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STATEMENT OF
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ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION
U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
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Good Morning, Mr. Chairman and Members of the Committee. Thank you for inviting me here today to discuss the current state of the Department of Veterans Affairs (VA) care and services for our Veterans in rural areas, specifically in Veterans Integrated Service Networks (VISN) 19 and 20. I am accompanied today by Mr. William Schoenhard, Deputy Under Secretary for Operations and Management; and Mr. Glen Grippen, Network Director for the Rocky Mountain Network (VISN 19).

Increasing access for Veterans is one of the Secretary's top priorities for the Department. This has several components immediately relevant to rural Veterans: it means bringing care closer to home, sometimes even into the Veteran's home; it means increasing the quality of the care we deliver; and it means providing Veteran-centered care in a time and manner that is convenient to our Veterans. This is the obligation we have, inspired by the service and sacrifice our Veterans have made on behalf of this Nation.

My testimony will discuss VA's national efforts to improve the access, quality, and coordination of care for our rural Veterans, then detail specific initiatives in VISN 19 and VISN 20 that directly relate to our rural Veterans.

National Programs
VA offers a number of important programs designed specifically to increase access for our Veterans living in rural and highly rural areas. While the Office of Rural Health (ORH) oversees and administers many of these critical efforts, VA also uses telehealth as one method of improving accessibility for these Veterans. VA is also developing and instituting a revolutionary new model of care that will assist all Veterans, not just rural Veterans, by providing an even more Veteran-centric approach to health care. Moreover, the pilot required by Public Law 110-387 section 403 is specially designed to improve the quality and availability of contracted care in rural areas when a VA medical facility is just too far away.

Office of Rural Health Initiatives
Since it was established in 2008, the Office of Rural Health (ORH) has worked to address the significant challenge of serving our Veterans in rural areas. VA has planned and funded more than 350 projects and initiatives to address these concerns. Our efforts have supported many

successful projects including: institutional physical expansion in the form of new community-based outpatient clinics (CBOC) and outreach clinics; home-based primary care; mobile health care resources; and many other local initiatives.

CBOCs offer Veterans a full array of exceptional VA services, including primary care, mental health care, and in some instances, VA will arrange specialty care services in communities where Veterans live and work. In FY 2008, ORH established 10 outreach clinics in rural areas for our Veterans, followed by an additional 30 outreach clinics in FY 2009. These are part-time clinics that extend access to VA's primary care and mental health services where there is less patient demand, or for other reasons it is otherwise not feasible to establish a full-time CBOC. These outreach clinics are required to collaborate with the local community to support the continuum of care and can be either VA-staffed or contracted to a local provider.

ORH has continued to support the expansion of the innovative program of home-based primary care teams, funding 38 Teams, 14 of which involve collaboration with the Indian Health Service or Tribal Organizations. Overall, 30 teams are operational and 8 are still hiring staff to deliver these benefits to our Veterans. These highly-skilled medical teams provide comprehensive health care right in the home of our Veterans with multiple chronic conditions, conditions that would normally preclude a Veteran from being able to visit a VA clinic. Rural Mobile Health Care Clinics are now operational in VISNs 1, 4, 19 and 20. These Clinics extend access to primary care and mental health services in rural areas where it is not feasible to establish a permanent clinic or hospital. They also offer for our Veterans ongoing coordination of overall medical care, wellness promotion and immunizations, health screening, referrals to specialty clinics, individual counseling, and other important services. Through the end of the first quarter of FY 2010, these clinics had seen 236 (VISN 1), 104 (VISN 4), 143 (VISN 19), and 123 (VISN 20) unique Veterans, respectively. The VISN 19 Mobile Clinic is based out of the Cheyenne VA Medical Center (VAMC) and it conducted its first visit on August 25, 2009 in Sterling, CO. It regularly visits Laramie, Wheatland and Torrington, WY. The Mobile Telehealth Clinic is staffed with VA health technicians and nurses providing onsite care to our Veterans and has a secure tele-video connection with the Cheyenne VAMC. This ensures Veterans receive the care they have earned through their service in their community; in essence, we're bringing VA to Veterans.

Rural Health Resource Centers (RHRC) provide an essential resource that helps VA study what is important for rural Veterans, test new programs, and educate rural Veterans with the latest information. There are three RHRCs across the country, with the Western Rural Health Resource Center located in VISN 19's VA Salt Lake City Health Care System in Salt Lake City, UT. These Centers perform policy analyses, design pilot projects, develop collaborations with a range of partners (such as the Indian Health Service, Tribal Organizations, and academic affiliates, to name a few), and provide education and updates to health care providers and Veterans on how VA can better deliver high quality, accessible health care to rural Veterans. Some focus on specific populations of Veterans; for example, the Western Region RHRC is focusing on Geriatric and Native Veteran populations.

VA has also established a dedicated Rural Consultant for each VISN who enhances the delivery of health care to Veterans in rural areas and leads activities to build an ORH Community of

Practice, promoting information exchanges and learning within and across VISNs and supporting a stronger link between ORH and the VISNs.

The mission of the Veterans Rural Health Advisory Committee is to examine outstanding issues and recommend ways VA and its team can improve medical services for enrolled Veterans who live in rural areas. The Committee developed a set of guiding principles which they have recommended to the Secretary for consideration in developing rural health policy. The Committee represents a broad cross section of Veterans and rural health care providers and advocates.

Telehealth

Telehealth is another mechanism by which VA is increasing access to health care for Veterans in rural areas. All together, between 30 and 50 percent of telehealth activity in VA supports Veterans in rural and highly rural areas, depending upon the area of telehealth. Data from FY 2009 show ongoing growth in all areas of telehealth.

Telehealth involves the use of information and telecommunication technologies as a tool in providing health care services when the patient and practitioner are separated by geographic distance. VA has three robust national telehealth platforms in place to support expanded health care access for Veterans through telehealth at the VISN, facility and CBOC level. These platforms are: real-time video conferencing, store-and-forward telehealth, and home telehealth, which are discussed in greater detail below. Because of the support of telehealth by VA and Congressional leadership, more Veterans are able to realize their benefits. Telehealth provides health care to underserved rural areas and involves 35 clinical specialties in VA.

Over the past 6 years, telehealth in VA has transitioned from use in a range of discrete local projects and programs toward a unified, enterprise level approach that provides routine telehealth services that are mission critical to the delivery of care to Veterans. VA has long been acknowledged as a national leader in developing effective and sustainable telehealth programs that increase access to care. VA's senior leadership, at both the national and VISN level, are committed to the expansion of telehealth to enhance access to care for Veteran patients, especially in rural and remote locations.

The importance of the systems approach VA is taking to its ongoing telehealth development is that the health care assets that are needed to provide care in rural areas exist in urban areas, and VA can leverage its clinical assets through a large interoperable telehealth network to support care locally. It is important to emphasize that although telehealth increases access to care, there remains an obligate need for face-to-face delivery of care. An appropriate balance of both "physical" and "virtual" clinical services is needed to provide comprehensive health care to meet the needs of Veterans, including Veterans in rural areas.

The successful implementation of robust and sustainable telehealth services that VA entrusts to provide care to Veteran patients must satisfy stringent clinical, technological and business requirements that ensure they are appropriate, responsive to the needs of Veterans, and cost-effective. These requirements include acceptance by patients and practitioners as well as staff training and quality management systems. To make sure we deliver safe and effective care, VA has introduced quality management programs for CCHT, Clinical Video Telehealth (CVT) and

care coordination store-and-forward (CCSF). In FY 2009, these quality management programs were combined for all three areas of telehealth to create a single assessment process in which the policies and procedures of telehealth programs are assessed biannually in each VISN. In addition, VA collects routine outcomes data for program management purposes. These systems allow us to quantify, validate and monitor the clinical benefits of these approaches.

VA provided real-time video-conferencing, also known as CVT, to more than 37,000 Veterans in rural and highly rural areas in FY 2008. Of these, 2,030 Veterans from rural areas served in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) and 112 OEF/OIF Veterans lived in highly rural areas.

The majority of CVT services were for mental health conditions, but Veterans also receive rehabilitation, speech pathology, polytrauma and spinal cord injury care. Ensuring VA is responsive to the needs of our Veterans and making mental health care accessible is a top priority for VA. In FY 2009, 21,603 Veterans received tele-mental health services in rural areas and 1,600 in highly rural areas. CVT services were available to Veterans at 250 sites in rural or highly rural areas. Moreover, VA is establishing a National Tele-Mental Health Center. This Center will coordinate tele-mental health services nationally with an emphasis on making specialist mental health services, such as those for post-traumatic stress disorder (PTSD) and bipolar disorder, available in rural areas.

Store-and-forward telehealth, known as CCSF, involves the acquisition and interpretation of clinical images for screening, assessment, diagnosis and management. These images can include photographs, x-rays, MRI results, and retinal scans, for example. These services were provided to 61,776 Veterans in rural areas and 2,911 in highly rural areas during FY 2008. In FY 2009, this workload increased by 86 percent. CCSF services were predominantly delivered to screen diabetic eye disease (tele-retinal imaging) and prevent avoidable blindness in Veterans. Last fiscal year, VA offered tele-retinal screening services at 283 sites, 78 of which were in rural or highly rural areas, and today, VA has 310 participating sites, 84 in rural or highly rural areas. The remainder of CCSF activity primarily covered tele-dermatology. VA set a goal of a 20 percent increase in use in FY 2010, and just as with CVT, VA is on pace to meet that objective. VA also has a pilot program underway to expand nationally for tele-dermatology in five VISNs in 35 sites, 20 of which are in rural areas.

Every Veteran wants to live as independently as possible, but sometimes health conditions mean this cannot be done safely. To help Veterans continue living in their own homes and local communities, VA provides home telehealth services, known as CCHT. CCHT covers a range of chronic conditions including diabetes, chronic heart failure, hypertension and depression. Currently, 41,000 Veterans receive CCHT for non-institutional care, chronic care management, acute care management and health promotion or disease prevention. Thirty-eight (38) percent of these patients are in rural areas and two percent are in highly rural areas.

Concerning specialty care, VA has home telehealth programs in 140 VA medical centers that enable 41,000 Veteran patients to remain living independently in their own homes. These programs are particularly applicable for the management of chronic disease and non-institutional care. Forty (40) percent of home telehealth patients are in rural and remote locations. Using funding in FY 2009, VA increased the delivery of care via home telehealth to Veteran patients in

rural and remote locations by 19 percent and is seeking to achieve a further increase of 20 percent in FY 2010.

VA continues to optimize its Polytrauma Telehealth Network to facilitate provider-to-provider and provider-to-family coordination, as well as consultation from Polytrauma Rehabilitation Centers and Network Sites to other providers and facilities. Currently, about 30 to 40 videoconference calls are made monthly across the Network Sites to VA and DoD facilities. New Polytrauma Telehealth Network initiatives in development include home buddy systems to maintain contact with patients with mild traumatic brain injury (TBI) or amputation, and remote delivery of speech therapy services to Veterans in rural areas.

VA is undertaking a range of initiatives to expand access to telehealth services in rural and highly rural areas. These initiatives focus on the clinical, technological and business processes that are the foundation for the safe, effective and cost-effective implementation of telehealth in VA to support Veteran care. For example, VA is working to formalize the clinical processes necessary to use telehealth to support the 41,096 Veterans with amputations receiving care from VA. Telehealth enhances access to care in rural areas as close to Veterans' homes and local communities as possible, if the Veteran wishes to use the services. We are also working to implement CVT services to make specialist care more widely available, including in rural areas. VA recently completed the necessary work to implement its Managing Overweight and/or Obesity for Veterans Everywhere (MOVE!) program within CCHT programs. This development will expand the reach of this successful and groundbreaking program for weight management to Veterans in rural and highly rural areas. We have also completed a program for supporting Veterans with substance abuse issues via home telehealth available during FY 2009.

New Model of Care – Moving Forward

One key element of VA's strategy for improving services for Veterans in rural and highly rural areas is a new model of care. VA is undertaking the most significant change in its model of care delivery since the rapid expansion of CBOCs began in the 1990s. In many ways, this new approach is a continuation of the same strategy VA has always pursued: bringing care closer to Veterans and making care more accessible.

To support this effort, VA has joined the Patient-Centered Primary Care Collaborative, a national coalition of other public and private sector members to improve primary care. We are redesigning our systems around the needs of our patients, improving care coordination and virtual access through enhanced secure messaging, social networking, telehealth, and telephone access. An essential component of this approach is transforming our primary care programs to increase our focus on health promotion, disease prevention, and chronic disease management through multidisciplinary teams. These changes will focus on improving the experience patients and their families have when seeking care from VA. We will benchmark with private sector organizations such as Kaiser-Permanente. We intend to seek patient input to help guide this transformation.

The President's FY 2011 budget submission describes this model in greater detail. The VA Tele-Health and Home Care Model initiative will use technology to remove barriers to Veterans and increase access to VA services. This initiative will enable VA to become a national leader in transforming primary care services to a medical home model of health care delivery that

improves patient satisfaction, clinical quality, safety and efficiencies. VA Tele-Health and Home Care Model will develop a new generation of communication tools (i.e. social networking, micro-blogging, text messaging, and self management groups) that can be used to disseminate and collect information related to health, benefits and other VA services.

The Veteran-Centered Care Model will improve health outcomes and the care experience for Veterans and their families. The model will standardize health care policies, practices and infrastructure to consistently prioritize Veterans' health care over any other factor without increasing cost or adversely affecting the quality of care. VA looks forward to working with Congress to ensure these plans become a reality for Veterans of all eras across the country.

Public Law 110-387, Section 403 Pilot Program
Public Law 110-387, Section 403 requires VA to conduct a pilot program to provide health care services to eligible Veterans through contractual arrangements with non-VA providers. The statute directs that the pilot program be conducted in at least five VISNs. VA has determined that VISNs 1, 6, 15, 18 and 19 meet the statute's requirements. This program will explore opportunities for collaboration with non-VA providers to examine innovative ways to provide health care for Veterans in remote areas.

Immediately after Public Law 110-387 was enacted, VA established a cross-functional workgroup with a wide range of representatives from various offices, as well as VISN representatives, to identify issues and develop an implementation plan. VA soon realized that the pilot program could not be responsibly commenced within 120 days of the law's enactment, as required. In March and June 2009, VA officials briefed Congressional staff on these implementation issues.

VA has made notable strides in implementing section 403 of PL 110-387, with the goal of having the pilot program operational in late 2010 or early 2011. Specifically, VA has:
• Developed an Implementation Plan, which contains recommendations made by the Workgroup on implementing the pilot program;
• Analyzed driving distances for each enrollee to identify eligible Veterans and re-configured its data systems;
• Provided eligible enrollee distribution maps to each participating VISN to aid in planning for potential pilot sites;
• Developed an internal Request for Proposals that was disseminated to the five VISNs asking for proposals on potential pilot sites;
• Developed an application form that will be used for Veterans participating in the pilot program; and
• Taken action to leverage lessons learned from the Healthcare Effectiveness through Resource Optimization pilot program (Project HERO) and adapt it for purposes of this pilot program.

VA has assembled an evaluation team of subject matter experts to review the proposals from the five VISNs regarding potential pilot sites. This team will then recommend specific locations for approval by the Under Secretary for Health. We anticipate this process will be complete this summer. After sites have been selected, VA will begin the acquisitions process. Since this process depends to some degree on the willingness of non-VA providers to participate, VA is unable to provide a definitive timeline for completion, but VA is making every effort to have

these contracts in place by the fall. This would allow VA to begin the pilot program in late 2010 or early 2011. VA notes that section 308 of Public Law 111-163, which was signed by the President on May 5, 2010, amends the requirements of Public Law 110-387 section 403 regarding the "hardship exception" and the mileage standard.

VISN 19 Initiatives

VA's Rocky Mountain Network (VISN 19) actively works to enhance the delivery of health care to Veterans in rural and highly rural areas in the Rocky Mountain region. VA understands that Veterans and others who reside in VISN 19's rural and frontier areas face a number of challenges associated with obtaining health care, such as geography, weather, and terrain. VISN 19 is pursuing a range of initiatives to share the expertise and experience of the entire VA system with these Veterans.

For example, VISN 19 is supporting four projects made possible by VA's Office of Rural Health (ORH) that harness technology to improve access and quality. VISN 19 received $7.3 million from ORH to develop 10 Primary Care Telehealth Outreach Clinics that will serve more than 7,000 Veterans in Glenwood Springs and Salida, Colorado; Hamilton and Plentywood, Montana; Idaho Falls, Idaho; Moab and Price, Utah; and Evanston, Rawlins and Worland, Wyoming. All of these clinics will be established by the end of 2010. VISN 19 also received $2.8 million to develop an innovative virtual Intensive Care Unit (ICU) and Rapid Response Team monitoring system with video conferencing; the virtual ICU is operational and successfully maintaining access to critical care services in Fort Harrison, MT, Grand Junction, CO, and Cheyenne, WY. VISN 19 received another $3.8 million to establish a VISN Telehealth Care Shared Resource System to provide expanded specialty care conferencing and consultation for care providers and Veterans in rural areas. Some of the disciplines or conditions included are endocrinology, traumatic brain injury (TBI), cognitive impairment services, pain management, dementia, post-traumatic stress disorder (PTSD), dermatology, rehabilitation and wound care, cardiology, and pre- and post-surgery care. This project is also exploring the feasibility of expanding services to non-VA telehealth networks. Finally, VISN 19 received $1.7 million to provide innovative education and wellness strategies to Veterans in rural areas using primarily telehealth modalities. The program will deliver intensive case management and education to Veterans with high-risk conditions, such as TBI, PTSD, depression, obesity, heart failure, diabetes, pulmonary disease, and substance use disorders.

VISN 19 also utilizes rural outreach clinics to offer services on a part-time basis, usually a few days a week, in rural and highly rural areas where there is not sufficient demand for full-time services or it is otherwise not feasible to establish a full-time CBOC. There are currently six designated outreach clinics in VISN 19: Havre, MT; Burlington, CO; Craig, CO; Elko, NV; Afton, WY; and Logan, UT which were recently approved and funded.

With regard to specialty care for our Veterans, the VA Rocky Mountain Network received four grants totaling $1.4 million to support non-institutional care for Veterans. These resources have helped us expand the home-based primary care and medical foster home programs to more Veterans in the region, preserving their independence while providing them the safe and effective care they need. VISN 19 is also home to the Mental Health Care Intensive Care Management-Rural Access Network for Growth Enhancement (MHICM-RANGE) Initiative, which has added

mental health staff to CBOCs and increased the use of tele-mental health services. Similarly, VISN 19 has conducted outreach and developed relationships with the Indian Health Service, as well as other agencies and academic institutions committed to serving rural areas.

Other efforts specific to Montana include:
• A $6.7 million contract for construction of a 24 bed inpatient mental health facility at the VA Montana Healthcare System. This expansion will provide Veterans residential rehabilitation in substance abuse and PTSD in Montana. Currently, Montana Veterans needing these longer stay programs are required to travel to VA facilities in North Dakota, Wyoming, or Idaho.
• A pair of grants totaling $707,172 to partner with a private company, Billings Clinic, to pilot Programs of All-Inclusive Care for the Elderly (PACE) services for Montana Veterans in Yellowstone County and Livingston, Montana. PACE provides community-based care and services to frail, elderly individuals as an alternative to institutional nursing home placement, and provides all health care and related services to participants over time and across all delivery settings. VA Montana plans to serve 15 Veterans through the PACE program.
• A part of the grant previously mentioned for a Home-Based Primary Care Team to provide the maximum of in-home care to rural and frontier Montana Veterans with complex medical conditions. The Team provides assistance to caregivers supporting concerns with housing and financial issues, and helps improve home safety and fall prevention, which maximizes the independence of the Veterans. VA Montana plans to serve 25-30 patients in the HBPC program.
• An $818,506 rural health eye care project in the Missoula and Bozeman Montana CBOCs. Each site will utilize Tele-Retinal Equipment to connect providers at the site with locations throughout the VA Montana HCS. In addition, VA Montana proposes to rent surgical space as needed, along with support staff for a VA ophthalmologist to perform eye surgeries (cataract removal) in Bozeman, MT at a local contract surgical site. This site will provide support to VA locations in Eastern Montana including Billings, Miles City, Glasgow, Glendive, Lewistown, Havre, as well as Western Montana in Missoula, Kalispell, Cut Bank and Hamilton. We expect services will be available at the Missoula and Bozeman CBOCs by the end of August 2010.

VISN 20 Initiatives
Much is happening in VISN 20 to support Veterans in rural areas, particularly in Alaska. The Alaska VA Healthcare System (Alaska VA) has recently opened, or will soon open, three clinics: the Mat-Su CBOC in Wasilla opened in April 2009; the Homer Outreach Clinic, opened in December 2009; and the Juneau Outreach clinic, which is currently operating part-time in temporary space in the U.S. Coast Guard Clinic, Juneau Federal Building, and will be moved to a permanent space later this fall after renovations on the first floor of the Federal building are complete.

In the area of telehealth, VISN 20 has implemented a tele-dermatology consultation system using store-and-forward technology and a consistent, defined curriculum of basic training and continuing education for primary care providers. This program has been implemented in Anchorage and has expanded to the clinics in Fairbanks and Kenai during FY 2010. The Kenai CBOC recently received funding to obtain tele-retinal imaging equipment and has begun offering this service, which particularly benefits Veterans with diabetes. VISN 20 also has adopted care coordination home telehealth (CCHT) programs; in Alaska, 220 Veterans have enrolled. Twenty-seven (27) percent of the enrollees live in highly rural areas, 20 percent live in rural areas, and 53

percent live in urban areas. The Alaska VA has been a leader in the rollout of this technology, and CCHT has been adopted by the Alaska Federal Health Care Partnership. It is being offered to other federal beneficiaries, to include clinics of the Alaska Native Tribal Health Consortium, as a result of VA collaboration.

During FY 2009, the Alaska VA successfully recruited a psychiatric nurse practitioner to support a tele-mental health clinic in Kenai, operating 3 to 5 days per month. As of May 31, 2010, 62 unique patients are being seen through this clinic, with an increase of 4 to 6 Veterans per month. In addition, a Social Work Mental Health Clinic for intake and ongoing therapy will begin at the Kenai CBOC during June, and a pain management group will begin at the Kenai CBOC in July 2010. At the end of March 2010, the Alaska VA neuro-psychologist started a TBI screening clinic via videoconference with the Fairbanks VA CBOC. Tele-mental health services are also offered to the Yukon-Kuskokwim Health Corporation (YKHC) in Bethel, AK, as they identify a need or forward a request. The Alaska VA has visited both YKHC and Maniilaq Health Corporation in Kotzebue to educate local health care providers about its tele-mental health resources. A January 2010 presentation to the Alaska Federal Health Care Partnership Telehealth and Technology Committee resulted in positive contacts with staff from the Alaska Native Tribal Health Consortium, Bristol Bay Area Health Corporation, and Maniilaq Health Care Corporation. This venue holds promise for spreading the message about tele-mental health resources at the Alaska VA. VA staff will continue to attend these quarterly meetings.

The Alaska VA is conducting a project focusing on collaborations with existing Alaska Native Tribal Health Corporation (ANTHC) facilities and federally-supported Community Health Centers (CHC) to provide primary care and mental health services to Alaska's Veterans. This project began in August 2009, with its goal to maximize existing VA authorities to enhance access to primary and mental health care for rural Veterans through purchased care provided by ANTHC and the CHCs. The project includes the Bethel census area; Bristol Bay Borough, Dillingham Census Area, Nome Census Area, Northwest Arctic Borough, Wade Hampton Census Area, and the City of Cordova. Under the project, Veterans may be authorized three primary care visits and two mental health visits within a 6 month period. If the Veteran requires additional visits, the Veteran or health care provider may contact VA to request additional care as needed. VA sent letters to 548 enrolled Veterans in the pilot areas inviting them to participate, and through May 2010, approximately 20 percent (N=110) have enrolled and 17 have requested and been granted authorizations for care (14 for primary care and 3 for mental health care).

Another initiative underway in Alaska involved VA hiring a full-time employee, a Rural Veteran Liaison, to be a local community-based contact for VA questions on health care and benefits. In June 2009, the Alaska VA hired a Bethel-based liaison to perform outreach to the Yukon-Kuskokwim area. There are two other outreach programs the Alaska VA is supporting: the Tribal Veteran Representative (TVR) Program, which uses local community volunteers to assist VA in reaching out to Alaska Native Veterans; and an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) program focused on the newest generation of Veterans. The TVR Program identifies Alaska Native Veterans recognized or appointed by an Alaska Native health organization, tribal government, tribal council, or other tribal entity to act as a liaison with local VA staff. The representative is a volunteer, unless paid by the Alaska Native entity. VA provides

collaborative training for the TVRs on VA health care and benefits programs. Four training sessions have been completed, two in Anchorage, one in Juneau, and one in Ketchikan. As of April 2010, 16 people have completed TVR training.

The Alaska VA has made special efforts to reach out to Alaska Native Tribal Health Consortium organizations upon the first major deployment of the Alaska National Guard in support of OEF/OIF. A multi-disciplinary group of VA staff traveled to rural areas to educate Veterans and the community about PTSD, TBI, and suicide awareness and prevention. In addition to the educational aspect of these sessions, VA staff and Alaska Native Tribal Health System staff focused on providing a pathway of care for each system to work together to ensure returning Servicemembers and other Veterans living in rural areas could seamlessly access their Alaska Native health benefits as well as access their benefits through the VA health care system. The presentations on the pathway of care focused on the VA enrollment, eligibility, and fee authorization process to assist Veterans in accessing VA health care and how to bill for reimbursement from VA should their health corporation seek authorization to provide services to Veterans. Packets of information with contact names and phone numbers were given to each participant, and information tables were staffed in community settings such as post offices, grocery stores, and other areas to raise awareness in the general community.

Finally, the Alaska VA has a signed a memorandum of understanding with the State of Alaska Department of Military and Veterans Affairs that outlines a partnership to work together to meet the needs of returning soldiers. OEF/OIF staff members regularly attend Post-Deployment Health Re-Assessment (PDHRA) events. In addition, the Alaska VA actively participates in pre- and post-deployment events for active duty Servicemembers. The National Guard's "Yellow Ribbon" events deliver information about VA benefits to Servicemembers and their families. The Rural Veteran Liaison and OEF/OIF staff members have accompanied these liaisons on a number of trips to rural Alaska to provide information about various VA programs and benefits.

Conclusion

VA continues to work to improve the quality and access of services for this important population. Thank you again for the opportunity to discuss VA's programs for Veterans in rural and highly rural areas. Again, this is a priority for the Secretary, and VA is bringing to bear all of its resources to ensure that every Veteran can access the care he or she earned through their service in uniform. This concludes my prepared statement. My staff and I look forward to answering your questions.