encourage veterans to get the essential primary care and basic mental health services that they might otherwise not seek.

Let me add at this point, Mr. Chairman, it is my intention to bring to this Committee hopefully a new model program for rural markets where we consider collocating VA outpatient clinics in with federally chartered community health centers, where we share the footprint of a delivery point and potentially at least share the technology

components of X-ray, copiers, the things that we do not need to duplicate, and we will work out the professional staff if there is any shared along those lines. But I think it is time that we begin to think outside of the box at how we increase the number of points that we deliver health care, facing the reality that if we are unsuccessful at doing that, we will never accomplish the level of primary care that is needed to make sure that our veterans are not, in fact, inpatient fatalities within the system.

Along with these new clinics is the opportunity to expand our use of telemedicine. That technology now permits remote consultations and even some medical procedures or examinations to occur in the comfort of a patient's own home, which I would say we have done with great success thus far.

As this technology continues to improve, it will open the doors to deliver more care to more veterans in remote areas.

Finally, access to care for rural veterans raises the potential to work in coordination with health care providers in rural areas, as I have said, and this is a tremendous area of interest to veterans who live in these rural areas and are faced with the decision of how do they get from where they live to a delivery point when travel seems to be their number one concern.

Last year Congress passed legislation to test this concept with a pilot program allowing the VA to team up with community providers for the care of veterans who live far away from VA facilities, and I look forward to hearing how those pilot programs are going.

Mr. Chairman, again, I thank you again for calling this important hearing. I do not believe that there is any area of greater concern that we have than how we address the delivery of health care in rural America and as we continue to see the demographic shift that is happening in this country. I go into this with the realization that many of those retired veterans are choosing North Carolina to be their home and that we cannot possibly, without the right amount of attention in rural markets, understand how we are going to service this population, regardless of which State they choose, unless we are willing to tackle new ways to deliver health care in the rural areas of this country.

I thank the Chair.

Chairman Akaka. Thank you very much, Senator Burr.

Let me call now on Senator Burris for his opening statement.

OPENING STATEMENT OF SENATOR BURRIS

Senator Burris. Thank you, Mr. Chairman, and I want to thank the witnesses for appearing here as well.

Mr. Chairman, over my break, I was able to go not to a

rural VA hospital, but I visited the most modern one up in Great Lakes in northern Illinois in my State, and I was impressed with the move to combine the medical services from the naval base over at Great Lakes with the veterans hospital. And they are doing this as the only program in the country that is trying to do complete service with DOD and with the VA. And the hospital administrators are all excited about it. The Navy leadership is all excited about it. But it is not getting to our rural communities, and we have rural communities in Illinois as well.

As you all may know, there was that one incident in Illinois where that one doctor created a lot of problems for some veterans, and I understand that that has really been taken care of. But we have to be concerned about how they get access to health care. And when you see that 39 percent of the veterans enrolled in the VA health care system reside in rural areas, the model we have for providing care to veterans via large hospitals and clinics does not make sense in the area of low population density. We must find new ways to serve our rural veterans. And I hope a newly created Office of Rural Health and those clinics will find ways to eliminate the discrepancies in the care between urban, suburban, and rural veterans.

There are some urgent issues right now that we must face, and we must solve them on behalf of the members who

gave their all for us to be safe in this great democracy. We cannot forget them. We cannot let them suffer. We must take care of them.

Thank you very much, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Burris.

Senator Begich, your opening statement, please.

OPENING STATEMENT OF SENATOR BEGICH

Senator Begich. Thank you, Mr. Chairman. I am going to be, as usual, brief, just say thank you. I am looking forward to your commentary. There is no State more rural than Alaska, and how you deliver health care systems up there, we have grave concerns, and the issues that I am going to look to--and I appreciate Senator Burr's comment regarding delivery to rural communities.

I like pilot ideas, but I like aggressive approaches. I think the system has to change dramatically, especially in Alaska, in how we partner with, for example, some of the best health care that is offered in regards to our Native health care systems that are all throughout the State of Alaska. And I know there are a couple ideas that are being kicked around. They are kind of jammed up a little bit, is what I understand. I am looking forward to seeing a long-term, aggressive approach in especially what I would consider the most rural of rural States in this country and how you deliver health care systems.

So I am looking forward to your testimony. I know we are going to be voting at 10:30. I do not know how this will all work, but I am looking forward to it. If I miss it, I am anxious to hear from both of you at a later time.

Chairman Akaka. Thank you, Senator Begich.

Senator Brown?

OPENING STATEMENT OF SENATOR BROWN

Senator Brown. Thank you, Mr. Chairman, and thank you to the witnesses for being here and for your public service. Thank you.

In my State of Ohio of 11 million people, there are more than 1 million veterans, and that number is growing rapidly, of course, as men and women return from Iraq, Afghanistan, and other deployments. These brave men and women were made a solemn promise that if they defended our country, we would provide them with services they have earned and they deserve.

Veterans in rural America and rural Ohio face barriers, as others have pointed out, to healthy transition to civilian life. From a lack of access to VA facilities to a lack of VA reimbursement for community hospitals, rural veterans are struggling to regain a healthy life. That is why this hearing is so important, and I thank the Chairman for doing this.

Last year I held a joint field hearing with Congressman

Zack Space, now a two-term Member from Ohio, that examined issues facing veterans in Appalachia, Ohio. During the hearing I heard from Terry Carson, the CEO of Harrison Community Hospital, a 25-bed community hospital that serves the small village of Cadiz--the boyhood home of both Clark Gable and General George Custer, I might add. I asked Mr. Carson to testify after receiving a letter from him describing the enormous financial strain that small community hospitals experience when they provide urgent care for veterans, despite knowing the hospital may not receive VA reimbursement.

After hearing Mr. Carson's story and that of other community hospitals treating rural veterans, I introduced and this Congress enacted the Veterans Emergency Care Fairness Act of 2007 that requires the VA to reimburse community hospitals for all care a veteran receives before that veteran is transferred to another VA facility.

But that act addresses just one issue that confronts veterans in rural areas. Today's hearing examines important issues of recruitment of physicians in rural communities, strengthening telemedicine resources to compensate for the shortage of providers in rural communities, and other ways to ensure a concerted effort to provide adequate health care for our veterans.

Much work needs to be done. Veterans, whether living

in Cadiz or Cleveland, deserve access to the quality health care that honors their sacrifice.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Brown.

Senator Murray?

OPENING STATEMENT OF SENATOR MURRAY

Senator Murray. We do have a vote in just a couple minutes, so I will put my opening remarks into the hearing record. But I would just say that I think this is a critical, critical hearing, and I look forward to your testimony and the opportunity to talk to all of our witnesses today about how we are going to address these needs.

Mental health is something that I have talked about for a long time. It is very hard in rural communities on mental health needs when we expect people to drive miles and miles, hours at a time, to get the help they need. It just does not happen.

So we have a lot of work ahead of us, and I am concerned about, as all of our colleagues have talked about, what we can do to make sure that we are taking care of our veterans wherever they live. I look forward to this hearing.

Thank you very much.

[The prepared statement of Senator Murray follows:]

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Chairman Akaka. Thank you very much, Senator Murray.

As you know, we are expecting a roll call on the floor, but in the meantime, let me welcome our first panel of witnesses. We will hear first from Kara Hawthorne, Director of the Office of Rural Health for Virginia. The Office of Rural Health was created by Public Law 109-461 to address the needs of our rural veterans. We will hear today how her office has been addressing these needs.

Second, we will hear from Dr. Adam Darkins, who runs VA's telehealth program.

I want to thank you all for joining us today. Your full statements will appear in the record, and, Ms. Hawthorne, before we have the vote on the floor, please proceed with your statement.

STATEMENT OF KARA HAWTHORNE, DIRECTOR, OFFICE OF RURAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. Hawthorne. Good morning, Mr. Chairman and members of the Committee. I am delighted to be here today to talk to you about the very important work that VA is doing to enhance the care delivery to veterans who live in rural and highly rural areas. I would like to request that my written statement be submitted for the record.

Let me begin by saying that we know rural health is a difficult national health care issue. Veterans and other citizens face a number of challenges. But VA has aggressively pursued a national strategy of outreach to ensure that veterans, regardless of where they live, can access the expertise and experience of one of the best health care systems in the Nation. In partnership, I know that Congress and VA can do even more. We do deeply appreciate your support and interest in this area, and we are happy to report that portions of the $250 million included in this year's appropriation have already been distributed to the field to support new and existing projects.

In January, VA provided almost $22 million to VISNs across the country to improve services for rural veterans. VA's Office of Rural Health, or ORH for short, has allocated

another $24 million to sustain fiscal year 2008 programs and projects, including the Rural Health Resource Centers, Mobile Health Care Clinics, Rural Outreach Clinics, VISN Rural Consultants, mental health and long-term care projects, and rural home-based primary care.

Another project supported by Congress is Section 403 of Public Law 110-387. This section requires VA to conduct a pilot project that would provide non-VA care for highly rural enrolled veterans in five VISNs. VA is working to implement this pilot while resolving two questions.

First, we must reconcile how VA has traditionally defined "highly rural" and how the statute defines it. VA's data has been structured based upon our definitions using drive times, and we are currently analyzing that data to develop a new baseline assessment using mileage.

Second, VA must develop a regulation to define the "hardship provision" in Section 403(b)(2)(B). We have been active in our development of an implementation plan, and once that assessment and the regulatory process are complete, VA will identify qualifying communities and local providers willing and able to participate. VA staff is available to meet with members of the Committee or staff to discuss additional ways forward.

ORH's primary mission is to address the needs of rural veterans and improve access and quality of care, and its

mission is in our mind at all times. VA understands that veterans can only use our services if they know about them, so VA has initiated a Veterans Call Center that has been reaching out to OEF/OIF veterans from all parts of the country to inform them of their benefits and ask if they need any help. ORH will be reviewing the Call Center's work to determine what more we can do for rural veterans.

We are also in close collaboration with HHS to address the needs of the OEF/OIF veterans by coordinating seamless referrals from community health centers to VA Medical Centers and sharing VA's wealth of educational material.

One of the most significant health care challenges in rural and highly rural areas is the shortage of health care providers, particularly specialty care providers. VA is working diligently to develop and implement creative solutions that will provide incentives and opportunities to bring qualified health care providers to these areas.

For example, we are currently 1 year into a 3-year pilot for VA's Travel Nurse Corps, which is designed to improve recruitment, decrease turnover, and maintain high standards of patient care. Additionally, VHA Office of Health Care Retention and Recruitment is establishing a national contract for retained search firms and is hiring recruiters who will focus on rural areas. VA also continues to grow education debt reduction and recruitment, retention,

and relocation programs.

The Office of Rural Health embraces technology as an essential component for expanding care and increasing access for rural veterans, and we are identifying new ways to collaborate with the community. In coordination with VA's Office of Information and Technology and VHA's Office of Health Information, we are exploring opportunities to exchange information with non-VA providers through the use of the Nationwide Health Information Network.

Another innovative approach that has been piloted uses text messaging to help veterans send their home-based blood pressure readings to their clinicians. Researchers found that veterans who use this method achieve their blood pressure goals 2 weeks sooner than those using other methods.

My HealtheVet is another example of technology at work. It offers veterans access to the personal health record anytime anywhere. Veterans access My HealtheVet through an Internet-based, secure, and convenient portal that allows veterans to renew and refill prescriptions online, review medical information, self-report their clinical data, schedule and view appointments, and view wellness reminders. ORH will ensure that My HealtheVet meets the needs of rural veterans and directly supports their care.

My colleague Dr. Darkins will discuss the important

role that telehealth plays in harnessing technology for improved access for rural veterans as well.

Mr. Chairman and Committee members, the VA's Office of Rural Health is working with every available partner to coordinate and support programs aimed at increasing access for veterans in rural and highly rural communities. Let me conclude by assuring you that we share your passion for this effort, and we are prepared to address any questions that you may have.

[The prepared statement of Ms. Hawthorne follows:]

Chairman Akaka. Thank you. Thank you very much, Ms. Hawthorne.

Now we will hear from Dr. Darkins.

STATEMENT OF ADAM DARKINS, M.D., CHIEF CONSULTANT FOR CARE COORDINATION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. Darkins. Aloha, Mr. Chairman. Thank you very much for the opportunity to be here and to the Committee for highlighting the issues related to delivering care to veterans in rural areas. It is a privilege to work for the VA and to be involved in addressing those problems, and using telehealth to do so.

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

Chairman Akaka. It will be included in the record.

Dr. Darkins. Thank you.

Telehealth uses information and telecommunications technologies to support clinical care where a patient and practitioner are separated by geographical distance. It increases access to specialist services and reduces both patient and provider's travel, thereby reducing one of the major barriers to care in rural areas, where recruiting of health care professionals can be problematic.

However, I should just say at the beginning that telehealth is not a panacea in the sense that there are obligate needs for face-to-face delivery of services, and telehealth has to fit into a spectrum of proper care

requirements in any particular locality. But it can fit into that when the requirements are met for safe, effective, and efficient care when we address the clinical technology and also the business processes associated with telehealth.

The cost and complexity of managing chronic disease in rural areas challenges all health care organizations--hence, telehealth's focus on these conditions in VA. VA's vision for telehealth is providing veteran patients with the right care in the right place and at the right time. The VA goal is to make the home the preferred place of care wherever this is possible to do so. And in order to achieve this, VA has established three enterprise-wide telehealth programs that serve veterans in urban, rural, and in highly rural locations, as well as the special circumstances of addressing the challenges for American Indian/Alaskan Native and Hawaiian Native and Pacific Islander communities. VA has seven telehealth programs supporting these various communities, and further deployments are in progress to serve 15 more tribes.

The first enterprise program that I would like to cover is Care Coordination/Home Telehealth, or CCHT. This uses a national VA telehealth technology platform that collects vital sign data, disease management responses, and conducts video consultations into the home. This platform supports standardized clinical processes that care currently for

36,400 veteran patients, 20,000 of whom are receiving non-institutional care. Thirty-eight percent of these patients are in rural areas and 2 percent are in highly rural areas--proportions that show now urban bias in the deployment of this technology. CCHT data shows a 25-percent reduction in hospital stays and a 19-percent reduction in hospital admissions, a 50-percent reduction in highly rural areas, and 17 percent in rural areas associated with the use of this technology. These services are provided from 140 VA medical facilities and 28 rural or highly rural clinics.

The second program I want to mention is Care Coordination/General Telehealth. It is another enterprise program that uses clinical videoconferencing systems to deliver services between VA Medical Centers and community-based outpatient clinics. In fiscal year 2008, over 48,000 veterans received these services, covering 35 clinical specialties, mainly mental health, of which 29,000 received this care. These services are provided to 171 sites in rural or highly rural areas.

Patients receive their tele-mental health care as part of VA's mental health universal service care plan, which is certainly addressing what was mentioned about primary care delivery of these services and the importance of that. And they have shown a 24.6-percent reduction in hospital admissions and a 24.4-percent reduction in bed days of care,

which is really associated with people achieving care more rapidly and reducing the need for travel to care.

VA has established a Polytrauma Telehealth Network in fiscal year 2007 which links VA's polytrauma sites of care and links them back also to Walter Reed Army Medical Center and Bethesda Naval Hospital. In fiscal year 2009, we are planning to expand this network into a national infrastructure, which we are calling the Clinical Enterprise Videoconference Network. The intent of this is ultimately to lead to any site being able to connect to any site for the delivery of care.

We are also establishing a national tele-mental health center for the delivery of specialist mental health services via this network, and we will seek to address particularly issues in rural delivery of care.

The third enterprise program I want to mention is that of Care Coordination/Store-and-Forwards. It involves capture and storage of digital images for patients' transmission to health care providers to report. Twenty percent of the veteran patient population receiving health care has diabetes, and this program screens for diabetic eye disease. Last year, 98,000 veteran patients received this care and helped prevent avoidable blindness by doing so. In addition to this, we are expanding this area into areas of tele-dermatology.

VA is training staff to use telehealth technologies and adherence to the associated clinical and business processes. We have three designated telehealth training centers: one in Lake City in Florida, a second in Salt Lake City in Utah, and a third which is in Boston, Massachusetts. These centers have trained over 6,000 staff to provide VA with a tele-mental health competent workforce. The associated training curricula are standardized and utilize virtual training modalities wherever possible.

VA has an internal system in place that assesses the quality and consistency of its telehealth programs that is conducted biannually in each one of the VISNs. A fundamental underpinning for all areas of telehealth we are implementing is the use of our VA electronic health record.

In closing, I would like to recognize the VA staff that develops these groundbreaking services. Our staff is driven by a commitment to support independence of the veterans we serve in all locations by providing access to high-quality care. The successful marriage of people and technology that I have just described is enabling VA to sustain a rapid pace of telehealth expansion and makes us a recognized leader in the field.

Mr. Chairman, that concludes my prepared statement. I would like to take the opportunity to demonstrate this technology to you at an appropriate future time, and I am

now pleased to answer any questions that you may have.

[The prepared statement of Dr. Darkins follows:]

Senator Murray. [Presiding.] Thank you very much to both of you for your testimony. We do have members coming back and forth. I will ask a couple questions and turn it over to Senator Burr.

I think you talked a lot about telehealth, the importance of that, but I was really disappointed to learn from the staff of this Committee that telehealth use is actually decreasing in a lot of our rural communities, and a lot of that is attributed to lack of space or trained personnel. Can you comment, Dr. Darkins, on how the VA is overseeing these programs so that they are utilized?

Dr. Darkins. Certainly, bringing these programs together depends on having the clinical staff. It also requires the facilities to do it and the telecommunications bandwidth. We are expanding these enterprise programs as we are doing so, making sure that these requirements are taken into consideration.

The enterprise programs that we are rolling out are taking over in many cases from previous pilot programs that did not have this kind of infrastructure to back them.

Senator Murray. Do you have the resources to do this?

Dr. Darkins. I believe there are. These decisions are made at a local level, and what we are seeing is transition of services which was previously delivered face to face and now are being used to deliver services via telehealth.

These decisions are made very much at a local level in bringing those requirements together.

Senator Murray. I am told that a lot of the health care providers who use telemedicine to deliver telehealth have to be credentialed and privileged at each and every facility that gets the care as well as the site that the provider provides the service. Can you help me understand whether this credentialing or servicing presents a challenge to our ability to--

Dr. Darkins. It certainly does so. It does for us in VA as it does for all health care organizations providing telehealth services. VA has a benefit in terms of licensure for a VA practitioner allows them to cross State lines, which is a benefit we have above those in private sector organizations. However, one of the requirements that we as all providers face is that staff need to be credentialed at sites delivering care, and in many cases have to be privileged.

Senator Murray. So this is a real challenge.

Dr. Darkins. It is a challenge because there is an administrative burden, particularly in some of those rural sites, where there may be quite a turnover of staff. And we are seeking ways that we can address this actively because of the burden to delivering services.

Senator Murray. All right. And then very quickly--and

I have to leave to vote--Ms. Hawthorne, the VA IG's May 2007 assessment of VHA's Suicide Prevention Initiative said that some of the data suggested that we are seeing higher suicide rates in rural areas. Are we seeing that among the veterans population as well?

Ms. Hawthorne. I am not the expert in this subject matter area, but I would like to take that question for the record so I could provide you a more accurate one.

Senator Murray. If you could, because I am concerned about whether or not that is accurate, and if it is, what we are doing to do outreach and better access for our soldiers in more rural areas.

[The information follows:]

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Senator Murray. I am going to turn it over to Senator Burr for his questions, and thank you very much.

Senator Burr. Thanks, Senator Murray. I am only going to ask one, and then I am going to turn it to Senator Tester, and I am going to go vote, and I will save the majority of my time for me to come back. I just want to try to clarify a question you were asked and how you answered, and it dealt with the credentialing issue. Credentialing, as I understand it, is one's ability to practice a particular specialty. Am I correct?

Dr. Darkins. Credentialing verifies that the qualifications of a practitioner are indeed the qualifications that they have. So it is a way to check their licensure, their professional training.

Senator Burr. But we do not

Dr. Darkins. We don't have a licensing issue because it is not like telemedicine in the private sector where, if you are not licensed in the State you are delivering the service into, you have got a problem.

Dr. Darkins. We do not have a licensing issue in terms of licensing being used across State lines. However, one of the things I ought to point out is that it is important to ensure that a practitioner is indeed licensed to provide the services they can. Credentialing makes sure that the person you are seeing in front--ensures the patient the person you

are seeing in front of you is indeed competent to deliver the care.

VA has a national system called VetPro, which is very beneficial. So credentialing is less of a problem for us.

Senator Burr. I will get into more of this when I get back. I am going to turn it over to the Chairman so I can go vote.

Chairman Akaka. [Presiding.] Senator Tester?

Senator Tester. Yes, thank you, Mr. Chairman, and I apologize for not being able to hear all of your testimony. I think I got most of yours, Ms. Hawthorne, and if questions were asked previously along the same lines I am asking, I apologize ahead of time.

I am curious to start out with--as I was reading over your testimony, Ms. Hawthorne, you said that--and these are just the rurals, but highly rural areas are seven people per square mile or less, and that 2 percent of the veterans live in those kind of areas. Did you do anything differently for folks that live in the highly rural areas--and that could go to either one of you--over folks who live in rural areas or urban areas?

Ms. Hawthorne. Veterans who live in highly rural areas obviously have some unique challenges that neither their urban nor rural counterparts have. So as far as delivery of care, we are looking at specific ways that we can increase

that, and we will be leveraging some of the same service modes, such as telehealth. But we are also looking at partnering with our community providers to see if this is an appropriate way to expand care in those highly rural areas, as well as mobile clinics. Could this be another opportunity to get into those more remote and highly rural areas? And then outreach clinics are a little less feasible, but, again, partnering with our community providers, we may be able to expand access in that way as well.

Senator Tester. Have you started those endeavors yet as far as partnering up with folks? Is that actually happening in the highly rural areas yet?

Ms. Hawthorne. We have initiated a pilot project for mobile vans and have four. One is currently operational; the other three they have purchased the equipment and hope to be within operation in a few months.

As far as partnering with the communities, we are actively engaged in seeking out ways to do this. We recognize, though, that continuity of care is very important. So before we move forward, we want to address all the quality issues, ensure that we are measuring properly, so that we can make a determination that our veterans are receiving the highest quality of care.

Senator Tester. Okay. Speaking from a mental health

perspective, in rural or highly rural areas where, for instance, in eastern Montana right now I do not think we have got a mental health professional east of Billings, Montana, and there are several hundred miles east of Billings, Montana, before you hit the North Dakota line.

If you partner with primary care settings and it is a mental health issue, how is that handled?

Ms. Hawthorne. If I could first share with you that my background is of a clinical social worker, so I am very aware of mental health issues. I have directly worked with the mental health population.

Senator Tester. That is good.

Ms. Hawthorne. And, again, continuity of care is extremely important, even more so in this case. So if we work with non-VA providers, we have to have to ensure that the VA clinicians are getting their medical records and that there is proper case management following up with their care, and that the points, the control points to ensure that if care is exasperated and needs a higher level of care, that we have in place a method to ensure that that happens.

Senator Tester. I do not have an answer to this question. Most questions you ask you have an answer for, but I do not. So you have got a situation where the nearest mental health professional is several hours away, maybe as far as 8 hours away; and you have got a person that is ready

to commit suicide. They have called the hotline, and there is no doubt about it, we have got a problem. How is that handled? Either one of you can speak to that. That would be fine with me.

Ms. Hawthorne. I will have to take that question for the record because our Office of Mental Health Services is actually coordinating the suicide prevention hotline, and I am sure that they have some things in place that would address that question.

Senator Tester. Okay.

[The information follows:]

/ COMMITTEE INSERT

Dr. Darkins. Again, I think obviously it depends, services being local, exactly what--for the particular situation. But as an extreme urgency for the VA, as you know, everything the VA is currently doing is very much aimed in mental health services towards addressing those kinds of issues. From my particular remit, I can give you the issues around the use of tele-mental health, which, as I say, is not a panacea. In some sense, in some cases it is possible to use telehealth for those kind of urgent interventions. It is also possible to use telehealth directly into the home to be able to obviate people getting into that circumstance.

Connection with local services and the ability to access local--so telehealth fits into those wide areas of care, and the VA's universal service plan for mental health, other work in mental health is certainly aimed at addressing those issues.

From my point of view and my particular expertise, telehealth can lend a hand, can be useful in some of those circumstances, but certainly is part of that continuum of services that need to be provided to help that person in that kind of distress.

Senator Tester. All right. I know the VA has been hiring a bunch of folks to deal with mental health issues, to the point where I actually talked to some folks in the

private sector, and they cannot hire anybody because the VA is hiring them all. And I commend them on that, you know, making a solid attempt to address that.

Are there incentives offered to get them into rural America, into highly rural areas? Because that also is a big issue. And the conundrum is, as you are talking about, only 2 percent of the vets living in the highly rural areas, that means 98 percent live somewhere else. How big of a priority is it to get mental health professionals into those areas and are there incentives?

Ms. Hawthorne. Getting providers into rural areas is one of the primary focuses of the Office of Rural Health and part of our core initiatives. So we are working very closely with the VHA program offices that oversee this. We do offer the education debt reduction and other services currently, and we are initiating some new, innovative recruiting methods as well. Specifically, 3RNet seeks rural providers, and we have teamed up with them.

Also, the Office of Rural Health is working with our Office of Academic Affiliations, and we are looking at how we can expand physician residency into rural areas, knowing that when providers train in rural areas, they are more likely to stay in rural areas.

Senator Tester. What about the highly rural areas? Are we doing anything different from rural areas as far as

getting people into them?

Ms. Hawthorne. Not specifically at this time.

Senator Tester. Do you think there should be something done?

Ms. Hawthorne. I cannot answer that directly right now. I think they are two very tough populations. It is even more difficult in the highly rural areas because you are less likely to have the academic affiliations and the resources to--

Senator Tester. Thank you very much. I will check off. If there is another round, I have got some more. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Tester.

Senator Begich?

Senator Begich. Thank you very much, Mr. Chairman, and I apologize we had to slip out there. But I am looking at the testimony--Dr. Darkins, I think this is from you--in regards to the VA telehealth programs extended, and you talk about the Indian/Alaska Native community, the Hawaiian community, Alaska. Can you just expand a little bit on that? Then I have some specific questions. But can you expand on how you see that working or how that has been working, and what kind of volume of response? I am not sure who could answer that, but I saw it in your testimony, but I would look to both of you.

Dr. Darkins. Yes, I can certainly address that. There are telehealth programs in both Alaska and in Hawaii and serving the islands as well. The three enterprise programs I mentioned are all present there. There is the home telehealth programs. I think on the order of 230 patients are currently being served for home telehealth out of Anchorage. So it has become established. We also have teleretinal imaging which is taking place in Anchorage, plus the telehealth real-time videoconferencing that is taking place.

There are close associations between the VA and the other Federal agencies through the Afghan Project, which is there to be able to provide access to multiple sites throughout Alaska.

We have variations around the country in terms of how telehealth is being implemented. We have enterprise systems, as I mentioned, which are readily available to implement. We are gradually rolling forward now.

One of the salutary things about technology is that it is very much in the end down to relationships, so what we are finding is extending the use of this technology is very much around relationships--relationships between individual clinicians and their patients, being comfortable on both sides doing it, but also the relationships between the Federal agencies and then working and partnering in this way

of taking it forward.

So what I would like to say is I think that the infrastructure, the various components are there to do this. Moving it forward is very much a sense of that organizational change. But as we are seeing, I certainly look back over these last 2 years, 3 years, of what has been happening in Alaska with the home telehealth, what has been happening with the teleretinal imaging, and I am seeing pleasing increases in the results with patients and would hope to look forward to that being even more rapid.

If there are any suggestions either from yourself or other members of the Committee that you think things that we can do to address--things for your population or for the population of the Hawaiian Islands, then that is certainly a huge priority for us. Given what we are addressing, given what we have heard of returning military, to go the extra mile to be able to serve those people, we will do anything that is necessary.

Senator Begich. Great, because as we talk about rural, you know, and you talk about drive miles, they are not drive miles in Alaska. That is why in your comment that you said about mileage versus how many miles away by road, you know, we measure by air because that is how we can get to locations. And then telemedicine in a lot of ways in Alaska, education through technology and others has been

pioneered in a lot of ways to Alaska because of the uniqueness of it, in rural communities especially, where you may have a hub that you can fly to, but you may have a village you cannot get to because of weather conditions as well as many other factors. I absolutely will look at some ideas we would like to pass on to you.

I do not know which of you would answer this, but in regards to the extensive Native medical care system that we have in Alaska that is continuing to be developed, and we announced Monday there will be a facility in Nome, Alaska, about a $150 million facility starting construction this year, again, offering enormous quality health care. How can we--and I know you have a couple partnerships you are in the midst of trying to develop, and there is some lag time on that. But it just seems so logical--and I know Senator Tester and I have talked about this when I had him up in Alaska. That is, to allow these veterans--because we do not have a VA hospital in Alaska. Why not just allow the veterans to utilize the services of any hub medical facility--in this case, Native Hospital, which is run by a consortium of Native tribes, but also is funded by a Federal agency anyway. It is all Federal money. So why not figure out a way that that system can be utilized much more aggressively than just a couple pilots, but just use them and then VA reimburse.

I know there is an argument that, well, VA does not have a budget line for that, and then there is this other argument. But building a hospital would be a huge expense, but yet we have these beautiful hospitals, the clinics being built all throughout Alaska.

I do not know who can answer that, and I know there are one or two--I cannot remember which ones right off the bat, but pilots that you are looking at. But it just seems for an Alaskan veteran who lives in a village like Kwethluk and has to spend $1,500 in airline tickets to get to a location and then know they have to go back there is not a very good way to deliver health care.

Dr. Darkins. Soon after I joined the VA, I went to Alaska, I went to Bethel and I went up river, actually saw the--

Senator Begich. Did you go in an open boat? That is the way to go.

Dr. Darkins. I did. I went in an open boat, yes.

Senator Begich. That was the test. They tested you. Very good.

Dr. Darkins. And the boatmen, when they came back--

[Laughter.]

Senator Begich. That is the test. He survived. Good.

Dr. Darkins. When the boatmen came back, they took us for some salmon strips in the shed. But it was possible to

see exactly as you describe the tremendous health needs throughout there, and I was enormously impressed to see how locally it is possible to deliver through the health aides the care that is taking place.

There are already, I know, really good relationships for certain services between the VA and the DOD and the Indian Health Service where they do share relationships, and Senator Burris mentioned in North Chicago the relationship that is taking place there and how that is growing. So I think there are models of both how it is being done, and I think things like North Chicago show the way forward for how it can be done further.

It is somewhat outside my remit or my piece of the world to be able to say overall, but I think certainly there is encouragement in ways in which, exactly as you say, it is going forward, and it is a very high priority for VA.

Senator Begich. Very good. Thank you.

Ms. Hawthorne, did you have anything?

Ms. Hawthorne. I would like to follow by saying we also recognize that leveraging our community partners and the infrastructure already in rural areas is a direction that we do need to consider.

I would like to point out that our Veterans Rural Health Resource Center, based out of Salt Lake City, has developed infrastructure to specifically look at these

populations, and we are looking at it from a policy perspective and also testing out ideas. So we have some pilots and those are going well, but we hope to take those pilots eventually that are successful and distribute them through the larger health care system.

Senator Begich. Very good. I will leave it at that for now, Mr. Chairman. Thank you very much.

Chairman Akaka. Thank you very much.

Now let me call on Senator Burris for his questions.

Senator Burris. Thank you, Mr. Chairman.

Dr. Darkins, how does telehealth facilitate the care if an issue is discovered in the teleconsultation that requires a veteran to seek direct care? How does that telecare operate?

Dr. Darkins. It addresses a lot--there are two pieces to delivery of health care. There is a direct delivery of care itself, which is often hands-on in terms of being able to intervene, to be able to diagnose, to be face to face with a patient. The second piece is to be able to make sure the right patient has got to the right place at the right time. So there is a piece about health care decisionmaking and then the actions associated with it.

What telehealth can do is to make sure that those health care decisions can be made as close to the patient as possible, so let me give you a hypothetical case.

You have the situation where somebody has had a stroke. Having had a stroke, the issue is what should be done. What kind of urgent treatment might be used to be able to help that person and make sure that they get the maximum chance of success and survival? So the ability of telehealth is to be able to take a specialist who might be elsewhere and to be able to help address in primary care or even in a smaller community hospital, so you can get absolute special expertise right to where that decision needs to take place. And often having that kind of decisionmaking in the acute stage can make the difference between life or death to somebody. So telehealth is something really--so that is in the very acute stage.

We manage, as I said, 36,700 patients. I mentioned the reduction in travel times--sorry, the reduction in hospital admissions. What we are doing is instead of somebody having to come who may have chronic heart failure along to the hospital regularly for outpatient treatments, where there is the travel, there are the wait times, et cetera, what we are doing is monitoring them on a daily basis, so if they start to get into trouble, so if their weight starts to go up, if they start to get symptomatic, such as breathless--

Senator Burris. Or blood pressure going up, yes.

Dr. Darkins. Yes. What we can do is contact them. Usually a nurse will contact them by telephone, can adjust

their medications under orders they have been given, and can actually prevent their deterioration.

So telehealth is very much about changing the location of decisionmaking, also trying to stop people getting into trouble, supporting their own understanding or their own health care and self-management.

Senator Burris. Thank you very much.

Ms. Hawthorne, what are we doing to make community providers more willing to treat vets on a fee basis? I am aware that many vets are not being reimbursed and providers are only receiving a percentage of the payments. Can you help me out there?

Ms. Hawthorne. I cannot speak to specifics of the fee basis program, but can take that back for an answer.

Senator Burris. Okay, please.

[The information follows:]

/ COMMITTEE INSERT

Ms. Hawthorne. I would like to point out that Office of Rural Health is looking at, though, when we engage in contracts, how we can best ensure that our providers are willing to work with us by making contracts amenable to both parties and ensuring that there are quality standards within those contracts.

Senator Burris. Because pretty soon even the rural doctors will not come to these communities because of the low ability to get any type of compensation, and then if they cannot get compensated for their reasonable services, it is going to make it even harder for them to do it if they cannot even get it on a fee basis.

Ms. Hawthorne. Correct.

Senator Burris. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Burris.

A consistent question has been are we meeting the needs of our veterans. VA is spending billions of dollars buying care in the community, and Congress appropriated another quarter billion dollars for specific rural health care and projects as well.

Given all of this effort and funding, my question to both you: Are we meeting the needs of rural veterans? Ms. Hawthorne?

Ms. Hawthorne. Thank you. As I stated, increasing access to good quality health care is going to be--is the

focus of the Office of Rural Health and is how we will meet the needs. So I believe we are meeting the needs of our rural veterans. We, of course, can always improve and look to the Committee and to you, Mr. Chairman, for ideas on how to do that. But for now we are proceeding to develop new innovative ideas that are going to address the uniqueness of the rural and the high rural populations, and we will continue to focus on that as we move forward.

Chairman Akaka. Dr. Darkins?

Dr. Darkins. From the perspective of the services I am responsible for, telehealth services, I believe we are. I believe we are on a trajectory to increasingly do so. My evidence for saying that really is the expansion that we are seeing in rural areas, seeing the home telehealth growth in rural areas, seeing the services delivering out to rural locations. Our plans are to expand this, both expand in terms of numbers, but also expand in terms of the breadth of it.

The delivery of specialist care, expanding that scope of specialist care delivery I think is something we can increasingly do more of. I think the needs of rural patients is something all health care organizations have problems with, and everybody could do more. I certainly believe in telehealth. With the developments we are making and the trajectory we're on, we will be able to increasingly

meet the needs that you have addressed.

Chairman Akaka. Yes. Well, no question telehealth services need expansion.

Dr. Darkins, in my State of Hawaii, we still have VA operations lacking telemedicine equipment, namely, on the island of Molokai. As you know, Hawaii has separate islands. Is this just an isolated instance, or are there other VA spots where the equipment has not been purchased?

Dr. Darkins. There are certainly sites in the VA where there is not equipment which is there currently. The equipment, as I mentioned before, is only part of the equation. So having the equipment does not guarantee the service is going to be provided. So the issues that we face as we roll out these programs around the country is the sites at which care has to take place must be private and have sufficient space for the patient to be able to have a consultation conducted with privacy and those concerns taken care of. There needs to be the telecommunications bandwidth.

Also, crucially, as I mentioned, it is about relationships. It really has to be that there are clinicians at the local sites and the services to be able to be provided.

So I can't, my apologies, comment on one individual site, but this tends to be the reason why we are not seeing

necessarily something in every single site. Having equipment which is there but not functioning equally well is not what I would like to see either. My goal and what we are pushing towards is that we get all three pieces of this equation: the clinical service delivery, the right environment for the patient to be able to have the care, and the equipment to be able to do so.

Chairman Akaka. Ms. Hawthorne, quality assurance is always a goal of VA. How can VA be sure that the non-VA doctors who see veterans in the community know how to treat combat-related illnesses like PTSD?

Ms. Hawthorne. I would like to address that first at the broader level. It is important for us to ensure that veterans receiving non-VA care are getting the top quality for all services. So when we partner with non-VA providers, we are implementing a set of core quality measures that the VA is looking at. We are working with the Office of Quality and Performance to identify outcome measures so we will know specifically if they are providing adequate care or not based on these measures.

Regarding PTSD and other mental health services, likely the same with Office of Rural Health, the Office of Mental Health Services has specific outcome measures that they look at to ensure that care is being provided as the VA sees fit

Chairman Akaka. Thank you. I am going to start on a

second round and ask Senator Burr for any more questions.

Senator Burr. Thank you, Mr. Chairman. I would just point out to the Chairman I cheated myself on the first round, so I may go over.

I want to go back to the telemedicine issue, Doctor, just real quick for the purposes of trying to sort this out for all the members.

The Asheville VA Hospital, as an example, services a population out of Tennessee. Today, if telemedicine is done out of Asheville and they monitor a Tennessee patient, that doctor, not licensed in Tennessee, licensed somewhere, enters the VA system, has no trouble with providing that service in Tennessee, though he is physically in North Carolina. Correct?

Dr. Darkins. From the point of legality, he or she can practice across State lines absolutely with their licensure. However, in order to do so, there are still requirements that regulatory bodies require. One of those requirements is that in Tennessee, it is necessary to check the credentials. So, in other words, to safeguard the patient, it is necessary to make sure that that physician who is in North Carolina indeed has his or her medical license, has got the professional training to be able to deliver those services. That is a requirement for VA, as other organizations.

In addition to that, there is a second piece which needs to be done, which is that there are two pieces to the competency of a clinician: firstly is what you can do by virtue of your training; and, secondly, the environment is right to do it in.

So to give you an example of a cardiac surgeon, somebody may be a fully licensed, professionally trained cardiac surgeon whose credentials are fully up to date and there is no issue with their practice. However, he or she would not be able to practice in a small hospital which did not have access to the necessary support to provide cardiac surgery. So that privilege is somebody at the site, so it is something related to the site.

Senator Burr. I agree. It is more of a privileging issue that you are talking about.

Dr. Darkins. It is a privileging issue. So because of that privileging issue that relates back to the physical delivery of services, it is necessary for us to privilege at these various sites, and that is a considerable administrative burden in terms of establishing these services, particularly as we look towards what we would like to see in the future is establishing national services.

Let me give you the hypothetical example of a woman veteran who is pregnant who is on antipsychotic medication. The ability to be able to provide access to expertise that

is very specialized is something that potentially could be done around the country. However, determining the site at which the person is going to be and the site it is going to be delivered and making sure all that privileging is done is a logistic issue I hope I have well enough described.

Senator Burr. You have, and it is the point I wanted to make for the members. If we want the ideal, most efficient, highest quality of the delivery of care utilizing telemedicine, then we have got some barriers to overcome. And it should be of great interest to us to help try to facilitate that in a way that assures us of the high quality.

Let me, if I could, take the services provided in telemedicine and group three in a category: congestive heart failure, diabetes, and blood pressure monitoring. Share with me today, of the services we provide through telemedicine, what percentage do those three health conditions make up, and what makes up the rest?

Dr. Darkins. I mentioned the three areas of health care delivery enterprise systems: the home telehealth, the videoconferencing between clinic and hospital, and the store and forward--the taking of digital images to share.

For the home telehealth, about two-thirds are taken up by the conditions that you mentioned. These are supporting people with chronic conditions in their own homes. It

provides non-institutional care, is helping veterans live in their own homes who would otherwise be potentially in nursing home care. So a very high focus on those high areas of need which are very expensive, as you know.

In terms of videoconferencing, the major area we are doing videoconferencing between rural sites is mental health and is rehabilitation. We are moving towards doing more in those areas of congestive heart failure, but our concentration has been much more in this proactive approach with home telehealth. And I mentioned for diabetes, 20 percent of the veteran population we serve has diabetes that have seen the Veterans Health Administration, and so diabetic retinopathy screening, preventing avoidable blindness, is a very high priority.

So mainly the home telehealth and the store and forward, but certainly an increasing amount we are going to see specialist care being delivered by these services as well.

Senator Burr. In your testimony on page 2, you said, "Currently over 140 VA medical centers provide"--telemedicine--"CCHT"--

Dr. Darkins. Yes.

Senator Burr. --"in addition to 28 clinics located in rural and highly rural areas." Can I interpret that to mean that of those 28 clinics, they actually initiate the

telehealth from that clinic, or are you referring to that clinic is a service point for one of the medical centers?

Dr. Darkins. They initiate care from that clinic.

Senator Burr. So they would do home telehealth from that rural clinic.

Dr. Darkins. They do.

Senator Burr. Okay.

Dr. Darkins. There is no requirement--sorry, the 140 medical centers I mentioned, they can deliver services hundreds of miles from the medical center. So the fact they are in VA Medical Centers does not mean, by any means, they are not delivering rural services. There are logistic issues around issuing the technology, refurbishment of the technology, that make it easier at the moment to do so from a medical center. However, in terms of expanding these services, what we have been doing is looking towards also making them available from local clinics such as I mentioned.

In some instances, patients travel to the hospital or to the clinic to be enrolled in the program and get the technology. In other instances, the staff go out to the patient home. But certainly it is something that has been very pleasing for us to see what we thought was going to be more difficult, to go into clinic settings, has been rolling into the clinic settings in rural and highly rural areas,

and something I am encouraging and want to push very much more for.

Senator Burr. Let me just turn to Ms. Hawthorne for one question. Last year's legislation that was enacted directed the VA to establish a pilot program for collaboration with non-VA providers to deliver health care services to veterans specifically in rural areas. Just real quickly, are these programs fully underway? And what, if any, obstacles to timely implementation have we run into?

Ms. Hawthorne. Sure, good question. The Office of Rural Health has always had the vision to partner with community providers, so we welcome this piece of legislation to facilitate this.

We took swift action in developing an implementation plan to execute this pilot, and we will be ready to present that at the end of April. And we are still dealing with two technical issues right now. One is the statutes definition of "highly rural" differs from ours. And the second is a regulatory issue with the definition of "hardship." Once those two issues are resolved, I am going to be happy to work with the Chairman and the Committee members on that, and we will be able to promptly move forward.

Senator Burr. Thank you very much.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Burr.

Senator Tester?

Senator Tester. Real quick, just kind of dovetailing off of Senator Burr's question, in areas that you are going to contract with local communities, how do you envision accuracy of medical records when the health care is being provided by those local folks?

Ms. Hawthorne. When we identify the areas to specifically partner with, we will be working at the local level to execute this, so the VISNs will help to identify the providers, and they will also be working to ensure that the medical records come back to the VA. And we will be asking them to use our electronic medical health records, and this will ensure the continuity of care and ensure that we do get a copy of the encounters.

Senator Tester. As you implement this program, has there been any resistance from the hospital using the VA's medical records, the electronic version?

Ms. Hawthorne. At this point in our implementation, we have not contacted individual providers.

Senator Tester. Okay.

Senator Burr. Could I ask one question?

Senator Tester. Sure.

Senator Burr. Where we have used non-VA contractors, which we currently do, part of the contracts, as I understand it, is a requirement that those records be

supplied to the VA and electronically supplied. Am I right?

Ms. Hawthorne. Correct.

Senator Burr. So currently that is in place where we are using it.

Senator Tester. Yes. I just did not know if there was resistance to that. There should not be, but one never knows.

Senator Burr. It is part of the contract.

Senator Tester. Right. Exactly.

One more question deals around mental health issues, and I guess the question is: Are there plans or how do you see us increasing mental health crisis beds to be available within a reasonable driving time? Or is that an issue you have talked about?

Ms. Hawthorne. Increasing the availability of mental health inpatient beds is not something that I have worked with the Office of Mental Health Services on, and so I will be happy to go back and address that question with them.

Senator Tester. That would be good. All right. Thank you.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you, Senator Tester.

Now let me call on Senator Johanns for your questions.

Senator Johanns. Senator, thank you.

If I could just follow up on questions by Senator Burr,

I have very high hopes for this pilot program, because there is, in some cases, at least, capacity in rural areas, in some areas. And it just seems to me that it would be a natural.

But recognizing the difficulty of trying to match the VA system with that local hospital or medical provider in terms of the electronic system, how big of an impediment do you think that will be? Because they cannot all have the system that would interconnect. And is that holding us back?

Ms. Hawthorne. I do not believe it is holding us back because we already do it.

Senator Johanns. Okay.

Ms. Hawthorne. So there are methods for the non-VA providers to link into our system without having full access to the entire medical records.

So to directly answer your question, no, I do not believe that will be an impediment, but it is something that we will, of course, have to address and be tracking.

Senator Johanns. Then if I might follow up on a question by Senator Tester, I appreciate his question about mental health services, because I suspect in his State we have identical problems, just a lack of services in the rural areas, just in some rural areas just a complete lack of services. It is hard to get a psychiatrist to go to

rural areas, et cetera, et cetera.

Any idea on a novel approach? Because many veterans desperately need these services. They come home, they go back to the ranch or the farm, and all of a sudden things are falling apart for them. How do we deal with that?

Ms. Hawthorne. You have identified a very real problem, and we have done some analysis looking at highly rural areas, and what you stated is exactly the fact. There are not always the non-VA providers to even fee out to or contract with.

Senator Johanns. Right.

Ms. Hawthorne. So we are looking at--well, telehealth is obviously one of the major ways we are going to increase access to those veterans. We are also looking at other methods, such as using the telephone lines for care management. And we will have to be even more creative in identifying other methods and look to you if you have any ideas you would like to share.

Senator Johanns. I will just offer this thought: Telemedicine is a big resource here. It is an interesting thing. For example, on counseling services, people do not seem to be bothered communicating through that television set. And that offers at least the possibility to connect somebody in a very rural area with somebody in an urban area and, again, provide counseling services. I have seen it at

work.

Many hospitals now do have telemedicine. Do you see an opportunity to contract into that hospital, for example, using their telemedicine services if we do not have those services out in the rural area?

Dr. Darkins. Perhaps I could comment on that. Certainly, VA has a very extensive experience in delivery of tele-mental health. The area you mentioned of counseling is extensively done throughout VA, not only in terms of individual counseling of patients, but as opposed to in terms of group counseling and group therapy, which is possible to do in locations. Also, treatment of PTSD, depression, and treatment of psychosis is all routinely done now. Not only is it done between hospital and smaller hospital, hospital and clinic, it is also being done directly into the patient's home. So the VA has a very extensive experience of that.

We are working very closely in terms of addressing these issues because telehealth is--it can provide part of the solution, but what it has to do is to fit into how you crisis manage, how you fit into that wider spectrum of care. And, therefore, I work enormously closely with my colleague Dr. Katz in the Office of Mental Health Services.

VA has made incredible strides, I believe, over the last few years in terms of becoming really a model that

other organization are looking to about the kinds of innovative approach delivering care that you have just mentioned. So we have been looking towards how we move telehealth into rural areas, how we use it in the context of also physical bases of services.

You asked about doing it with other organizations. Yes, that is possible. There are difficulties in terms of not having a really robust contracting system for telehealth in the world outside. There are issues about exchange of health information. There are privacy issues in terms of linking onto networks, and there are just, again, those barriers to delivery of care, something which we are very well aware of working actively and hard to do. So it is really not for the want of either enthusiasm or wish, but just as we work through those details to make it happen. And, again, we would be very glad for any suggestions from either yourself or other members of the Committee on how you think we might address this more.

Senator Johanns. I am out of time, but I will just wrap up with a suggestion. Having dealt with many of these issues as a Governor, one thing I would recommend--and I suspect you are doing it already--is to reach out to the Chief Medical Officer in the State. Every State would have one. The public health network, some States have better networks than others, but it is probably going to exist to

some degree in every State, just simply because they are traveling the same road you are. They are trying to figure this out, how do we get services out into rural areas, how do we deal with these very same issues. It could be a great partnership, certainly would be a resource that I would urge you to tap into. So thank you.

Chairman Akaka. Thank you, Senator Johanns.

Senator Johanns. Thank you, Mr. Chairman.

Chairman Akaka. Senator Burris, for any second-round questions?

Senator Burris. I am fine, Mr. Chairman. I am listening and learning. Thank you.

Chairman Akaka. Thank you. I will submit my questions for the record and dismiss the first panel.

[The questions of Chairman Akaka follow:]

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Chairman Akaka. Thank you very much for your responses. You have been very helpful this morning.

Dr. Darkins. Thank you very much.

Chairman Akaka. Now let me call on the second panel. I welcome our second panel of witnesses to today's hearing.

We will hear first from Reverend Ricardo Flippin, a community leader on the front lines, describing the health problems of our veterans who live in rural areas.

Then we have Alan Watson, who is Chief Executive Officer of two rural hospitals. He will described some of the challenges in providing hospital care for veterans in communities where there are no VA hospitals.

And next we will have Tom Loftus, Commander of an American Legion Post. Commander Loftus will tell the Committee about the problems that our veterans face when they are trying to obtain outpatient care in communities without a VA clinic.

Finally, Matt Kuntz, Executive Director of the Montana Chapter of the National Alliance on Mental Illness, will share information on the particular problems faced by veterans with mental illness who need to obtain care in a rural community.

Thank you all for joining us today. Your full statements will appear in the record.

Reverend Flippin, will you please begin?

STATEMENT OF REVEREND RICARDO C. FLIPPIN, PROJECT COORDINATOR, WEST VIRGINIA COUNCIL OF CHURCHES, CARE-NET: CARING BEYOND THE YELLOW RIBBON

Rev. Flippin. Chairman Akaka, Ranking Member Burr in absentia, and members of the Senate Committee on Veterans' Affairs, thank you for the honor and the opportunity to speak to you today about the health care needs of our rural veterans.

My name is Reverend Ricardo Flippin from Charleston, West Virginia. I represent CARE-NET: Caring Beyond the Yellow Ribbon, a project of the West Virginia Council of Churches funded by the Claude Worthington Foundation and the Attorney General Office of the State of West Virginia.

The State of West Virginia supports a military complex of Army and Air National Guard, Army and Air Reserve Components, plus Navy and Marine Reserve Units. Many of our soldiers in these units are serving their second or third tour of duty in Iraq or Afghanistan.

Unlike the regular active army member who returns to a permanent base with medical clinics, surrounded by other soldiers and soldier families for support, our military members--National Guard--return home to a civilian community where few understand their military experiences. West Virginia armories are scattered across the State, many hours' drive from military or veteran health care

facilities.

CARE-NET: Caring Beyond the Yellow Ribbon works to connect communities and helping professionals in the community to our returning veterans. This is particularly important in the areas without VA facilities. CARE-NET identifies the needs of the veteran and his or her family--needs like the tools to fight addiction, post-traumatic stress disorder, and traumatic brain injury, and equipping their families with the skills to cope with these invisible wounds. And then we try to match those needs with the resources in our small communities.

This is particularly important to our rural veterans. In West Virginia, more than half of our veterans live in rural areas. And we know that veterans living in those areas are more likely to suffer from PTSD or depression than our veterans in urban areas. Our researchers think the reason for this is a lack of mental health care providers in rural areas. The VA itself has done work showing that rural veterans have more serious and costly health care problems than urban veterans.

Many believe that TRICARE, the military insurance that provides veterans with 6 months of coverage after discharge, solves this problem. However, many providers in rural communities will not take TRICARE because it does not reimburse at the community rate. Then when TRICARE runs

out, our veterans must rely on the VA. Many of our community providers will not accept VA payments either. In West Virginia, this can mean that our veterans must travel for hours to get care at VA facilities.

Organizations like CARE-NET across the country are trying to connect our community resources with our returning veterans in those areas without VA hospitals or clinics. We urge the Committee and the VA to work with community health care providers and organizations like CARE-NET to use all our resources in rural communities to care for our veterans. We must reach out to our wounded veterans wherever they live and guarantee that they can get the care they need--a promise should be a promise, no matter where the service member calls home.

Thank you for this opportunity to speak on behalf of our rural veterans and their communities.

[The prepared statement of Rev. Darkins follows:]

Chairman Akaka. Thank you very much, Rev. Flippin. Now we will hear from Mr. Watson.

STATEMENT OF ALAN WATSON, CHIEF EXECUTIVE OFFICER, ST. MARY'S MEDICAL CENTER OF CAMPBELL COUNTY, LAFOLLETTE, TENNESSEE

Mr. Watson. Thank you, Chairman Akaka, Ranking Member Burr in absentia, distinguished members of this Committee. Thank you for opportunity to speak to you today about the challenges small communities encounter when providing health care to our veterans.

I am Alan Watson, Chief Executive Officer of St. Mary's Medical Center of Campbell County in LaFollette, Tennessee. St. Mary's Medical Center of Campbell County is located in a rural Appalachian community and provides 56 acute-care beds, 10 senior behavioral health beds, and 98 long term care beds. We offer a broad array of acute-care services including emergency care, general surgery, pulmonary medicine, cardiology, senior behavioral health, and imaging services.

In our county, almost one-fourth of the population is below the Federal poverty level. All of our health care providers provide care each day without the guarantee of reimbursement for that care, making it difficult for physicians to be recruited into this area. The National Health Service Corps has been a valued resource in recruiting providers; however, we still need more providers in the community.

Many of the patients that we serve on a daily basis are veterans. Thirty-five hundred veterans live in the county where our hospital is located. I would first like to say that I believe the care that veterans receive in VA facilities is excellent if they are fortunate enough to have the means to travel to those facilities or live near them. Our concerns with the VA system are not with the care it delivers to veterans within the system, but with the access to that care and continuity of care for our rural veterans.

Access to care for our veterans is limited by the distance to VA facilities and the number of providers available at those facilities. The closest outpatient clinic to LaFollette, Tennessee, is located 1 hour away in Knoxville. This clinic provides primary care, pharmacy, and limited diagnostic services. Specialist care is not available to manage the many disease processes identified in our veteran population. Veterans who require hospitalization and/or specialist care must drive to the Veterans Administration Medical Center in Mountain Home, Tennessee, a 2-1/2-hour drive. The next closest VA Medical Center is located in Murfreesboro, Tennessee, 3-1/2 hours by car.

These distances present significant challenges to our veterans considering that many cannot drive and do not have family members available to drive them to either Mountain

Home or Murfreesboro. In addition, it is reported that local ambulance services are reluctant to transport patients because payment by the VA has been denied in the past.

The second limiting factor related to care access is the low numbers of providers at the various VA clinics. Appointments are scheduled weeks and sometimes months in advance. Acute patients can "walk in." However, there is no guarantee that they will be seen that day. In many cases, the patients will be forced to seek care in our emergency department while waiting for appointments in VA clinics.

The continuity of care that is provided to our veterans is the second area of concern for our community. Problems occur related to communication between providers, long-term-care placement, and the options for homeless veterans.

First, follow-up communication between VA providers and local primary care physicians is non-existent. In addition, it is difficult to obtain records from the VA clinics regarding ancillary testing and current medication lists.

Second, it is challenging for hospitals to place patients needing long-term care. Many local long-term-care facilities are reluctant to accept VA patients due to poor reimbursement and the volumes of paperwork required. This results in longer lengths of hospitalization while placement options are being explored. It has been well documented

that longer-than-expected hospitalization stays are considered to be a patient safety issue due to the potential for exposure to hospital-acquired infections.

Third, there are no resources for homeless veterans who do not qualify for placement in long-term care but are too sick to return to the street.

I leave you with a patient care story that we have experienced in our own community.

A 50-year-old veteran entered our hospital with liver failure. He needed residential hospice care because his elderly mother could not care for him during his last days. The only options provided by the VA were transfer to the Mountain Home facility 2-1/2 hours away or admission to a local nursing home. All of our local nursing homes were either full or initially refused the patient due to payment concerns. The patient's elderly mother sat at his bedside in tears due to fear that her son would be moved to Mountain Home and she would not be with him during his death. After 13 days of hospitalization, a local nursing home finally agreed to take the patient.

Thank you for your time and concern for our veterans in rural communities.

[The prepared statement of Mr. Watson follows:]

Chairman Akaka. Thank you very much, Mr. Watson. Mr. Loftus?

STATEMENT OF THOMAS LOFTUS, COMMANDER, THE AMERICAN LEGION, POST 45, CLARKSVILLE, VIRGINIA

Mr. Loftus. Chairman Akaka, Senator Burr in absentia, and distinguished members of the Committee, thank you for the opportunity to speak today about veterans living in rural areas.

My name is Tom Loftus. I work every day with veterans living in rural areas, trying to help them find health care. I am myself a veteran, a disabled veteran, having served in the Air Force Medical Service Corps during the Vietnam era and in the Public Health Service Corps as a commissioned officer, in the National Health Service Corps, and at the community health clinics. Having left the Air Force, I was also the Chief Operating Officer of the National Health Service Corps, Region III. I was Chief Executive Officer of the Public Health Service's Occupational Health Division, and Administrator of the Occupational Medicine Department at State. More recently, I have worked with a variety of community health centers on physician recruitment, physician retention, and staffing.

What brings me here today is the situation in the community where I live, a small town in southern Virginia called Clarksville, population 1,200. The county has a population of 30,000. Prior to opening up this new command position at the American Legion, I was running a community

health service clinic in Boydton, Virginia, population 400. So I am very familiar with the issues of both where you are located and health care delivery.

Many of the issues that I have about the veterans you have already heard. Many revolve around access to health care. Our particular catchment area is in VISN 6 out of Durham. We are approximately an hour and a half to Richmond; we are an hour and a half to Durham.

The big problem is neurological problems. We are 4 hours to Salem, 3 hours to Hampton. And many of our patients who have PTSD have to go to group therapy either at Durham or in Richmond, or if they have some profound psychotic diagnoses, which a lot of them do, they have to go Hampton or Salem.

As a minimum, there should be community-based personnel who can assess post-traumatic stress disorder and traumatic brain injury, with the understanding that our veterans can get follow-up at Hampton and Salem Hospital if needed. The problem is access. Our particular part of the country has no intra-city bus service, no intra-city train service, and no airplanes. You have to fly out of Durham, which is an hour away, or you have to fly out of Richmond. So the transportation itself does not offer an easy way for veterans and family members to travel.

The second issue we have is we are part of a national

network, National Health Service Corps, and I was very impressed with Senator Burr's comment that there is dialoguing going on between the Department of Health and Human Services, the Health Resources Service Administration, and the Bureau of Primary Care, and the Indian Health Service issue that was spoken about earlier.

People forget that we have 10,000 federally qualified community health clinics in the United States. In my area alone, covering six counties, we have seven of them--seven fully equipped, very modern, well equipped. I regret to say I am losing my board-certified psychiatrist next month, and I am losing my trauma-trained counselor next month because they cannot make a living on Medicaid reimbursement. So a lot of these clinics, people should see these community health clinics as being extremely robust.

The other issue, which is not in my State but which I want to add, is women's health issues. A significant fraction of the staffing of the community health clinic are women. A significant fraction of students in medical school are women. A third of the graduates of medical school are women. So as a result, a significant fraction of women practitioners are in these community health services, and they should be utilized for veteran women health problems, because the women have just as much problem as the men--family separation, relationship problems, et cetera.

The problem with the VA is voucher services. The only people that are allowed to get a voucher from the VA now is a 100-percent disabled vet only, and it is only good for $150 to $200.

I will summarize by saying this: The simplest solution from the community health service is basically put in a terminal--VA could put a terminal into a clinic, have the passwords right there, and most of these clinics have electronic medical records. And I want to also compliment VA-Richmond and VA-Durham. They do a superb job in medical care.

Thank you, Chairman.

[The prepared statement of Mr. Loftus follows:]

Chairman Akaka. Thank you very much, Mr. Loftus. Now we will hear from Mr. Kuntz.

STATEMENT OF MATTHEW KUNTZ, EXECUTIVE DIRECTOR, MONTANA CHAPTER, NATIONAL ALLIANCE ON MENTAL ILLNESS

Mr. Kuntz. Chairman Akaka, Ranking Member Burr in absentia, and members of the Committee, as Executive Director of the Montana Chapter of the National Alliance on Mental Illness (NAMI), I appreciate your invitation to testify before this Committee. Also on behalf of the NAMI National Office, please accept NAMI's collective thanks for this opportunity.

Mr. Chairman, my formal statement submitted to the Committee included information about NAMI and its work and important issues relevant to veterans living with mental illness under VA care. In the interest of time, I am not discussing those issues, but they are policy matters that I hope you will consider.

As a proud and grateful consumer of the VA, I thank you for your work on this Committee. I also want to thank Senator Jon Tester for identifying me to your staff as a potential witness today. Senator Tester is an incredible ally in the fight to secure adequate treatment for veterans with mental illness. After my step-brother's death, I called politicians across Montana to get help on this issue. Senator Tester was the only who called me, and I cannot thank him enough for that.

For my background, I came into this position the hard way. I lost my step-brother to a PTSD-induced suicide 15 months after he returned from Iraq. It was a tragic and utterly preventable situation. I started fighting for better care 1 week after Chris' death, and I continue to this day, eventually giving up my law practice and taking over for NAMI, and I will be addressing you from that position.

Our main issue is geography. Plain and simple, Montana is the fourth biggest State in the country. We have over 147,000 square miles. That is 36 Big Islands, 3-1/22 States of Virginia, and 2 States of Washington. It is big. And we also have a high per capita need for these services. We have a high percentage of veterans. We battle Alabama for the highest illness rate in the country, and we also have the highest percentage of wartime injuries per capita, with over 22 per 100,000. So I think it is a logical assumption that we also have just about around the highest rate of wartime PTSD per capita.

Our challenges are further complicated by our State mental health system. It is overburdened and underfunded. With all honesty, we just cannot expect that they will be able to pick up the veterans that get through the cracks.

We also have challenges in serving our Native veterans. A significant portion of our warriors come from Montana's

Indian population. They have distinct and proud cultural backgrounds, and the VA must serve them in a culturally sensitive manner. While we take our enemy as we find them, we take our heroes as they find us. Our tribal veterans' representatives are a critical tool in this effort and making sure that the veteran does not get played "hot potato" between IHS and the VA.

One of the most critical issues that we have is a lack of crisis beds in our community. Plain and simple, if a veteran in Scobey, Montana, wants to commit suicide, we have no humane solution to deal with that. It is an 8-hour drive to our State mental hospital, and that is a long time for one of our heroes to be stuck in the back of a squad car.

We need to ensure that the VA has access to, or can arrange, geographically dispersed crisis beds to ensure that no veteran is made to travel more than 2 or 3 hours to a safe place of care. We are working on this at the Montana Legislature, but realistically, we cannot do it without your help. The lack of inpatient services is only making this worse.

I will come to one last conclusion. I have been working with Senator Baucus on preparing a screening measure for the Department of Defense. The real way to tackle this problem is to screen them before they hit the VA. We cannot have them dumped on our system not having any treatment for

their mental illnesses, and I ask you to support us in that fight.

Thank you, Mr. Chairman. Mahalo and thank you for your Kekua.

[The prepared statement of Mr. Kuntz follows:]

Chairman Akaka. Thank you very much, Mr. Kuntz. We are certainly glad to have you here. I will now defer to Senator Tester for your questions.

Senator Tester. Yes, thank you, Mr. Chairman. We will just kind of go down the line.

Reverend Flippin, a couple questions on the CARENET program. First of all, is it statewide?

Rev. Flippin. Yes, it is. It covers all 55 counties.

Senator Tester. That is good. How do you know--how is a person referred to your program?

Rev. Flippin. Through ten mini-grantees that we have dispersed throughout the State of West Virginia. Initially we were funded with enough money to go out and subcontract within our rural communities so we would be able to find out exactly what is going on. So we have our feelers throughout the State.

Senator Tester. Okay. And I assume those same feelers that make the referring, they also know who to match people up with?

Rev. Flippin. No, they do not.

Senator Tester. How do you do that?

Rev. Flippin. That then becomes my job.

[Laughter.]

Rev. Flippin. Let me give an example of what may happen. We receive a phone call from a young lady who is 20

years old, has a 2-year-old son; she is 4 months pregnant, and her husband in the Guard is currently in Afghanistan. She is having trouble trying to find a provider, and so she calls CARENET. I then call a local area in West Virginia and ask them to find us a provider who will at least talk with her and get her on the right track. That is basically it.

Senator Tester. Very good. How do you deal with issues that revolve around mental health? Or do you?

Rev. Flippin. Could you repeat that question?

Senator Tester. Excuse me. I will try to do it without the cough. How do you deal with issues that revolve around mental health? Or do you? Is that in your purview?

Rev. Flippin. Basically, we will do a referral. We will call someone in the mental health area, and then we will ask them for direction.

Senator Tester. All right. Well, I absolutely appreciate your work. Thank you very much for being here.

Mr. Watson, you talked about your hospital facility in Tennessee, and I am just curious. Do you have mental health capabilities in your hospital? Do you have mental professionals on staff?

Mr. Watson. We only have mental health capabilities for senior adults. That basically is 55 and over. The younger adults that require mental health capabilities, we

must seek care in larger communities where there are mental health facilities.

Senator Tester. I got you. So that would be--you talked about the hospitals being an hour and a half and 2-1/2 hours away. That is where they would be typically?

Mr. Watson. For veterans, yes, sir.

Senator Tester. How about for regular folks? How far would they--

Mr. Watson. Regular folks, it would be 1 hour to Knoxville or 45 minutes to Oak Ridge, Tennessee.

Senator Tester. Okay. Just your perspective, and I am going to ask you the same question, Mr. Loftus, because you deal with community health centers. You are dealing with a hospital. Do you think there are negative impacts that could happen on the VA with contracting services to hospitals? And you will get the same question about the community health center. Do you think there is any negative impacts to that? And if there are, what are they? Or if there are none, that is fine.

Mr. Watson. I do not believe there would be negative impacts. I think it would actually enhance the services that the VA is currently offering by contracting with local providers and take care of those veterans before it becomes an emergency.

Senator Tester. Good. How about you, Mr. Loftus?

Mr. Loftus. Yes, I agree with that. As a matter of fact, there is a pilot test in VISN 6. The principal investigator is Dr. Harold Cutler, who is the head of psychiatry. I serve on a committee with him for what is called "Virginia for Heroes," and we are doing a pilot test in Hampton, Virginia where the VA works with the local Community Services Board, which are mental health services, field welfare office. And I was trying to get the assessments done at the lowest level in the community so these undiagnosed veterans can be picked up and processed. And it is a consortia between the State of Virginia, the Virginia Commission on Veterans, and the Medical School of Virginia in Richmond.

The answer to your question is no, there is no stigma to it, as far as I am concerned.

Senator Tester. Actually, I am not talking from a stigma standpoint. Just the numbers, I mean for providers, your hospital has to have a certain number of patients to maintain a level of profitability. The same thing with the clinics. If you are going to stay open, you have to have a certain number of people.

I guess the question I had is if we--and I agree there is need for contracting services, but I do not want to take away from the VA's effectiveness by pulling down their numbers. But you do not see that as a problem?

Mr. Loftus. No, no. The biggest pm is reimbursement. That is your biggest problem. Community health clinics only have four payers: the medically indigent, the Medicaid, the Medicare, on a sliding-fee schedule, and commercial pay.

Senator Tester. Right.

Mr. Loftus. So, actually, the fusion of VA patients who are insured would actually be a boon to them.

Senator Tester. In Virginia, are there any cases where CBOCs is combined in with community health care centers?

Mr. Loftus. No. There is a CBOCs that is in Danville, which is about an hour from where we are. But because of some idiosyncratic-ness with the VA, there are medical records issues. If you signed up in Richmond and you go to Danville, you have got to take all your records from Richmond and take it to the Salem Hospital. So there are territorial problems with the va.

Senator Tester. Okay. I have got more questions, Mr. Chairman, but my time has run out. I will do another round if we can.

Chairman Akaka. Thank you very much.

Senator Burris?

Senator Burris. Thank you, Mr. Chairman. I would just like to commend the panel for your work in this area. It is going to take dedicated persons like you coming before us to make the case and let it be known what is going on out

there.

I would like to ask Reverence Flippin, Do you find your resources are strained by the need of veterans in West Virginia for professional helping vets? Do they provide these services pro bono or at a discount? And what happens if the vet cannot afford the treatment?

Rev. Flippin. That is a complicated question for the State of West Virginia, and I would like to do that for the record.

Senator Burris. Okay. Thank you, sir.

[The information follows:]

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Senator Burris. Mr. Watson, the issue in your area with access and continuity of care for veterans, why has this not been addressed previously? Or is it something that is just coming up? And what is the biggest weak link that has led to this failure to serve?

Mr. Watson. I think it has always been a problem for rural communities, for veterans to just get to the local VA facilities--2-1/2 hours to one facility, 3-1/2 to another. So I do not think it is a new issue. It has been ongoing for years.

Typically what has happened is the veterans just seek care among the routine medical systems and avoid using VA systems, if at all possible, just because of the distances. There do become times when veterans have to access the system, and I think that is when they begin moving to drive those distances. But I do not think it is a new problem that has just occurred.

Senator Burris. Now, would some of these be some of the Vietnam veterans who for so long did not come forward and now maybe some of them are coming forward, which is perhaps impacting the system more than it would normally? Not counting Desert Storm or the current Iraq/Afghanistan situation.

Mr. Watson. I think many of them have had private insurance through their employers, and so they have sought

care among the local community providers. As they become unemployed or they retire and no longer have full coverage from their employers, then they will seek care among the VA system.

Senator Burris. Do you see an increase in that, a pick-up from actually the Vietnam vets? Because they had all that confusion about those individuals who served, and they were really treated not so grandly when they returned home, and some of them were ashamed to even let it be known that they were Vietnam vets, which is just unconscionable.

Mr. Watson. I cannot say that we have seen an increase in numbers per se. It is just that is the traditional progress. If they no longer have commercial insurance or need supplement to Medicare and those type things, then they begin seeking care.

Senator Burris. And one last question. Mr. Kuntz, how could the VA set up geographically diverse crises beds for these mentally ill patients? And where would they be located in your State? Or how would they be staffed? Do you have any thoughts on that?

Mr. Kuntz. Senator Burris, I think realistically it will have to be contracted out. In our State, if I was in charge, I would probably put one in Glasgow, Montana, in our northeast; one towards Glendive or I might actually just put money into Billings to make sure that their clinic stays

open, because they have got a clinic but it is closing; potentially Kalispell in our northwestern section; and I would probably be happy with the State hospital in the southwest, potentially Lewistown in the central--but I think it is going to have to be a partnership with our hospitals, and it is going to be private staffing.

We are working with the counties in the State to try to get them in, but I think that we are going to need some additional help, Senator.

Senator Burris. Mr. Chairman, thank you very much.

Chairman Akaka. Thank you very much, Senator Burris.

You have just talked about working with VA. That is what we hope can be improved. Let me ask each of you that question.

From your vantage point, how could VA best work with you and your organization to help that? Reverend Flippin.

Rev. Flippin. First of all, I would say that the Veterans Administration and the Veterans Affairs Office, I think they have developed such a tight, bureaucratic organization that they do not welcome or they do not court outside assistance. I firmly believe that if we are going to be a bridge to our veterans, the community at large must be involved. The community at large cannot be closed out because we are not military.

As an example, the community does not feel they are a

part of the military force because they are not called upon to be directly involved in any activity--in most of the activities that occur. And I find that to be the situation where I am daily dealing with the National Guard and the local community--the National Guard, they are doing a great job as far as referring their personnel. However, it is like a closed society, and the community wants to be involved in supporting our military veterans. The civilian community needs to be educated as well as the VA needs to realize that the good job they are doing is not getting to the community at large.

And so, again, to summarize, I do not really believe we are going to help the invisible wounds, the mental illness and so forth, unless the civilian community is actively involved. And I am not talking about reaching out to churches. I am talking about reaching out to local community agencies who are nongovernmental or non-military aligned. And I thank you very much.

Chairman Akaka. Thank you, Reverend.

Mr. Watson?

Mr. Watson. I believe that the best way for VAs to work with local community providers is just through partnerships. Use the physicians that we have in the communities to take care of the patients early in their disease processes. When we do have to admit them to a local

hospital, make it easier for us to provide that care for them locally, if possible. If not, make it easier for us to transfer them to an appropriate level of facility as close to home as possible.

And, finally, reimburse us when we do take care of these patients in a timely manner. As I said, one-fourth of our population is below the poverty level. We are already caring for a lot of folks that cannot afford to pay. And when we take care of a veteran, we need to be reimbursed timely and reimbursed for the cost of that care.

Chairman Akaka. Thank you.

Mr. Loftus?

Mr. Loftus. Mr. Chairman, yes, I would like to propose that the VA actively look at doing a pilot test in the South Side of Virginia. We have got seven community health centers there. They are all brand-new, very modern. And there is a CBOC scheduled to be built in 2012 in Emporia. I do not know what the status of that is, but I certainly think we can implement many, if not all, of the recommendations that this Committee heard this morning as a pilot test. Thank you.

Chairman Akaka. Thank you.

Mr. Kuntz?

Mr. Kuntz. Mr. Chairman, one of the critical things is educating family members. People with mental illness who

have educated family members do better, and they are cheaper to treat. And the VA is partnering with NAMI to offer the family course. It is a free 12-week course, and we just started up one in Helena last week, and we are pretty excited about it. I would have given anything to have taken that course when our family needed it.

But one of the things that we need to do is work with the VA on offering that course via teleconference, because it is going to be hard to get family-to-family in Molokai or in Heart Butte. But we can do it via teleconference when they get the teleconference equipment in Molokai.

Thank you, Mr. Chairman.

Chairman Akaka. Thank you so much. Thank you for your responses.

I am going to ask Senator Tester for his questions and also to preside as Chair of the Committee.

Senator Tester. [Presiding.] Thank you, Mr. Chairman. Thank you very much. I have just a couple more questions.

Thank you all for being here. I mean that as sincerely as possible. I appreciate your opinions and perspectives. I have got a few questions for Matt real quick.

You know fully well about Montana's National Guard program that is requiring a face-to-face, in-person mental health evaluation for soldiers returning from combat. It is something that you addressed in your comments. How do you

see that program working? Is it successful? Is it worthwhile? Is it money well spent? Is it time well spent?

Mr. Kuntz. Senator Tester, I think it is a brilliant program that helps get the National Guard members who need help in before their life spirals out of control and they reach for help. We would throw them the line before they ask for it. And with mental illness, it is utterly critical to get early treatment, and it is far more expensive if we wait. And I think that the best proof for how well this is working is from the Montana National Guard's own actions. They have already been recognized as the best National Guard in the country at dealing with this. But this was originally funded, this face-to-face screening using LCPCs. Our counseling session once every 6 months for 2 years upon redeployment was originally funded by a grant from TriWest, and that grant ran out. And the National Guard immediately picked it up. There was no doubt that this was helping their soldiers.

Senator Tester. If you think back to your brother's situation, was there an evaluation with him when he came out? I am talking about a mental health evaluation.

Mr. Kuntz. There was a brochure that he was asked to fill out, Senator.

Senator Tester. Was his hidden injury--could it have been caught if there was an evaluation, in your opinion?

Mr. Kuntz. I believe so, Senator. I think that it may not have been caught immediately after redeployment, because I talked to him then, and he knew that he had some things that he was struggling with, but he thought it was just part of what he participated in. But the genius of the Montana screening model is it happens every 6 months. So I do not think that they would have caught it up redeployment. But I really in my heart believe that if they would have sat down with Chris 6 months later when he could no longer go to drill, when he was having the flashbacks, when he was having trouble dealing with his own family, that is when that counselor could have got him to come out of his shell. But I will tell you, we tried later, a year later, and it was too late.

So we need staged things, because these things get worse. It is just like cancer or anything else.

Senator Tester. Okay. Well, I certainly appreciate the perspective on a very difficult situation, and I once again want to echo what the Chairman said about the appreciation for you guys being here. We appreciate your time and appreciate your wisdom.

We are adjourned.

[Whereupon, at 12:04 p.m., the Committee was adjourned.]