CORT NORDEOFF, SOUTHEAST GEORGIA DISTRICT COMMANDER, DISABLED AMERICAN VETERANS

STATEMENT OF
CORT NORDEOFF
SOUTHEAST GEORGIA DISTRICT COMMANDER
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
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AUGUST 26, 2009

Senator Isakson and Members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this oversight hearing of the Committee to evaluate Georgia veterans' perceptions of Veterans' Affairs (VA) community-based outpatient clinics in terms of their quality of care, availability of services, and the placements of clinics in Georgia. Also the Committee specifically asked that I address the recent contract that was rebid for the community based outpatient clinic in Brunswick, GA. We value the opportunity to discuss our views. Rural health is an issue of significant importance to many DAV members in Georgia and veterans in general.

Approximately 3.2 million, or 41 percent, of veterans enrolled for VA health care throughout the country are classified by VA as rural or highly rural. Also, 44 percent of current active duty military service members, who will be tomorrow's veterans, list rural communities as their homes of record. In the State of Georgia, rural Georgians have a proud tradition of military service dating all the way back to the American Revolution. VA estimates that 773,000 veterans live in Georgia, of which almost 23,000 are proud members of the DAV. In Georgia, VA meets veterans' health care needs with major medical centers in Atlanta, Augusta and Dublin. VA operates fourteen community-based outpatient clinics, in Albany; Athens; Columbus; Decatur; East Point; Lawrenceville; Macon; NE Georgia/Oakwood; Perry; Rome; Savannah; Smyrna; Stockbridge; and, Valdosta. VA plans to establish additional clinics based on unmet need. As a general rule, DAV is very pleased with the VA commitment to rural health care access in the State of Georgia. Nevertheless, research shows that when compared with their urban and suburban counterparts, veterans who live in rural settings in general have worse health-related quality-of-life scores; are poorer and have higher disease burdens; worse health outcomes; and are less likely to have alternative health coverage. Such findings anticipate greater health care demands and thus greater health care costs from rural veteran populations.

Over the past several years, through authorizing legislation and additional appropriations, Congress has attempted to address unmet health care needs of veterans who make their homes in rural and remote areas. With nearly half of those currently serving in the military residing from

rural, remote and frontier areas, access to VA health care and other veterans services for them is perhaps VA's biggest challenge. We recognize that rural health is a difficult national health care issue and is not isolated to VA's environment. We also appreciate that many service-connected disabled veterans living in rural areas face multiple challenges in accessing VA health care services, or even private services under VA contract or fee basis. Shortage of health care providers, long travel distances, weather conditions, geographical and financial barriers all negatively impact access to care and care coordination for many rural veterans, both the service-connected and nonservice-connected alike.

Section 212 of Public Law 109-461 authorized VA to establish the Veterans Health Administration (VHA) Office of Rural Health (ORH). We deeply appreciate the due diligence of this Committee and Congress as a whole in exerting strong support for rural veterans by enacting this public law.

As required by the Act, the function of the ORH is to coordinate policy efforts across VHA to promote improved health care for rural veterans; conduct, coordinate, promote and disseminate research related to issues affecting veterans living in rural areas; designate in each Veterans Integrated Service Network (VISN) rural consultants who are responsible for consulting on and coordinating the discharge of ORH programs and activities in their respective VISNs for veterans who reside in rural areas; and, to carry out other duties as directed by the Under Secretary for Health. In the Act, VA also was required to do an assessment of its fee-basis health care program for rural veterans to identify mechanisms for expanding the program and the feasibility and advisability of implementing such mechanisms. There were also a number of reports to Congress required including submission of a plan to improve access and quality of care for enrolled veterans in rural areas; measures for meeting the long term care and mental health needs of veterans residing in rural areas; and, a report on the status of identified and opened community-based outpatient clinics (CBOCs) and access points from the May 2004 decision document associated with the Capital Asset Realignment for Enhanced Services (CARES) plan. Finally, the Act required VA to conduct an extensive outreach program to identify and provide information about VA health care services to veterans of Operations Iraqi and Enduring Freedom (OIF/OEF) who live in rural communities for the purpose of enrolling these veterans into the VA health care system prior to the expiration of their statutory eligibility period (generally, five years following the date of military discharge or completion of deployments).

In addition to establishing the ORH, in 2008, VA created a 13-member VA Rural Health Advisory Committee to advise the Secretary on issues affecting rural veterans. This panel includes physicians from rural areas, disabled veterans, and experts from government, academia and the non-profit sectors. We applaud former VA Secretary Peake for having responded to our recommendation in the Fiscal Year (FY) 2009 Independent Budget (IB) to use VA's authority to form such a committee. We hold high expectations that the Rural Veterans Advisory Committee will be a strong voice of support for many of the ideas we have expressed in previous testimony before Congress, and joined by our colleagues from AMVETS, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States, in the IB.

We are pleased and would like to congratulate VA on its progress to date in establishing the necessary framework to begin to improve services for rural veterans. It appears that ORH is

reaching across the Department to coordinate and support programs aimed at increasing access for veterans in rural and highly rural communities. We note; however, that the ORH has an ambitious agenda but only a minimal staff and limited resources. The ORH is still a relatively new function within VA Central Office and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals of Congress for rural health improvements, we are concerned about the organizational placement of ORH within the VHA Office of Policy and Planning rather than being closer to the operational arm of the VA system. Having to traverse the multiple layers of VHA's bureaucratic structure could frustrate, delay or even prevent initiatives established by this office. We believe rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VA Central Office, with staff augmentation commensurate with its stated goals and plans.

We understand that VA has developed a number of strategies to improve access to health care services for veterans living in rural and remote areas. To begin, VA appointed rural care designees in all its VISNs to serve as points of contact in liaison with ORH. While we appreciate that VHA designated the liaison positions within the VISNs, we expressed concern that they serve these purposes only on a part-time basis. We are pleased that VA is conducting a pilot program in eight VISNs to determine if the rural coordinator function should be a part-time or a full-time position.

VA reported that its approach to improving services in rural areas includes leveraging existing resources in communities nationwide to raise VA's presence through outreach clinics, fee-basis, contracting, and use of mobile clinics. Additionally, VA testified it is actively addressing the shortage of health care providers through recruitment and retention efforts; and harnessing tele-health and other technologies to reduce barriers to care. Also, in September 2008, VA announced plans to establish new rural outreach clinics in Houston County, Georgia, Juneau County, Alaska, and Wasco County, Oregon. VA plans to open six additional outreach clinics by August 2009, in Winnemucca, Nevada, Yreka, California, Utuado, Puerto Rico, Lagrange, Texas, Montezuma Creek, Utah, and Manistique, Michigan.

VA also reported that it has conducted other forms of outreach and developed relationships with the Department of Health and Human Services (HHS) (including the Office of Rural Health Policy and the Indian Health Service), and other agencies and academic institutions committed to serving rural areas to further assess and develop potential strategic partnerships. Likewise, VA testified it is working to address the needs of veterans from OIF/OEF by coordinating services with the HHS' Health Resources and Services Administration community health centers, and that these initiatives include a training partnership, technical assistance to community health centers and a seamless referral process from community health centers to VA sources of specialized care.

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

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the IB veterans service organizations believe that these veterans, too, should have access to specialized services offered by VA's Readjustment Counseling Service, through its Vet Centers. In that regard, we are pleased to acknowledge that VA is rolling out a fleet of 50 mobile Vet Centers this year to provide access to returning veterans and outreach at demobilization sites on military bases, and at National Guard and Reserve units nationally.

The issue of rural health is an extremely complex one and we agree with VA that there is not a "one-size-fits-all" solution to this problem. To make real improvements in access to the quality and coordination of care for rural veterans, we believe that Congress must provide continued oversight, and VA must be given sufficient resources to meet its many missions, including improvements in rural health care.

In regard to funding for rural health, in 2008 VA allocated almost $22 million to VISNs to improve services for rural veterans. This funding is part of a two-year program and would focus on projects including new technology, recruitment and retention, and close cooperation with other organizations at the federal, state and local levels. These funds were used to sustain current programs, establish pilot programs and establish new outpatient clinics. VA distributed resources according to the fraction of enrolled veterans living in rural areas within each VISN. It is DAV's understanding that 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.

The ORH has testified VA allocated another $24 million to sustain these programs and projects into 2009, 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, and has convened a workgroup of VISN and Central Office program offices to plan for the allocation of the remaining funds. In February 2009, ORH distributed guidance to VISNs and program offices concerning allocation of the remaining funds to enhance rural health care programs.

Concurrently, Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, approved on September 30, 2008, included $250 million for VA to establish and implement a new rural health outreach and delivery initiative. Congress intended these funds to build upon the work of the ORH by enabling VA to expand initiatives such as telemedicine and mobile clinics, and to open new clinics in underserved and rural areas. Notably, the bill also included $200 million for additional fee-basis services.

Health workforce shortages and recruitment and retention of health care personnel, are also a key challenge to rural veterans' access to VA care and to the quality of that care. The Institute of Medicine of the National Academy of Sciences report "Quality through Collaboration: The Future of Rural Health" (2004) recommended that the federal government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deep and long-term commitment to health professions education seems to be an appropriate foundation for improving these situations in rural VA facilities as well as in the private sector. VA's unique relationships with health professions schools should be put to work in aiding rural VA facilities with their human resources needs, and in particular for

physicians, nurses, technicians, technologists and other direct providers of care. The VHA Office of Academic Affiliations, in conjunction with ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. While VA maintains it is moving in this general direction with its pilot program in a traveling nurse corps; VA's pilot program in establishing a "nursing academy," initially in four sites and expanding eventually to twelve; its well-founded Education Debt Reduction Program and Employee Incentive Scholarship Program; and, its reformed physician pay system as authorized by Public Law 108-445, none of these programs was established as a rural health initiative, so it is difficult for DAV to envision how they would lend themselves to specifically solving VA's rural human resources problems. We do not see them as specific initiatives aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

The DAV has a national resolution from its membership, Resolution No. 247, reaffirmed at our National Convention in Denver, CO, August 22-25, 2009, fully supporting the rights of rural veterans to be served by VA, but insisting that Congress provide sufficient resources for VA to improve health care services for veterans living in rural and remote areas. We thank VA and this Committee for supporting specific-purpose funding for rural care without jeopardizing other VA health care programs, consistent with our adopted resolution. Furthermore, we appreciate the Committee's interest in conducting this oversight hearing to learn more from VA about the local situation here in Georgia. Such information serves everyone's interest in ascertaining how rural veterans receive care at VA's expense that otherwise might not have received care were it not for the new resources made available for rural veterans, as well as gathering data on how their health outcomes have been affected as a measure of the quality of care.

VA's previous studies of rural needs, identified the need for 156 priority CBOCs and a number of other new sites of care nationwide, recently including some here in Georgia. A March 30, 2007, report submitted to Congress indicates 12 CBOCs had been opened, 12 were targeted for opening in FY 2007, and five would open in FY 2008. In June 2008, VA announced plans to activate 44 additional CBOCs in 21 states during FY 2009. As of the end of the second quarter of FY 2009, VA reported 768 clinics in operation, 392 of which are in urban settings, 337 in rural areas, and 38 in highly rural locations. VA directly staffs 540 clinics, and the remainder of these CBOCs are managed by contractors. Of the CBOCs VA operates, 353 are doing real-time video conferencing (predominantly tele-mental health), while 130 CBOCs are transmitting tele-retinal imaging for evaluation by specialists in VA medical centers. Services such as these greatly enhance patient care, extend specialties into rural and highly rural locations, and drastically cut down on long-distance travel by veterans. In addition, VA is expanding its capability to serve rural veterans by establishing rural outreach clinics. Currently, 12 VA outreach clinics are operational, and more are planned. These are major investments by VA, and we appreciate both VA and Congress for supporting this level of extension of VA services into more and more communities.

While we applaud the VHA for improving veterans' access to quality care and its intention to spread primary and limited specialty care access for veterans to more areas, enabling additional veterans access to a convenient VA primary care resource, DAV urges that the business plan guiding these decisions generally first emphasize the option of VA-operated and staffed facilities. When geographic or financial conditions warrant (e.g., highly rural, scarceness, remoteness, etc.), we do not oppose the award of contracts for CBOC operations or leased facilities, but we

do not support the general notion that VA should rely heavily or primarily on contract CBOC providers to provide care to rural veterans.

We understand and appreciate those advocates on this Committee and in Congress in general who have been successful in enacting authority for VA to increase health care contracting in rural areas through a new multi-VISN pilot program enacted in Public Law 110-387. However, in light of the escalating costs of health care in the private sector, to its credit, VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected and nonservice-connected veterans might seek care in the private sector as a matter of personal convenience, doing so may well cause them to lose the safeguards built into the VA system by its patient safety program, prevention measures, evidence-based treatments, national formulary, electronic health record, and bar code medication administration (BCMA), among other protections. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, ones that are generally not available in private sector systems or among individual practitioners or group practices (especially in rural areas), would equate to diminished oversight and coordination of care, lack of continuity of care, and ultimately may result in lower quality of care for those who need quality the most.

For these reasons, we urge Congress and VA's ORH to closely monitor and oversee the development of the new rural pilot demonstration project from Public Law 110-387, especially to protect against any erosion or diminution of VA's specialized medical programs, and to ensure participating rural and highly rural veterans receive health care quality that is comparable to that available within the VA's health care system. We are pleased that the ORH reported it is coordinating with the Office of Mental Health Services, to implement this pilot program. We ask VA, in implementing this demonstration project, to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state or other federal agencies, as VA has previously claimed it would be doing) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs, of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements and other appropriate variables, compared to similar measurements of a like group of rural veterans who remain in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions academic affiliates. We recommend the principles outlined in the Contract Care Coordination section of the FY 2010 IB be used to guide VA's approaches in this demonstration, and that it be closely monitored by VA's Rural Veterans Advisory Committee, with results reported regularly to Congress.

We also recommend that VA be required to provide more thorough reporting to this Committee, to enable meaningful oversight of the use of the funds provided, and the implementation of the authorizing legislation that serves as a foundation for this work.
We urge the Committee to consider legislation strengthening recurring reporting on VA rural health as a general matter. We are concerned that funds Congress provided to VA to address shortages of access in rural areas will simply be dropped into the VA "Veterans Equitable Resource Allocation" (VERA) system, absent means of measuring whether these new funds will be obligated in furtherance of Congress's intent—to enhance care for rural and highly rural veterans, with an emphasis on outreach to the newest generation of war veterans who served in

the National Guard, and hail from rural areas, including our State. Reports to Congress should include standardized and meaningful measures of how VA rural health care capacity or "virtual capacity" has changed; VA should provide recorded workload changes on a quarterly or semi-annual basis, and disclose other trends on whether the rural health care initiatives and funds allocated for them are achieving their designed purposes.

In closing, DAV believes that VA is working in good faith to address its shortcomings in rural areas, but VA clearly still faces major challenges and hurdles. In the long term, its methods and plans may offer rural and highly rural veterans better opportunities to obtain quality care to meet their specialized health care needs. However, we caution about the trend toward privatization, vouchering and contracting out VA health care for rural veterans on a broad scale. As VA's ORH develops its policies and initiatives, DAV cannot stress enough the importance of communication and collaboration between this office, other VA program offices, field facilities, and other federal, state and local organizations, to reach out and provide VA benefits and services to veterans residing in rural and highly rural areas. As noted above, we are concerned that the current staffing level assigned to ORH will be insufficient to effectively carry out its mission. Moreover, DAV believes ORH's position in VHA's organizational structure may hamper its ability to properly implement, guide and oversee VA's rural health care initiative. Also, Congress should monitor VA's funding allocation to ensure that rural health needs do not interfere with other VA medical obligations. Finally, we are hopeful that with continued oversight from this Committee and, with these principles in mind; rural veterans will be better served by VA in the future.

Senator Isakson, your invitation letter asked specific questions regarding the local situation in rural Georgia, and in particular about the status of the Brunswick community-based outpatient clinic, that I would be pleased to discuss in my oral remarks.

This concludes my formal statement submitted on behalf of DAV. I would be happy to address questions from you or other Members of the Committee.