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STATEMENT OF
KARA HAWTHORNE
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BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

FEBRUARY 26, 2009
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Good morning, Mr. Chairman. Thank you for the opportunity to discuss the Department of Veterans Affairs' (VA's) work to enhance the delivery of health care to Veterans in rural and highly rural areas. This is an issue of significant importance to the Department and we look forward to working together with the Committee in the coming session to ensure Veterans in geographically remote areas receive the care they have earned through service to our country.

On behalf of the Secretary and the Under Secretary for Health, I'd like to welcome the newest members of the Committee: Senator Mark Begich, from Alaska; Senator Roland Burris, from Illinois; and Senator Mike Johanns, from Nebraska. Each of you represents a state that is home to rural Veterans and I know this hearing will cover a topic of great import to you. We are very interested in hearing your ideas and concerns on this issue today and on others on future occasions.

As the Secretary has said, rural health is a difficult national health care issue. Veterans and others who reside in rural areas face a number of challenges associated with health care. The published literature suggests that greater travel distances and financial barriers to access can negatively impact care coordination for many rural Veterans. VA has pursued a national strategy of outreach to ensure Veterans, regardless of where they live, can access the expertise and experience of one of the best health care systems in the country. In partnership, Congress and VA can do even more. We deeply appreciate Congress' support and interest in this area, and we are happy to report portions of the $250 million included in this year's appropriation have already been distributed to the field to support new and existing projects.

VA's rural health strategy reflects the insight and counsel of experts both inside government and out. Our approach is four-fold:
? First, we have created an Office of Rural Health that coordinates efforts in programs across the Veterans Health Administration to reduce redundancy and disseminate best practices;
? Second, we are leveraging existing resources in communities across the land to raise VA's presence through Outreach Clinics, fee-basis and contracting, and mobile vans;

? Third, we are actively addressing the shortage of health care providers through recruitment and retention efforts; and
? Finally, we are harnessing technology to remove barriers to care and bring the best experts in the world to every corner of the country, and to empower Veterans as active participants in their health care through telehealth, which my colleague, Dr. Darkins, will address in his statement.

Before I begin discussing these issues in greater detail, I would like to share with you how VA defines urban, rural, and highly rural as categories. Our definitions are based on the U.S. Census Bureau's definition, which designates areas down to the census block level. The Census Bureau defines urban as all territory, population, and housing units within an urbanized area or an urban cluster. An urbanized cluster consists of a core census block group or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. Urban clusters are found in small towns surrounded by a lower density population. Urbanized areas consist of contiguous densely settled block groups that along with adjacent densely settled census blocks together encompass a population of at least 50,000 people. VA defines urban enrollees as any enrollees who are located within a Census-defined urbanized area. Rural enrollees are any enrollees not designated as urban (including those who live within urban clusters), while highly rural enrollees reside in counties with fewer than seven civilians per square mile. Based on VA's definitions, approximately 60 percent of enrolled Veterans reside in urban areas, while approximately 37 percent reside in rural areas. Fewer than two percent reside in highly rural areas.

Office of Rural Health
VA's Office of Rural Health (ORH) was authorized by § 212 of Public Law 109-461 and empowered to coordinate policy efforts across VHA to promote improved health care for rural Veterans. One of the mandated functions of ORH includes the designation in each Veterans Integrated Service Network (VISN) of Rural Consultants who are responsible for consulting on and coordinating the discharge of ORH programs and activities in their respective VISN for veterans who reside in rural areas. These consultants are enhancing service delivery to Veterans residing in rural areas and will lead activities in building an ORH Community of Practice, which will facilitate information exchanges and learning within and across VISNs, while providing a crucial link between ORH and VISNs. The authorizing legislation required each VISN identify a Consultant; VA is currently conducting a pilot program in eight VISNs with full-time consultants to determine if this staffing level is more appropriate than a part-time position. The VISN Rural Consultant Pilot Project facilitates information exchanges and learning across VISNs and to VA Central Office. The Pilot collaborates with local communities through outreach, education and other activities to ensure Veterans' access to quality care reflect local needs and conditions; each rural area is different and there is no "one size fits all" strategy we can adopt. Consequently, our Pilot is focused on engaging the VISNs in rural planning efforts to properly allocate resources and to support complementary efforts.

In addition, VA has created a 13-member VA Rural Health Advisory Committee to advise the Secretary on issues affecting rural Veterans. This panel includes strong advocates for the needs of Veterans in rural areas. It includes physicians from rural areas, Veterans, and experts from government, academia and the non-profit sectors. Earlier this month, Secretary Shinseki

appointed Dr. Susan Karol, from the Indian Health Service, as an ex officio member on the Advisory Committee. We welcome Dr. Karol's appointment and the expertise she will bring. The Advisory Committee will meet in Phoenix on March 3 and 4. A primary focus is to support collaborations with non-VA organizations, and in this regard, VA is making remarkable progress. VA has conducted outreach and developed relationships with the Department of Health and Human Services (including the Office of Rural Health Policy and the Indian Health Service), other agencies and academic institutions committed to serving rural areas. VA has also reached out through ORH to other government and non-governmental organizations, including the National Rural Health Association, the National Organization of State Offices of Rural Health, the National Institute of Mental Health Office of Rural Mental Health, the National Cooperative Health Networks, the Rural Health Information Technology Coalition, the Rural Assistance Center, the Rural Health Resource Center, the Georgia Health Policy Center, various rural health research centers, and other organizations to further assess and develop potential strategic partnerships. ORH is working in close collaboration with the Department of Health and Human Services to address the needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans to coordinate services with the Department of Health and Human Services' Health Resources and Services Administration Community Health Centers. These initiatives include a training partnership, technical assistance to Community Health Centers and a seamless referral process from Community Health Centers to VA medical centers.

VA opened three Rural Health Resource Centers at the start of this Fiscal Year. These centers develop special practices and products for use by facilities and networks across the country. The eastern Center is located at the White River Junction VA Medical Center in Vermont; the Central Center is at the Iowa City VA Medical Center in Iowa; and the Western Center is at the Salt Lake City VA Medical Center in Utah. Each Resource Center is appropriately staffed with administrative and clinical personnel who are identifying disparities in health care for rural Veterans. They are also developing processes and measures of health care outcomes to evaluate and pursue the most effective programs and direct resources accordingly. These Centers essentially serve as field-based clinical laboratories capable of experimenting with new outreach and care models. They also serve a crucial function in enhancing academic affiliations with nursing and medical schools and help promote direct outreach to Veterans.

In January, VA provided almost $22 million to VISNs across the country to improve services for rural Veterans. This funding is part of a two-year program and will focus on projects including new technology, recruitment and retention, and close cooperation with other organizations at the federal, state and local levels. Funds will be used to sustain current programs, establish pilot programs and establish new outpatient clinics. VA distributed resources according to the proportion of Veterans living in rural areas within each VISN; VISNs with less than three percent of their patients in rural areas received $250,000, those with between three and six percent received $1 million, and those with six percent or more received $1.5 million. ORH has allocated another $24 million to sustain Fiscal Year 2008 programs and projects, including the Rural Health Resource Centers, Mobile Clinics, Outreach Clinics, VISN Rural Consultants, mental health and long-term care projects, and rural home based primary care. ORH convened a workgroup of VISN and Program Office representatives to plan for the allocation of the

remaining funds. Earlier this month, ORH distributed program guidance to VISNs and Program Offices concerning allocation of the remaining funds as early as May to enhance rural health care programs.

VA's ORH, in its short time in existence, has produced a number of programs that are actively improving the delivery and coordination of health care services to rural Veterans. Some examples include:
? Expanding VA's existing Home Based Primary Care and Medical Foster Home programs (part of VA's Community Residential Care Program) into rural VA facilities with start-up funding for Fiscal Year 2008 and partial funding for Fiscal Year 2009;
? Developing the "Geri" scholars program, in collaboration with VHA's Office of Geriatrics and Extended Care, to target VA geriatric providers in rural areas and provide them with an intensive course in geriatric medicine and a tailored training program on providing geriatric medicine in rural VA clinics with curricula and supportive activities based on a needs assessment of each participant;
? Developing the "Idea Award" to reach beyond the Veterans Rural Health Resource Centers so additional staff and program offices can participate in pilot projects, studies and analyses, as appropriate; and
? Building relationships with complementary federal or non-federal programs and organizations, as described above.
One area of particular importance to ORH is American Indian/Alaska Native, Native Hawaiian and Pacific Island Insular Area Veterans. The VISN Tribal Veterans Representative Program is an inter-agency initiative between the Indian Health Services, Tribal Health Services, Community Health Centers, and Veterans Service Organizations. The Program was developed to provide outreach and open communication to Veterans in extremely rural and underserved areas, especially the American Indian/Alaska Native, Hawaiian Native, and Pacific Island Insular Area populations. The Program trains individuals on outreach techniques to assist, facilitate and encourage Veterans to access the full range of VA benefits they earned through service. There are approximately 185 Tribal Veterans Representatives throughout the nation working with Veterans and their families.

While Dr. Darkins will address telehealth and its unique benefits for rural Veterans, other technologies are also paving the way for easier access and better quality care. Rural communities have limited capital for health information technology investment, and the likelihood for rapid changes in technology and the absence of national technical standards pose additional challenges. Health information exchanges or regional health information organizations have been created in many localities to test the electronic exchange of protected health information, and VA is establishing connections with these successful networks.

Possibly VA's most promising expansion is My HealtheVet, which offers Veterans access to their personal health record any time, anywhere. This program was first launched in 2003. Veterans access My HealtheVet through an internet-based, secure and convenient portal that allows Veterans to improve their individual health through direct access. Access to this information

helps the Veteran and the Veteran's providers, whether in VA or elsewhere. Veterans can renew and refill prescriptions online, review medical information, self-report clinical data, schedule and view appointments and view wellness reminders. My HealtheVet reduces duplicate testing and increases our ability to prevent conditions from becoming worse by managing chronic diseases and adhering to evidence-based practices for quality care. ORH is working to ensure My HealtheVet meets the needs of rural Veterans and aids in their coordinated care.

Community Resources
VA recognizes that local problems require local solutions, and by identifying the resources already available, we can work together with each community to tailor solutions to their needs. We also understand Veterans can only use our services when they know about them. To that end, VA began a Veteran Call Center Initiative in May 2008 to reach out to OEF/OIF Veterans from all parts of the country who separated between FY 2002 and July 2008. The Call Center representatives inform Veterans of their benefits, including enhanced health care enrollment opportunities and to see if VA can assist in any way. This effort initially focused on approximately 15,500 Veterans VA believed had injuries or illnesses that might need care management. The Call Center also contacted any combat Veteran who had never used a VA medical facility before. Almost 38 percent of those we spoke with requested information or assistance as a result of our outreach. The Call Center Initiative continues today, focusing on those Veterans who have separated since September 2008. ORH will be reviewing the work of this and other Call Centers to determine what VA can do to reach out more effectively to rural Veterans.

Community based outpatient clinics (CBOCs) have been the anchor for VA's efforts to expand access to Veterans over the last ten years. CBOCs have proven to be instrumental in greatly improving access to high quality care in a cost-effective manner. Our most recent strategic planning guidance focused specifically on underserved areas, which are defined as those where less than 70 percent of enrollees are within the access drive time guidelines for primary care; these guidelines are within 30 minutes for urban and rural Veterans and within 60 minutes for highly rural areas.

Beyond our CBOCs, VA utilizes rural outreach clinics that offer services on a part-time basis, usually a few days a week, in rural and highly rural areas where there is insufficient demand or it is otherwise unfeasible to establish a full-time CBOC. The clinics offer primary care, mental health services and specialty referrals. Each rural outreach clinic is part of a VA network and maintains VA's quality standards. Veterans can use rural outreach clinics as an access point for referrals to larger VA facilities for specialized needs. Last September, VA announced the opening of 10 new Rural Outreach Clinics this Fiscal Year.

Vet Centers also provide services and points of access to Veterans in rural communities. Vet Centers welcome home Veterans with honor by providing quality readjustment counseling in a supportive, non-clinical environment. By the end of FY 2009, VA will have 271 Vet Centers and 1,526 employees to address the needs of Veterans; any county in the country with more than

50,000 Veterans will have services available through a Vet Center. A fleet of 50 Mobile Vet Centers are being put into service this year and will provide access to returning Veterans and outreach to demobilization military bases, National Guard and Reserve locations nationally.

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

Section 107 of Public Law 110-387 directs VA to conduct a pilot program in at least three VISNs to evaluate the feasibility and advisability of providing OEF/OIF Veterans with peer outreach and support services, readjustment counseling services, and other mental health services through arrangements with, among others, community mental health centers. VA's Office of Mental Health Services and the ORH are in the process of implementing this pilot program. The pilot will be conducted in a number of stages evaluating, in turn, the identification of rural areas that are beyond the reach of VA's mental health services for Veterans but have other mental health providers capable of providing high quality services; the willingness and capability of these entities for providing outreach and treatment services for returning Veterans; the feasibility of developing performance based contracts with these entities that meet the requirement of Section 107; and the use of services and the outcomes of care provided through these contracts.

Section 403 requires VA to conduct a pilot program that would provide non-VA care for highly rural enrolled veterans in five VISNs. VA is working to implement this pilot while resolving two questions. First, VA must develop a regulation to define the "hardship provision" in Section 403(b)(2)(B). Second, we must reconcile how VA has traditionally defined "highly rural" (based on Census data as discussed above) and how the statute defines it. VA's next steps involve identifying qualifying communities, identifying local providers willing and able to participate, and beginning with acquisition and exchanges of medical information as well as addressing pharmacy benefits and performance criteria for contracts and care.

Health Care Providers

Everyday, almost 60 million Americans in rural and highly rural areas face numerous challenges regarding health care, but one of the most significant in this area is a shortage of providers - particularly specialty providers. Recruitment and retention of health care professionals in rural areas is a national problem, not a VA-specific problem. However, 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 one year into a three-year pilot program for VA's Travel Nurse

Corps. This program was created in response to a nationwide shortage of nurses and places nurses in medical centers and clinics across the country on a temporary basis. These nurses reduce wait times and the reliance upon contractors while bringing with them high-skill services and valuable knowledge of procedures. The program is designed to improve recruitment, decrease turnover and maintain high standards of patient care. Nurses are compensated for their time on duty and their travel, while also receiving per diem allowances, making it competitive with the private sector. The Travel Nurse Corps has the added benefit of establishing a potential pool of skilled and experienced nurses capable of responding in the event of a national emergency.

One key incentive VA offers is the Education Debt Reduction Program, which provides for reimbursement of payments made to recently appointed Title 38 and Hybrid Title 38 employees on qualifying educational loans. The maximum award amount is $52,298 (as adjusted) over a total of five years of participation, but it carries an added value because of the tax exempt status of the award. As of January 2009, there were over 7,500 health care professionals participating in EDRP. The average amount authorized per student, for all years, is $19,596. While employees from 34 occupations participate in the program, 75 percent are from three mission critical occupations - registered nurse, pharmacist, and physician. Resignation rates of EDRP recipients are significantly less than non-recipients. The EDRP incentive may be used in addition to other federal incentives such as the recruitment incentive (hiring bonus), relocation incentive, or retention incentive - as hiring priorities dictate. While not exclusively used to recruit in rural areas, VA authorized over $66 million for non-EDRP hiring incentives for employees in Title 38 occupations. The recipients included physicians, nurses, and others. In each category, 93 to 95 percent of the funding was authorized for nurses and physicians as follows:

Recruitment (29%) Relocation (5%) Retention (66%)
Physicians - 27% Physicians - 72% Physicians - 27%
Registered Nurses - 66% Registered Nurses - 23% Registered Nurses - 66%

From a recruiting perspective. VA is expanding the use of internet-based venues for health care related job postings in addition to recruiting from the VA job board, USAJobs.gov, and other niche job boards. The VHA Healthcare Retention & Recruitment office is hiring recruiters who will focus on recruitment of health care providers for rural areas and as well as establishing a national contract for retained search firms targeting physician recruitment. They are also developing collaborative relationships with organizations focused on rural recruitment such as the National Rural Recruitment & Retention Network (www.3Rnet.org), increasing training courses specifically for practices related to rural recruitment issues, and hiring recruiters whose primary focus will be recruitment of physicians.

More than 100,000 health professions trainees come to VA facilities each year for clinical learning experiences. Many of these trainees are near the end of their education or training programs and become a substantial recruitment pool for VA employment as health professionals. The annual VHA Learners' Perceptions Survey shows that, overall, following completion of VA

learning experiences, trainees were twice as likely to consider VA employment as before the experience. This demonstrates that many trainees were not aware of VA employment opportunities or the quality of VA's healthcare environment prior to VA training but became considerably more interested after VA clinical experiences.
In an effort to initiate proactive strategies to aid in the shortage of clinical faculty, VA launched the VA Nursing Academy to address the nationwide shortage of nurses. The purpose of the Academy is to expand the number of nursing faculty in the schools, increase student nursing enrollment by 1,000 students, increase the number of students who come to VA for their clinical learning experience, and promote innovations in nursing education and clinical practice. Four partnerships were established for the 2007-2008 school year. Six additional partnerships were selected in 2008.

Both a recruitment and retention tool, the Employee Incentive Scholarship Program (EISP) pays up to $35,900 for academic health care related degree programs. The average scholarship awarded is $12,392 for the duration of the academic program. Since the program began in 1999, approximately 7200 VA employees have received scholarship awards for academic education programs related to Title 38 and Hybrid Title 38 occupations. Over 4000 employees have graduated from their academic programs thus far; many are still in progress. Scholarship recipients include registered nurses (93 percent), pharmacists, and many other allied health professionals. Focus group market research shows that staff education programs offered by VHA are considered a major factor in individuals selecting VA as their choice of employer. A five year analysis of program outcomes demonstrated positive employee retention. Less than one percent of nurses leave VHA during their service obligation period (from one to three years after completion of degree). As of October 28, 2008, scholarship funding for this program since 1999 through FY 2012 is $88.3 million. This figure includes future funds for those who have received scholarships for academic years extending through 2012.

The implementation of the physician pay statute (Public Law 108-445) has been very successful for VHA. The pay of VHA physicians and dentists consists of three elements: base pay, market pay, and performance pay. Between the implementation of the pay bill and the beginning of February 2009, we have increased the number of VA physicians by over 2,748.3 full time employee equivalents. This statutory authority has helped VHA's ability to recruit physicians and dentists. Additionally, section 5 of Public Law 108-445 authorizes the Chief Nurse of VHA to set Nurse Executive Pay to ensure we continue to successfully recruit and retain nursing leaders.

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