Cephus Allin, MD, Fort Collins VA Outpatient Clinic, AFGE Member

Good morning, I am Dr. Cephus Allin.
I am a member of the American Federation of Government Workers.
For the last 3 years I have been the sole physician in the Fort Collins CBOC.

I would like to personally thank Senator Salazar for inviting me to testify today. It is a rare honor and privilege for those who actually treat veterans to provide testimony to those who shape our professional lives.

Fort Collins can hardly be considered rural: 120,000 in the city with upwards of a quarter of a million in the catchments area. So how do I qualify as a rural provider ? I have veterans who drive 150 miles to see me, because I am the closest VA provider.

This is the reason we are here today.
To project VA benefits out to our rural veterans.

I have three proposals:
1) Congress needs to revise Public Law to allow Non-VA Physicians access to the VA formulary for our veterans. The MEDS ONLY proposal.

2) Initiate sharing agreements with the 25 Colorado Critical Access Hospitals. The Sharing Agreement proposal

3) Establish a strong Fee Basis program for Non-VA providers. The Fee Basis proposal.

Proposal One: MEDS ONLY
There is considerable bargaining power in the combined DoD/VA formulary. This leverage drives medications costs down and many veterans enroll with the VA solely to receive these low cost medications.

Many of our veterans have more time than money and will endure the waits and delays found at some VA facilities to avoid choosing between food and medications.

VHA Directive 2002-074: VHA National Dual Care Policy requires that a VA provider take an active role in patient management and documentation even after a qualified Non-physician has already delivered timely care.
Dual care is a travesty when so many are without any care.

Proposal Two: SHARING AGREEMENT
Senator Salazar has taken a leadership position on preserving the rural Critical Access Hospitals and as part of a bipartisan effort preserved federal funding for these rural hospitals.

Critical Access Hospitals are by definition part of rural communities.
The map of those facilities is so compelling that it is the first page in the handout.

Many of these hospitals already have staff who perform primary care and could function in that capacity for us. Many of them have an existing Information Technology infrastructure onto which the VA infrastructure might project.

We need sharing agreements, as we have with Department of Defense, we need sharing agreements as we have with Indian Health Service. We need rural sharing agreements so our VSOs have only to arrange travel across town rather than across the state.

Proposal Three: FEE BASIS
The March 2005 Office of the Inspector General report indicates that the VA does an excellent job of managing on-station Fee Basis.
We should expand this expertise into rural, off-station services.
When a rural physician sees one of our veterans, they should be able to send the bill to a Central Fee Basis Office for payment. If payment was prompt and, perhaps double the Medicare rate, veterans would immediately become the preferred patrons in rural practice.

We won't be able to project a significant amount of bricks, mortar or staff into rural communities. CBOCs are expensive and the pressure on Hospital Directors to place them in areas which will return the greatest number of new patients is almost overwhelming. About 11% of our CBOCs are in counties designated as rural (fewer than 100 people per square mile).

What we can project are care and caring into the rural setting. We need to support Non-VA providers who offer care to our veterans by providing them a generous reimbursement; we need to support the rural hospitals through which we will be able to project our information infrastructure and we need to support our veterans by supplying the medications they need from providers near their homes.

Again, I would like to thank Senator Salazar for inviting me to this forum and would be happy to answer questions.