VA HEALTH CARE IN RURAL AREAS

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WEDNESDAY, JUNE 16, 2010

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

The committee met, pursuant to notice, at 9:31 a.m., in Room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, chairman of the committee, presiding.

Present: Senators Akaka, Murray, Tester, Begich, and Johanns.

OPENING STATEMENT OF CHAIRMAN AKAKA

Chairman Akaka. This hearing will come to order. Aloha and welcome to everyone.

Today, we will discuss VA health care issues in rural areas. Rural settings are some of the most difficult for VA and other government agencies to deliver care, I believe, and I know many of my colleagues on this committee share the view that we must utilize all the tools at our disposal in order to provide access to care and services for veterans in rural and remote locations. Expanding the use of telehealth technologies, rural outreach centers, mobile clinics, and other options will help us to make health care accessible to more veterans and reduce the burden on those living in rural areas.

VA also has the authority to partner with other government agencies or to contract with community medical professionals in order to provide care in local communities. Monitoring and evaluating the quality of this type of contracted care remains a challenge and I look forward to hearing more from VA on how to improve this.

We have worked to make immediate improvements for rural veterans. Recently, legislation from this committee was enacted into law which now provides higher rates of mileage reimbursement and reimbursement for airfare for veterans who must travel to reach VA health care facilities. This law will now provide important incentives that the Department can use to recruit and retain high-quality health care providers in rural areas.

I remain concerned about how effectively we are reaching veterans in rural areas. This is significant and it is a concern in my home State, where a large rural population cannot drive to the VA facility on Oahu as they are separated by many miles of water. This poses a special challenge in helping these veterans access VA health care.

This committee has held several hearings on health care in rural areas. For my part, I have worked to ensure that the neighbor islands in Hawaii have telemedicine capabilities, regular visits from medical personnel, and viable outpatient clinics. We have been largely successful

in these efforts and I will continue to explore new ways to make further improvements.

Today, we will be focusing on States with exceptional challenges. Our first panel of witnesses will address care and services for veterans in Montana, which has large areas in which VA has little or no presence but has a significant veteran population to serve. Also on the first panel, we have a witness from Senator Burr's home State of South Carolina, who can discuss how they are reaching out in rural areas.

The second panel will address issues in Alaska, which is not just considered rural but actually a remote area. I do plan to review all the testimony and will be working with members of this committee and the full Senate to ensure that VA does its very best to meet the needs of veterans living in rural and remote areas.

[The prepared statement of Senator Akaka follows:]

Chairman Akaka. Now, I would like to ask Senator Johanns for his opening statement. Senator Johanns?

OPENING STATEMENT OF SENATOR JOHANNS

Senator Johanns. Mr. Chairman, thank you, and let me say good morning and aloha. It is great to be here with you today.

Chairman Akaka. Good morning and aloha.

Senator Johanns. I want to express, if I could, how much I appreciate the opportunity for the purpose of this hearing to act as Ranking Member. Senator Burr, as you know, asked me to pinch hit for him today. With the College World Series kicking off in Omaha this week, that seems especially appropriate.

I also want to indicate what an honor it is to be the Ranking Member next to the Chairman. Mr. Chairman, I have great respect for the work you are doing for our veterans.

Today's topic is one that every single member of this committee, I believe, understands in some form or capacity. Providing health care to rural veterans is critical, especially in States that are rural, like Montana, like Nebraska, Alaska, and I could go on and on.

I thought today it might be appropriate--sometimes we start with areas where we disagree. Today, I want to start with areas where we agree and build upon those areas in my comments.

First, I think we all agree that greater use of technology is essential. Technology provides the ability for medical professionals to perform remote consultation and even some medical procedures or examinations in the comfort of a veteran's own surroundings. That is part of the reason I introduced a bill last month with Senators Klobuchar and Murray to help veterans electronically access VA programs. Easier programs will likely be used more often.

Now, testimony from a similar hearing we held last year suggested that VA was increasing its use of telehealth and telemedicine, and I applaud that. I am very interested in hearing about the progress and where we have come in the next year and what we are anticipating in the year ahead.

The challenge of providing care for rural veterans also raises the opportunity for VA to work in coordination with providers in our rural communities. Their challenges are often identical to ours. That is one of the recommendations made by the Veterans Rural Health Advisory Committee, which is going to be mentioned, I think, in the testimony today.

In 2008, Congress passed legislation to test the concept of allowing VA to team up with community providers to care for veterans who live far away from a VA health care facility. Our goal here is to have VA deliver timely, quality health care services to our veterans. I also look forward to hearing where we are at with this effort of

working with our community health care providers.

Finally, outreach is tremendously important for providing care to our rural veterans. One of the reasons why Senator Burr wanted Mr. Putnam, a Veteran Service Officer in North Carolina, to testify today was to emphasize the importance of working with folks at the local level to meet the needs of rural veterans.

And on a final note, Mr. Chairman, I was pleased to see that the Office of Rural Health has released its strategic plan covering the next five years. I am just a big believer in looking out five years and even longer to try to assess where we are at today and where we need to be going.

The plan outlines several goals and objectives to improve the delivery of health care to rural veterans. It will give the committee a blueprint from which to ensure that VA is indeed reaching more rural veterans with a concerted strategy. It is my hope that five, six, and seven years, we can look back and check off goals being obtained.

So, Mr. Chairman, thank you again for your service to veterans. Thank you again for this oversight hearing, and I look forward to our witnesses' testimony. Thank you.

Chairman Akaka. Thank you very much, Senator Johanns. You have been a great member of this committee and have really been helpful.

Let me now ask Senator Murray to proceed with her

statement.

OPENING STATEMENT OF SENATOR MURRAY

Senator Murray. Well, thank you very much, Mr. Chairman, Senator Johanns, for holding today's hearing to talk about how our VA is caring for our veterans in rural areas. I want to thank our witnesses, all of them who are here today, as well. I look forward to hearing your testimony.

As we all know, the fiscal year 2011 budget includes $250 million to improve access to care in rural areas. It is a good step forward and I am glad to see that that is in the VA's budget. But we continue to hear from a lot of our veterans in rural areas and underserved areas that they are still really struggling to access basic care today.

When I go home and talk to veterans in Washington State, I often hear about how they just can't travel several or more hours on snowy or icy roads, especially during our winter conditions, just to see a physician. Despite the efforts the VA has made to increase access to rural veterans through the establishment of new CBOCs and veteran centers and mobile medical units, all great progress, there are a lot of gaps still with our rural veterans.

Throughout Eastern Washington in my State and out on the peninsula, the VA still doesn't have enough services there to treat a lot of our veterans. I have been pushing

the VA very hard to open some contract clinics in Omak and Colville and Republic and to expand care in Port Angeles. We have got to be creative with the resources we have and continue to aggressively find alternate options for care, whether it is the contract facilities or fee basis or other innovative programs to get care to our rural and isolated communities.

This is a critical issue especially because the lack of access to care means a lot of these veterans put off preventive care and they don't get the necessary treatment they need. And, in fact, we know that the VA has found that rural veterans are in poorer health than those living in our urban areas. From recruiting and retaining health care providers in our rural areas to monitoring and managing the quality of care provided in non-VA facilities, we all know the challenges are very complex and there is no silver bullet to any of these issues. So I really appreciate this hearing today and I look forward to hearing from our witnesses about progress that is being made and how we can do better.

Thank you very much, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Murray. Senator Tester, will you proceed with your statement.

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. I want to thank you, Mr. Chairman. I

appreciate your leadership in this committee over the last many years on this issue and others. We appreciate it very much.

I want to thank the witnesses today, in particular Jim Ahrens. Jim, it wasn't easy getting here, but I do appreciate you coming a long way to tell a very important story.

Most of the folks in this room know the numbers. Forty-four percent of the enlistees in the military come from a rural or highly rural area, even though only one-quarter of the population lives in those rural areas. What the folks in this room may not think about is how this fact should change our approach in allocating VA dollars and resources. If we put all our energy into where the general population lives, we will not live up to our country's promises for all veterans.

It was three years ago next month that I held a field hearing in Great Falls, Montana, on the state of health care for rural veterans. At that point in time, the travel reimbursement for veterans was 11 cents a mile, not enough to pay for gas. There were only eight Community-Based Outpatient Clinics serving an area as big as the Eastern Seaboard. Mental health services were generally very tough to come by and many folks didn't understand how to respond to combat stresses, PTSD, and TBI. American Indian

veterans, who have the highest rate of enlistment of any minority group in the country, were shuffled between the VA and Indian Health Service. And a lot of folks who had served this country so honorably were not getting the quality of health care that they had earned.

I am pleased to say that things have gotten better since then. We have raised the travel reimbursement rate. We have expanded the number of CBOCs. We have started to make some progress to improve mental health awareness and services. We have done these things by working together, Democrats and Republicans on this committee, working with both a Democratic and a Republican VA Secretary. Veterans in Montana expect you to check your party politics at the door and focus on doing what is right and we owe them no less.

But make no mistake about it, there is always room for improvement, and that is what this hearing is all about. It is about seeing where to go from here. It is about making it easier for rural veterans to get to a VA facility for care or bringing the care closer to the veteran. It is about breaking down the bureaucracy so that Indian veterans get the care that they have earned. It is about making sure the VA has a steady supply of talented health care professionals in rural and frontier areas of this country.

I can promise folks from the VA that the Chairman and

Senator Burr will be having another hearing on this issue in the next Congress, too. It is critically important that we do not let our rural and frontier veterans lose out on the health care and benefits that they have earned. I will do everything I can to continue to advocate for them on this committee and in the United States Senate.

I know that many of the witnesses on the first panel feel the same way, so we will hear from them later and I appreciate, once again, you all being here.

Chairman Akaka. Thank you very much, Senator Tester.

Senator Begich, do you have a statement?

OPENING STATEMENT OF SENATOR BEGICH

Senator Begich. Mr. Chairman, I will hold my statement until maybe panel two. But first, I want to thank you for your willingness to hold this meeting on rural health care. It is very important, obviously, to many of our States here, but to Alaska, which is very, very rural in a lot of ways and access issues are a huge problem.

So I will just hold my comments and look forward to the testimony of both this panel, and obviously I am biased--no offense--to the second panel because there are lots of Alaskans on the second panel.

[The prepared statement of Senator Begich follows:]

Chairman Akaka. Thank you very much, Senator Begich.

I must address one further issue before we continue the hearing. Dr. Jesse, I know that this is not your fault, but unfortunately, as the Department's representative today, you must be the one to take this message back to VA.

I would like to note that the Department's testimony was submitted over 29 hours late. This is upsetting for me and, I am sure, for other members, as well, as it does not allow us and our staff sufficient time to review the testimony in order to have a productive hearing. The deadline for submitting testimony, which is clearly listed in the committee's rules, is there to avoid wasting everyone's time.

Frankly, I am very surprised that the Department could not meet the deadline for this hearing. This is a standard oversight hearing being held on an issue on which VA has been proactive and which has been the subject of recent attention, including hearings and briefings. This should not have been difficult testimony to develop, which suggests there is a serious flaw in the Department's processes. In the past, the Department has been able to meet this deadline without difficulty and I do not know what has changed to cause this habitual noncompliance, but I recommend the Department address this problem immediately so as to avoid any issues during the next hearing. So please take this

message back to the Department.

Dr. Jesse. Yes, sir, I will.

Chairman Akaka. I thank you.

Before we welcome our first panel and hear their statements, I recognize Senator Tester and Senator Begich. Both have been vocal advocates for the concerns of rural veterans. As our panels today are comprised largely of witnesses from their home States, I will be passing the gavel to them as they can each preside over the panel dealing with their home State. In the meantime, I have a hearing on the Armed Services Committee, and so I need to step out.

So I want to thank all of our witnesses for being here today and I will review all of your testimony in depth.

Senator Tester?

Senator Tester. [Presiding.] Once again, I want to thank the Chairman for his leadership and important attention to this issue.

I want to welcome the witnesses once again. I introduce Adrian Atizado, the Assistant National Legislative Director for Disabled American Veterans. Then next we have Jim Ahrens, the Chairman of the Veterans Rural Health Advisory Committee for the VA and Ronald Putnam, a Veteran Service Officer from Haywood County in North Carolina. Finally, we have Dr. Robert Jesse, the Acting Principal

Deputy Under Secretary for Health in the Department of Veterans Affairs. He is accompanied by Glen Grippen, the Network Director for VISN 19, which does include the State of Montana.

I want to point out that when we had the field hearing that I spoke of in my opening statement back in July of 2007, I think the only person newer on the job than me that day was Glen Grippen. Glen had been on the job at VISN 19 for two weeks at that point in time, as I recall. I am glad we are both still around.

Mr. Grippen. One week.

Senator Tester. Actually, one week. All right. I am glad we both are still around, Glen, and I want to thank you all for being here this morning.

We will start out with the testimony from Adrian.

STATEMENT OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Atizado. Senator Tester, members of the committee, I would like to thank all of you for inviting DAV to testify at this hearing on rural veterans health care. As you all know, DAV is an organization of 1.2 million service disabled veterans, and as such, rural health is an extremely important topic for our membership.

Veterans residing in rural to frontier areas face similar health care challenges as other citizens in these communities. Human and financial resources needed to provide quality health care and access to such care are the central shortcomings. Access to core services, such as emergency medical care, mental health and substance abuse services, hospital and long-term care is severely limited due to historical shortages of qualified health professionals.

Indeed, this deficit as well as the low-density patient population means establishing and supporting the types of specialized care veterans need is a great challenge. Such lack of resources results in what studies have shown as significant disparities and differences in health status between rural and urban veterans.

As a partner organization for the Independent Budget, the DAV believes that after serving their nation, veterans

should not experience neglect of health care needs by VA simply because of where they live. In fact, the delegates to our most recent national convention again passed a longstanding resolution to improve health care services for veterans living in rural and highly rural areas.

DAV believes Congress and VA are creating a potentially effective infrastructure to improve access and quality of care for enrolled highly rural veterans. However, we believe that there are some weaknesses that must be addressed in order to fully embrace the goal.

The Office of Rural Health, or ORH, is a relatively new function within VA's central office and it is only at the threshold of tangible effectiveness with many challenges remaining. Given its charge, we are mainly concerned about the staffing and organizational placement of this office. We believe that rural veterans' interests would be better served if ORH were elevated to a more appropriate management level with staff that is augmented commensurate with the office's responsibilities.

DAV believes that the three Veterans Health Care Resource Centers are key components of improving health care and health status of veterans residing in rural to frontier areas. The concept underlying their establishment was the support of strong VA Office of Rural Health presence within the enormous VA Health Care System. Currently, the centers

are under temporary charters with temporary staffs and receive centralized funding, but only for a five-year period. The nature of this arrangement has had unintended consequences, such as in the recruitment and retention of permanent staff to conduct their work.

If the concept of field-based Rural Health Satellite Offices is to be successful and sustained, we believe these centers need permanency of funding and, obviously, staff.

The VHA has also established VA Rural Health Care designees in all its VISNs to serve as points of contact and liaisons with the Offices of Rural Health. These VISN rural consultants, as outlined in the ORHS strategic plan, is crucial and we remain concerned over the part-time designation of 13 positions, which means only eight are full-time, and these 13 positions have collateral duties. We believe rural veterans' needs, especially those of the newest generation of war veterans, are so crucial and challenging that they deserve full-time attention and tailored programs.

Now, as a final matter, I would like to discuss a need to foster enhanced telehealth services functionality and availability that cannot only improve health care access, but quality of care and health status, as well. VA's pioneering work in telemedicine has proven to reduce hospital admission, shorten hospital stays, and lower health

care costs, and according to VA, the agency provides care to over 96,000 rural veterans through telehealth. But as you consider there are 3.1 million enrolled rural and highly rural veterans, the VA believes greater expansion of VA telehealth offers a great, but still unfulfilled, opportunity. Moreover, with the expected growth in VA's telehealth budget--I believe it is almost over a doubling of that budget--we urge VA management to coordinate rural technology efforts among all of its offices responsible for telehealth to promote advances, but also and more importantly to overcome privacy, policy, and security barriers that currently encumber expansion of this program.

DAV hopes VA and Congress will work together to address these and many other issues that will be laid out before the committee today. This concludes my statement and I would be happy to address any questions that this committee may have.

[The prepared statement of Mr. Atizado follows:]

Senator Tester. Thank you, Mr. Atizado. I appreciate your testimony. There will be questions when we are done with the panel.

Jim Ahrens?

STATEMENT OF JAMES F. AHRENS, CHAIRMAN, VETERANS RURAL HEALTH ADVISORY COMMITTEE, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Ahrens. Thank you, Senator Tester and members of the committee. I am from Craig, Montana, on the Missouri River. It is a beautiful place, somewhat like Alaska--somewhat. It is my distinct honor to serve as the Chairman of the Veterans Rural Health Advisory Committee, and that is a committee of 16 people across the country who work specifically on rural issues. That committee recently finished a report and sent it to the Secretary. He is reviewing it and hopefully we will get it published fairly soon after the review through the Department.

Let me outline for you just four of the issues, and we made 13 recommendations. I would like to just talk a little bit about four of those issues and then give you some of my own observations of what I think should be carried out by this committee and by the VA.

One of our recommendations is to--and you are going to hear a lot of this--pursue partnerships with State and Federal agencies and local health service providers to increase the enrollment of rural and highly rural veterans and to broaden their understanding of VA benefits and their programs. It is interesting to me that all the veterans aren't enrolled. You can't run a program, or market a

program, anyway, unless you know your customers, and we don't know where our customers are.

We need to ensure that access and continuity of care is facilitated as close to home as possible. I think this resonates well with the committee. This is something we really believe in.

And the committee also recommended an implementation of an enterprise-wide system that facilitates the organization and scheduling of VA telehealth services. Veterans need to be able to get into the system easy and use the services. And we need to deliver training programs at the local level to veterans and their families so that they understand what is going on and what services are available to them. I have a neighbor who was in the Korean War, never used the system at all, probably doesn't even know what is going on in the VA system. We need to let that person know what is happening.

Now I would like to share with you some of my own observations. I would be disingenuous if I said they are all my own. I have talked to a lot of people and they share these. These are not the recommendations of the Veterans Rural Health Advisory Committee or the VA, but these are things that people in the field are thinking about.

Obviously, there have got to be more services in places where veterans really live. You know, veterans--most of our

disabled veterans, from our data, live in the South and the West. And in the West, anyway, there are not a lot of services in some of the big areas. Senator Tester can tell you all about that from Montana.

We need to utilize more interactive telemedicine. They should focus on rural areas. In other words, recent legislation to create a tele-mental health program collaborative between the VA and critical access hospitals, well, that ought to be expanded. Private hospitals in Montana--every hospital in Montana has a telemedicine service, but the VA doesn't utilize that. Whether they can or can't, I don't know, but you could use it if you wanted to.

Van transportation networks need to be enhanced. Senator Tester and this committee did a wonderful thing in increasing the mileage reimbursement. We ought to up that to what the IRS allows. And it should be, I think, given to all enrolled veterans, including those with other than service-connected disabilities.

Enhance and promote the Internet utilization of My HealtheVet for all enrollees.

And offer a secure VISTA, veterans health record, that providers in the community can use. I don't know how many times I have talked to local doctors who have somebody in their office who can't find out what is going on with that

patient. Now, this is fraught with problems, HIPAA, confidentiality, and all that, but it can be done if we work at it.

Make the VA medical record available immediately to providers who see veterans in emergencies. You get somebody in an emergency room and can't even get their record. And perhaps these records could become available to hospitals and doctors by adding the staffing function to the 24-hour emergency suicide hotline which the VA runs. You could put somebody there and somehow or another some of that information could be given to the provider or to the hospital just to help the man or woman who is in an emergency situation.

I think we need to increase the availability of flexible scheduling at Community-Based Outpatient Clinics. Make it easier for the people to get into the system.

And there should be a more closer working relationship with the VA and Indian Health Service. It is starting, but we have got to do that. Well, you know the issues. There should also be more working relationships between the VA and other federally-funded health care organizations, like Community Health Centers, Rural Health Clinics, Critical Access Hospitals, and smaller facilities.

Mental health services should be readily available to all veterans, especially those living in rural areas. TBI,

in the West, there are no facilities, I don't think in Washington, either, or certainly not in our area, to take care of these people. There are major areas, and this is a growing concern.

All veterans in the 7s and 8s should get enrolled in the VA medical system, and maybe they could take advantage of the drug program.

And we need resources in local areas to educate people in the private sector and the VA so that they can help work together and solve these problems, because we have to be able to bring this collaborative effort together.

Mr. Chairman, I am out of time. I thank you for the opportunity to do this and I would be happy to answer questions at the right time.

[The prepared statement of Mr. Ahrens follows:]

Senator Tester. I appreciate your comments and recommendations.

Mr. Putnam?

STATEMENT OF RONALD PUTNAM, VETERAN SERVICE OFFICER, HAYWOOD COUNTY, NORTH CAROLINA

Mr. Putnam. Good morning, Senator Tester and members of the committee. I appreciate the opportunity to come here and testify. I would first like to let everyone know I am a County Service Officer. I see veterans every day and assist them in filing for their benefits, both health and other benefits from the Veterans Administration.

Haywood County is a remote county in the Western part of North Carolina, 200 square miles. It doesn't compete with Alaska and Montana, but we are still rural. My county has 57,000 citizens and 7,000 of those citizens are veterans.

I would like to report today on my colleagues that work in North Carolina, the other County Service Officers. I am a member of that association and on several committees. I want to report to this committee that the VA Medical Centers in North Carolina are all out in the community and starting to work with these rural teams. Not all the teams are fully staffed. The team out of the Charles George VA Medical Center in Asheville that I am working closely with still lacks a social worker. But I want to applaud the VA on actually coming out and collaborating with the County Service Officers and the State Service Officers and the other veterans associations to see where it is they need to

go to find these veterans that are not receiving the health care and have not applied.

Secondly, I would like to bring up that in rural America, all over rural America, I speak--I am also on the National Service Officers Committee and a chairman of one of their committees--across America, we face a generation that is quickly passing, our World War II veterans and our Korean War veterans. Just to shed a little in-light on the people that the VA is trying to reach with 21st century technology, just this past year, I did a claim for a veteran in Haywood County and the gentleman had a second grade education. North Carolina provides an opportunity for veterans to apply for a high school diploma from the Governor if they joined the service during wartime and served, and in the past two years, I have made application for eight individuals and the highest education level of those eight individuals was a seventh grade education.

These men live in remote, small, mountainous, rural communities. They don't go anywhere except to church and to the local feed store. These men find out about things from the newspaper and if their preacher tells them on Sunday morning. They do find out from other individuals. I feel that this social disconnect and the time that these individuals were brought up in history makes it very difficult for the Veterans Administration to reach without

personal intervention.

Once again, I do applaud the VA for working closely with county, State, and other Service Officers across the nation because we are the front line of the VA. We are funded by local Governments and this committee, I would like to bring up one bill that is in this committee, 3849, an outreach bill. I would like this committee to consider that strongly because that bill and those funds would enable the Service Officers across the nation to help the VA to reach these individuals.

I would like to let you know that the team that is working out of the Charles George VA Medical Center in my area has already been in the field. They came out this past weekend to two National Guard units and set up shop there. I can't say enough about how it started. It is getting on the ground. It is beginning to work. It is kind of scaring me because it is actually making sense and they are actually talking to the people they need to be talking to.

I would just hope that this committee and this Congress and this administration continues to fund that. As my colleagues here have already mentioned, there are quite a few veterans that are going to be around a long time, Vietnam-era veterans, Gulf War veterans that are going to be with us some time, and they are not going away and they are not going to move to town and we are going to have to go out

there and find them.

I appreciate this opportunity again, and I will be willing to take any questions that you have. Thank you very much.

[The prepared statement of Mr. Putnam follows:]

Senator Tester. Thank you, Mr. Putnam. I appreciate your comments.

Dr. Jesse?

STATEMENT OF ROBERT JESSE, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GLEN W. GRIPPEN, NETWORK DIRECTOR, VETERANS INTEGRATED NETWORK 19, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. Jesse. Yes. Good morning, Senator Tester, members of the committee, and our apologies for the lateness of our testimony. I am happy to have the opportunity to present to you today.

I would like to thank you for inviting us here today to discuss the current state of VA's care and service for our veterans in rural areas and specifically in VISNs 19 and 20. I am accompanied today on this panel by Mr. Glen Grippen, the Network Director for the Rocky Mountain Network, which is VISN 19, and on the next panel by Mr. William Schoenhard, who is the Deputy Under Secretary for Operations and Management.

Increasing access for veterans is one of Secretary Shinseki's top priorities. This means bringing care closer to home, increasing the quality of care that we deliver, and providing veteran-centered care in a time and manner that is convenient to our veterans.

My written testimony covers in great detail VA's national efforts to improve access, quality, and coordination of care for our rural veterans, as well as

specific initiatives in VISN 19 and 20 that directly relate to our rural veterans.

In the time I have now, I would just like to highlight the broader work VA is doing for the veterans in rural America. VA offers a number of important programs designed specifically to increase access to veterans living in rural areas. VA has planned and funded more than 350 projects, actually getting close to 400 at this point, projects and initiatives to help improve access for rural veterans. Our efforts have supported many successful projects, including new facilities, home-based primary care mobile health resources, telehealth, and many other local initiatives.

Telehealth is one of the major mechanisms by which VA is increasing access to health care for veterans in the rural areas. All together, there are between 30 and 50 percent of telehealth activity in VA supports veterans in rural areas, and data from fiscal year 2009 show ongoing growth in all these areas of telehealth, and as was mentioned, there is a robust increase in the budget to cover that activity.

Another key element of VA's strategy for improving services for veterans in rural areas is a new model of care. VA is undertaking probably the most significant change in its model of care delivery since the rapid expansion in the CBOCs beginning back in the 1990s, and 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.

We are redesigning our systems around the needs of our patients, improving care coordination and virtual access through secure messaging, social networking, telehelp, and telephone access. An essential component of this approach is transforming our primary care programs to increase the focus on health promotion, disease prevention, and chronic disease management through multidisciplinary teams.

Concerning Montana, VA's Rocky Mountain Network, VISN 19, actively works to enhance the delivery of health care to veterans in 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, including geography, but also weather and terrain. For example, VISN 19 is supporting four projects made possible by the Office of Rural Health that harness technology and improve access and quality. VISN 19 received $7.3 million from the ORH to develop ten primary care telehealth outreach clinics that will serve more than 7,000 veterans, and the VA Rocky Mountain Network received four grants totaling $1.4 million to support non-institutional care for veterans in that area.

Turning to Alaska, much is happening in VISN 20 to

support veterans in rural areas. The Alaska VA Health Care System has recently opened or will soon open three clinics, Mat-Su CBOC in Wasilla, the Homer Outreach Clinic, and the Juneau Outreach Clinic, which is currently operating part-time in temporary space and will be moved to a permanent space later this fall.

Alaska VA has also been conducting a project focusing on collaborations with existing Alaska Native Tribal Health Corporation facilities and federally-supported Community Health Centers to provide primary care and mental health services to Alaska's veterans. VA continues to work to improve the quality and access of services for this important population.

I would like to thank you all again for the opportunity to discuss VA's programs for veterans in 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 has earned through their service in uniform.

This concludes my prepared statement and my staff and I look forward to answering your questions. Thank you.

[The prepared statement of Dr. Jesse follows:]

Senator Tester. Thank you, Dr. Jesse. I appreciate your testimony.

Correct me if I am wrong, Glen. You are going to be here, available for questions, is that correct?

Mr. Grippen. Yes, sir.

Senator Tester. Okay. And I will make sure to at least have one or two for you.

We will have five-minute rounds. The order of questioning will be Senator Murray, followed by Senator Johanns, Senator Begich, and I will go last. Senator Murray?

Senator Murray. Thank you very much, Mr. Chairman, and to all of you for your testimony today.

Dr. Jesse, I have been working with the VA, as you know, to open new contract clinics in three of our underserved communities in my State, Omak, Republic, and Colville, so that those local veterans can get easier access. I have also been working with the VA to open a virtual clinic in Port Angeles that is really critical for that community, as well, and I wanted to ask you this morning, where are we with those efforts to expand care in Omak and Republic and Colville, as well as the virtual clinic in Port Angeles?

Dr. Jesse. I can't give you the exact details, but I do know that all of those are moving forward, but we can get

back to you on the record for their exact status.

Senator Murray. If you could do that for me, those veterans are waiting to hear--

Dr. Jesse. Absolutely--

Senator Murray. and we certainly are, as well. Do you have a time frame when you can get back to me on that?

Dr. Jesse. As soon as possible. We can get that in the next couple of weeks, I am certain.

Senator Murray. In the next couple of weeks. Okay. I would appreciate that a lot. Thank you.

Dr. Jesse. Sure.

Senator Murray. I have heard stories of veterans, as I said in my opening remarks, traveling for hours for routine care, and I hear a lot about dental appointments, as well, for folks. Can you tell us how the VA determines when to provide care on a fee basis instead of forcing the veteran to drive long distances?

Dr. Jesse. There are, I think, a couple issues that need to be discussed in the context of that. First of all, the most important thing for us is that the veteran can get the best care in a way that is most convenient for them. That being said, that generally means as close to home as possible. Sometimes, that care, when it is complex, is not available in the local areas.

A good example would be, and we have had some of this

discussion, I think, from the last meeting in regards to cancer care, that patients might need to be sent down to Seattle to get that care when, in fact, some of that care might be available in Anchorage, and we are actually now looking to build the kind of contracts we can get to get that care in Anchorage so they would have to travel less far, when appropriate. We do know that some of the veterans would prefer to travel down to Seattle, and if that is the case, we would accommodate that. And in certain cases--

Senator Murray. So is this a case by case, or are there guidelines? Are there rules, or just--

Dr. Jesse. Well, it is--it has been, I think, case by case. We are in the process of establishing contracts so that we can have those services available so that they don't have to travel.

Senator Murray. So there aren't any--

Dr. Jesse. But we don't have all the--

Senator Murray. --specific guidelines when you go to fee basis versus making somebody travel?

Dr. Jesse. Not that I am aware of.

Senator Murray. It is case by case determined. Should there be guidelines?

Dr. Jesse. Well, I think where the guidelines would come into play would be having the availability of those services through contracts or through other mechanisms

locally. We have historically not been as good about that as we should have been. We relied on the patients having to come to our centers, traveling many miles, in Montana going down to Denver, which would be a good 400 miles, just like to travel down to the lower 48. And I think one of the real initiatives--

Senator Murray. It takes that long in some places from my State to get--

Dr. Jesse. Yes. And so I think one of the major important initiatives of the Office of Rural Health is to really determine--to move that away from being the case by case and to develop the policy and the opportunity to deliver that care as close to the home as possible.

Senator Murray. All right. I wanted to ask you, as well, the VA recently proposed to adopt the Medicare payment method for all non-VA inpatient and outpatient health care services in the absence of contracts between providers and the VA. I am really concerned about the impact of that potential change on services like laboratory or dialysis providers, especially dialysis providers. We have heard a lot of concern about that.

You know, we all know we have got to be fiscally prudent, but a change this large, I think ought to be phased in so we can have a smooth transition process. And I am also very concerned about the impact on rural and undeserved

areas. So can you share with this committee what the status is of that pending rule?

Dr. Jesse. Certainly. So I think there are actually two issues here, one being fiscally responsible, but more important than that is access, and we need to ensure not only access today, but access five years now to the needed services so that we weigh both of concerns.

Specifically related to dialysis, this has been a huge financial burden on the VA. It is not that we have been paying a little bit more than Medicare. We have been paying sometimes 400 percent of Medicare and it has had a huge financial impact, which, as you know, takes away from the ability to provide other services. So the VA, in moving towards that Medicare, our proposal is to phase it in over four years--

Senator Murray. Four years?

Dr. Jesse. --which is historically what, I think, the Department of Defense did when they have made changes along these lines in TRICARE, but also what Medicare has done when they have made major changes like this.

Senator Murray. Okay.

Dr. Jesse. Four years, I think, should be sufficient time to--

Senator Murray. Well, I would like my staff to follow up with you--

Dr. Jesse. Sure.

Senator Murray. --because we are very concerned, especially about the dialysis and how we can mitigate some of the closure of the clinics in some of our rural areas.

Dr. Jesse. And the VA also is, as I mentioned, access is important and there is a lot of effort going on to improve the VA's ability to deliver dialysis services.

Senator Murray. Okay. I appreciate it. Thank you very much. Thank you, Mr. Chairman.

Senator Tester. Senator Johanns?

Senator Johanns. Thank you, Mr. Chairman.

Dr. Jesse, let me continue, if I could, with questions for you.

Dr. Jesse. Sure.

Senator Johanns. I haven't been to a hearing on these issues yet where the promise of telehealth, telemedicine wasn't emphasized, and I, as a former Governor, certainly promoted it, also recognizing this as a way of trying to get medical services into rural areas. I think we would all agree it would be great to have a cardiologist and a psychiatrist and an oncologist in every area of our States. It is just not going to be possible. We know that. They are hard to recruit, even to larger cities, much less a very rural area.

One of the things that you say in your testimony is

that you believe that telehealth has reduced hospital admissions. That conjures up the notion that maybe it saves some money. Do we have any measurement at all at our fingertips that can demonstrate to us that our investment in telehealth is, in fact, paying off by whatever measure you might use? Talk about that and walk me through how I can be convinced that, in fact, our continued emphasis on this effort is working, resulting in better care or fewer hospital admissions or whatever.

Dr. Jesse. Certainly. As a cardiologist, I appreciate your recognition of--

[Laughter.]

Dr. Jesse. --of how difficult it is to get the services, and particularly in the area I practice, which is acute cardiac care, where things are very time dependent. There are very real challenges that occur in getting the very urgent and timely care to these patients.

So telehealth--there are three forms of telehealth that we are looking at. Essentially, tele-consultation, which would get cardiology expertise, say, to a primary care provider in a remote area, so the connection of medical services.

The second is storing forward [ph.], which is what we do with the tele-retinal imaging, for instance. So rather than people have to travel distance just to get an eye exam,

the diabetics where we do this annually, and a good 25 percent of our patients are diabetics, we can do that. We can put that technology into primary care offices. It goes into the medical record. It is then read remotely by experts and we can codify this and follow it over years.

And then the other is the home telehealth. Again, I will use my background as a cardiologist and point out we have been actually doing this since the mid-1980s with the home monitoring of pacemakers and implanted devices. So it is not new, and, in fact, in that example, two years ago or three years ago, there was a large number of recalls of pacemakers and implantable devices. By having the home monitoring process in place, we estimated we saved 25,000 clinic visits across this country.

So just to see the travel costs, the staff time, the patients' time, you know, especially where they have to travel and be seen in clinics, it is a tremendous savings that adds up in that case.

In the broader sense, yes, we can easily quantitate that we reduce admissions because we can intervene and things early, and that is the rough block of money. I think the heart of this question, though, is as we move from a health care model that is inherently episodic, people come to us when there is a problem, to one that is driven by wellness, prevention, risk mitigation in the long sense, it

is having that connectiveness between the patient and the health care system in order to manage that, I think, will be the real payoff in the long run.

And we don't have those numbers right now, but if you look at the cost of managing just hospitalizations alone and managing patients with chronic diseases, if that can be better managed through telehealth and prevent those admissions, and worse, the secondary--the bad outcomes from those diseases, that is where the true cost savings comes in.

So the simple answer is we can give you hard numbers about prevented admissions. The larger, the 20-year plan is at this point, I think, a good model, but is not hard and proven.

Senator Johanns. This is something that the VA is really going to have to help us with, because we are putting money out there. I think we are testing a lot of different approaches here. We hear testimony, though, that, gosh, maybe this isn't doing all it needs to be doing or we need to do more. Somehow, some way, we have got to figure out how to measure this. We have got to be able to figure out that this strategy works very, very well with telehealth, this one doesn't, and be honest about that so we can focus our spending in an appropriate way, because, again, I would love to say that we are going to have specialists throughout

every rural area in America. There aren't that many. And so we have got to somehow figure out what is working and what is not working.

Mr. Ahrens, I think you offered a thought here about whether telehealth was getting the job done. I am out of time now, but if you could take just a minute and offer your thoughts in reaction to what Dr. Jesse has said. Are you as excited about telehealth maybe as you once were, or are there--are we making the progress you want to see?

Mr. Ahrens. Senator, let me answer it this way. I think we are making progress, but we ought to measure it. And some of the money that you put out could be used for measurement studies. Does it save money? I am convinced it does, but you have got to have the metrics out there that shows that it does. You need outcome measurements, and I think it would be well worthwhile for the Office of Rural Health to do one of those studies to show you. And we need to expand it. There is no question about it. You can't deliver health care to everybody in rural America without using it.

Senator Johanns. Yes. Adrian, you mentioned this in your testimony. Is there anything you want to offer as I wrap up here?

Mr. Atizado. Yes, Senator. I think that there is sufficient study that shows telemedicine does save money,

primarily on the preventive medicine side. The other anecdotal evidence shows the use of specialized consultants does help, as well. You have to understand that when you go to especially the frontier areas of our nation, there is no safety net. I mean, you have got one primary care doctor doing everything.

Senator Johanns. Yes.

Mr. Atizado. They are on call 24/7. They can take a vacation. So when they have these technologies, in fact, there is, I think, an article in the AARP Bulletin magazine about this where the physician actually had a telemedicine hook-up videoconference with a cardiologist who could listen to the vital signs and breathing sounds of a patient who had a chronic condition. That saved that patient having to drive seven, eight hours with a chronic condition to the nearest town or city that has the services that they need.

So, I mean, the evidence seems logical that it would save money. It is just a matter of proving it. The whole idea of saving admissions and lowering cost of health care is, VA parlance, they are a business. I mean, they are a health care provider, so they have to talk in this sense. But as far as users of VA health care, it seems apparent to us that it is something that VA should do.

I must note, if I could have a few more seconds, the FDA, FCC, and HRSA have set aside funding not only to build

broadband infrastructure to the rural communities, but certain initiatives are devoted to telemedicine in rural areas. And I think with the advent of new technology that is going rapidly as we speak for telemedicine, a lot of policy makers and a lot of industry experts are actually looking at VA and their research into whether or not they are going to invest in telehealth and telemedicine.

So I think it is crucial, as Mr. Ahrens said, that VA, in fact, document not only health outcomes, not only cost savings, but health status and the ability for telemedicine to deal with the workforce shortage that everybody is facing now.

Senator Johanns. Thank you, everybody.

Senator Tester. Senator Begich?

Senator Begich. Thank you very much, Mr. Chairman.

If I can, Dr. Jesse, let me do a little additional follow-up on kind of a couple of questions in regards to telemedicine, but also on utilization by other facilities that are non-VA but the contracts that you are trying to work out.

You had made the comment you were trying to expand these contracts, and you used Anchorage as an example, and you are working through it. Can you elaborate a little bit more? What does that mean? And why I say this is because, to be very frank with you, I have heard that on a regular

basis. This is one thing that we have is a huge opportunity of medical facilities, and Indian Health Care Service is a great example, because the way we manage them up there, but also huge facilities both in Anchorage and Fairbanks that, I think, are underutilized.

But help me understand. When you say you are working out a process or you are working through contracts, tell me what that means and what kind of time table.

Dr. Jesse. Okay. So I think Mr. Schoenhard could probably speak to that better, since he is involved in the details of that, but--

Senator Begich. Okay. He is behind you and smiling, so that is--

Dr. Jesse. Is it the Providence that--

Mr. Schoenhard. Yes.

Dr. Jesse. So it is the Providence Health System--

Senator Begich. If you want to reserve some of your answer, you can, and--

Dr. Jesse. Since you have asked for it, it is the Providence Health System in Anchorage that they are in the process of developing or negotiating to cover at least the cancer care.

Senator Begich. Let me ask you, if I can, and I will hold more detail until the next panel, but let me ask you, can you or do you keep data on, in any State, how

utilization of non-VA facilities by VA recipients, or do you have data points? If I said to you, what is the percentage in Montana or Nebraska or in Alaska that take advantage of that based on proximity and other reasons, do you have such a--and what kind of services they receive?

Dr. Jesse. Yes. So this is complex, because there are a couple terminologies that we need to be clear about. One is what is called fee care, and fee care by the strict definition means we don't provide the service and we authorize the veteran to go and get it.

Senator Begich. Right.

Dr. Jesse. And we pay that bill. That is a small component of what is in broadly more encompassing non-VA care, which would include both fee care but also care that is through contract, through community providers, care that is delivered through contract or other agreements, if you will, through our academic affiliates.

And the other is that we don't have a handle on, because we don't really pay for it, is care that the veteran themselves--

Senator Begich. Right, get on their own.

Dr. Jesse. --chooses to get on the outside, because many of them also do have secondary insurance and/or in addition to Medicare. And we have--that dual care is a particular challenge to us, not from the financial side, but

from the managing care side.

So we have the ability to track fee care, obviously. We have a lot of contract care that is--the ability to roll it up is a little less robust because some of it is--it rolls in rather than it is just a flat rate that we are paying out on an annual basis. But we can tell you what that is with at least some level of precision, I am sure.

Senator Begich. Is that something that you can provide to us--

Dr. Jesse. I believe so, and without making a promise, I will go back and tell you what granulary we can provide that to you.

Senator Begich. Excellent. And again, as you say, there is fee and there is contract and--

Dr. Jesse. Right. There is a host of vehicles by which we--

Senator Begich. The more defined you can do that, the better off--

Dr. Jesse. Sure.

Senator Begich. I would be very interested in that.

Dr. Jesse. Okay.

Senator Begich. Let me, if I can, and there has been some good testimony on telehealth. In Alaska, we use it a great deal, not only from a VA perspective, but our travel consortium, which is our Indian Health Services, which is a

huge piece of the puzzle, how we move through delivering health care in areas where even a van--I know, Mr. Ahrens, you talked about increasing the vans. We can't even get a van there, let alone a plane, depending on weather.

Both of you clearly have stated, do you feel that where--and I know there was a comment earlier about where Rural Health Centers are located, the Office of Rural Health Care is located. Do you think elevating that to a higher level will get some more recognition of the data that needs to be done, the need to understand it better and deliver it better, or is the location--you were concerned about where it was located and kind of the system where the office is. But, Mr. Ahrens, I didn't hear you make a comment on that. Do you have any comment in regards to that?

Mr. Ahrens. The Office of Rural Health in the VA?

Senator Begich. Yes.

Mr. Ahrens. I think the higher the elevation you can give it, the better off we are, and we are slowly getting it staffed. There have been a lot of staff changes. And I think it has got the attention of the Secretary and we ought to keep it right at the highest level we can, because it is very important.

Senator Begich. Do you think where it is located now, that the telehealth issues--I mean, I agree with you, if you don't have the data, it is irrelevant. I mean, you can

spend a lot of time talking about how important it is. We see it in real life in Alaska. But do you think that has any relationship to doing some of that hard data collection that is necessary, or is it just two separate issues that need to be addressed? In other words, data collection has its own, and then moving this office up higher.

Mr. Ahrens. Well, again, keep the office as high as you can. This data collection is very important. We don't even know where veterans are, and we need to know their utilization of their services, if that is what you are asking me. And we have to have certain data in order to proceed. If you are running a business, how are you going to pursue that if you don't know where your customers are?

Senator Begich. Right.

Mr. Ahrens. And so we have to continue to get that. We can't even make some decisions with our committee because we don't know where they are, what disease entity they might have, and what services should be placed in those areas. If we knew a little more of that, we would be better off. So the Office of Rural Health ought to get on that and get it done.

Senator Begich. Let me, and my time has expired, the report you sent up to the Secretary, do you anticipate that to be available to us? At what point do you think?

Mr. Atizado. I would--as I said, it is under the

Secretary's scrutiny. I would--if I could release it to you today, I would, but I can't. It is a public document. It should be available to you.

Senator Begich. Okay, great. Thank you very much, Mr. Chairman.

Senator Tester. Thank you, Senator Begich.

Jim, Senator Murray talked about, and it was a question that she had asked Dr. Jesse about fee basis and who goes where and about the fact that there were no guidelines for that. Has the Veterans Rural Health Advisory Committee taken that up at all? Is that something that is within your purview? Has it been part of the conversation?

Mr. Ahrens. There has been a lot of discussion about fee-based, and I think it is the consensus of the committee that, especially in rural areas, there ought to be more of it. Now, what is happening in this discussion is can you provide the same quality of care that the VA thinks they provide in the private sector, and so I think you can do that, but then we have got to overcome that barrier.

So this makes a lot of sense to me to use fee-based in areas where they are very remote, like Scobey, Montana, or someplace like that, or--

Senator Tester. I have got you. It seems a bit odd, as far as if we take individual by individual and not have guidelines. I mean, I appreciate your honesty, Dr. Jesse.

Does that seem odd to you? You have been in the business for a long time, Jim.

Mr. Ahrens. Well, I think I would establish protocols so they can be part of the business, and if they can't meet them, they shouldn't be.

Senator Tester. All right. Dr. Jesse, a quick question. It does deal with rural veterans' health care along the area of dialysis. Has the VA looked at home dialysis?

Dr. Jesse. Yes. Actually, we had a long discussion about this the other day. I think, if I remember the number correctly, it is about seven percent of our veterans now get home dialysis. There are two ways to do this. One is through a conventional hemodialysis type of machine. The other, which is where most of the home dialysis is done, is through peritoneal dialysis. It is doable. It doesn't require even sending somebody into the home, that patients and their families can be trained to do it--

Senator Tester. Is it cost effective?

Dr. Jesse. --and it is one of the options that we are looking at to improve the distribution of this. It is an area that even outside of the VA has struggled to really catch on.

Senator Tester. Is it cost effective?

Dr. Jesse. Well, we think it is at least cost neutral.

Senator Tester. Okay, because I think--yes, that is good. I think you have to take into account everybody--

Dr. Jesse. So those are exactly the two questions the Secretary asked me the other day when we were meeting about this. We think that this is an opportunity, but it has struggled to catch on and we are not sure why.

Senator Tester. Well, I think it is an incredible opportunity. It might be lack of knowledge. Let us move on.

Mr. Ahrens, I know for a fact, and you talked about it in your testimony as one of your recommendations, that we need to work more with IHS and VA, and you even took it a step further, VA and other health care facilities. Every time we have approached this, it has become somewhat of a turf issue. So could you talk a little bit more about what we could do to encourage IHS and VA to work together, because it is an incredible opportunity for saving some money and offering better health care.

Mr. Ahrens. I would be happy to. I think it has to start at the top. You have to have the head of the Indian Health Service and the head of the VA make it a priority. In my opinion, over the years, even working in the private sector, it hasn't been that priority. Once you do that, everything falls into place. But you have got to do that and you also have to do in each State collaboration at the

local level, where you can get the various Indian Health Service organizations and tribes together and sit down and start talking. It is a long, long process, but you have got to start it because we are wasting money by having these two systems.

Senator Tester. Any ideas on what we can do as far as recruiting and retaining health care folks in rural areas, what the VA could do better?

Mr. Ahrens. Well, I think most of the VA training facilities are located in major metropolitan areas, and somehow you have got to get practitioners to have some type of a residency or training program in rural areas. You know, we do this in Montana on the private side, where people stay in Montana. If they can serve their residency in Montana, you have got a pretty good retention rate. That is not happening to the full extent that it should, in my opinion. So you have got to do that.

Senator Tester. Okay. That is our priority with me, to try to get them back in the system. It is something I hear more about than any other single issue as I do my town halls.

We have spoken in the past about opportunities with prescription drugs for Priority 8s. Could you just talk to me a little bit about how it might work?

Mr. Ahrens. Well, I am not sure exactly how it will

work mechanically, but I think if you are enrolled and you are a veteran, you ought to be able to avail yourself of the services. So get these people enrolled in some fashion and let them use the drug benefit. I think it would be a wonderful opportunity.

Senator Tester. Okay.

Mr. Ahrens. Mechanically, I don't know how to do it. I leave it up to my friend, Dr. Jesse, to put it together.

Senator Tester. All right. Do you have any ideas on that, Dr. Jesse? Is that something you would support, or is there something that you think the VA could do for Priority 8 veterans?

Dr. Jesse. The Secretary has begun, and I think authorization through Congress to actually open things back up to Priority 8s. It was done in a fashion that would meter them in, because if we opened it up all at once, it would be overwhelming--

Senator Tester. How about just with respect to prescription drugs?

Dr. Jesse. In respect to prescription drugs, there are a couple of challenges there.

Senator Tester. Okay.

Dr. Jesse. One is that we don't have the authority right now--I hope I am saying this correctly--to accept prescriptions from outside providers, so that, in fact, VA

has to process that prescription. For many pharmaceuticals, the basics for hypertension and diabetic care and things, that is really not an issue. But for some, again, there are some cardiac drugs that require monitoring and the like, where there is a lot of responsibility on the provider when we can't ensure that it raises some other issues. From a purely technical perspective, whether we could just open up, we will have to get back to you on that. I don't have the--

Senator Tester. Could you, please? That would be good, if you could get back to us. If you need Congressional authorization, that would be something. I think it really could be a win for Priority 8 folks.

Dr. Jesse. I will take that back to the Secretary.

Senator Tester. Glen, I promised you a question. I am going to give it to you, and then we have got to go to a vote at 10:45, so we will recess and come back with Senator Begich's panel.

We have got more female veterans coming into the VA system every year. One of the services that is lacking in Montana--this is a Montana-specific question--is mammography screening, particularly in Helena. Is that something that we could really take a look at? Is it something that we could do? We need more than just equipment. We need more than space. Is it something that is on the radar screen as the female veteran population grows?

Mr. Grippen. Senator Tester, first of all, thank you for all your support, working together closely with us. Certainly, women veterans is one of our highest priorities. We are taking a close look at our programs in women's health and we will make sure mammography and cervical prevention care are two key pieces of that, and we will take a closer look and provide information to you about where we are planning to go in that direction.

Senator Tester. I would appreciate that a lot, Glen, and once again, thank you for your service.

I am sorry I didn't get a question for you, Mr. Putnam or Mr. Atizado. I really appreciate everybody's testimony today. I appreciate your commitment to veterans across this country.

With that, we will recess until Senator Begich gets back to reconvene.

[Recess.]

Senator Begich. [Presiding.] The meeting will come back to order. Thank you, guys, very much. I appreciate your patience. We have a little issue on the floor and some of us are having to have some negotiations while we were trying to vote and leave and get back here, so thank you very much for your time.

I am going to make my comments very brief and just go right into the testimony, but I do want to say, as I said in

my earlier comments, there is no more rural State than Alaska in the sense of delivery of services and how you can get from one point to the next, or, as I was just describing to Mr. Ahrens, he has a friend in Kodiak. I had to explain to him that I was just in Kodiak, could not leave for almost a full day because the weather conditions could not get me out of there, and I can only imagine when people need medical services.

As folks know from Alaska, with almost 76,000, 77,000 folks that are veterans or registered veterans, we have one of the highest percent per capita, so we have a huge demand for veterans' services in Alaska. At the same time, as I mentioned, it is very difficult to move around and get access for the services they need.

Today, this is the second panel that we have in front of us and I thank you all for being patient while we move through the process of voting on the floor and attempting to run committee meetings at the same time.

We are joined today, and I appreciate the Alaskans that are here, Brigadier General Deborah McManus is the Assistant Adjunct General for Alaska, commander of the Alaska Air and National Guard, and Alaska State Women Veterans Coordinator. She is accompanied by Verdie Bowen, who has traveled with us many places around the State, and I thank you, Verdie, for being here, Director of Office of Veterans Affairs for

Alaska Department of Military and Veterans Affairs.

Dan Winkelman is the Vice President and General Counsel for the Yukon-Kuskokwim Health Corporation. Dan, thank you for being here.

And finally, Robert Jesse gets a round two. You have survived round one, so that is a good sign, so welcome again to this panel.

And also, Bill Schoenhard, Deputy Under Secretary for Health for Operations and Management in VA. Thank you for your visit to Alaska and getting a sense of what Alaska is about. You lucked out because the weather was pretty good. It was very good. So you will be our opportunity to explain to all the folks in D.C., when we say it is warm and not humid, you actually know what we are talking about now. Again, thank you for being here.

What I would like to do, General McManus, if we could start with you and if you would like to give your testimony. You each have about five minutes. The clock in front of you will signal. If you bypass that, the floor will release below you. Just kidding.

[Laughter.]

Senator Begich. So, General?

STATEMENT OF BRIGADIER GENERAL DEBORAH McMANUS, ASSISTANT ADJUTANT GENERAL-AIR, JOINT FORCES HEADQUARTERS-ALASKA, AND COMMANDER, ALASKA NATIONAL GUARD; ACCOMPANIED BY VERDIE BOWEN, DIRECTOR, OFFICE OF VETERANS AFFAIRS, ALASKA DEPARTMENT OF MILITARY AND VETERANS AFFAIRS

General McManus. Thank you, Senator Begich. It is my privilege and honor to be able to be here today and to appear in front of the committee members and to be able to address our rural health care issues in reaching out to our veterans.

I would like to draw your attention to the map of Alaska. As you can see, Alaska is the largest State and it is one-fifth the size of the continental United States and it has five times the coastline. Over five percent of Alaskans speak one of the 22 indigenous languages.

And then we look at the 2000 Census and how they distinguish between urban areas, urban clusters and rural areas. We only have two locations that are urban areas and that is Anchorage and Fairbanks, and Anchorage the largest. Over 250,000 folks live there from the Census Bureau. And then we have Fairbanks, over 50,000. So that is about 300,000 of our Alaskans that live in urban areas.

And then they have urbanized clusters, and these are defined as those densely populated areas that have over

2,500 people, and in Alaska, the 348 localities, 17 of them are identified as clusters. I would like to point out that only about 11 of those clusters do not even reside on the Anchorage road system, and you can see the road system there. It is less than 5,000 paved miles reported by the Department of Transportation.

And then we have those non-urbanized areas that the term is typically referred to as rural. I would like to use the term remote when we address Alaska because they are off the road system. You can reach them by air, and that is on a good day and it is weather-dependent, seasonal-dependent, a lot of communication barriers. Some of our villages, they may not even have phone access and do not have Internet access. And they have a subsistence lifestyle, so they may not have regular stores in which you can go and shop for goods.

And you can see out of those that are not one of the urbanized area clusters, that is about 250,000 of our Alaskans, and the veteran population, as the good Senator said, is the largest per capita in the country. So the veteran population is dispersed similarly.

And there are some projects. The VA, they are active in that area. Of course, Anchorage, our largest area, they have a large outpatient clinic. They just opened a new one in May and it is attached to the Elmendorf Military

Treatment Facility. It is a wonderful facility, very large and very welcoming to women veterans and also to families. Our younger veterans like to bring their families in to serve with them.

And the CBOCs up at Fairbanks, Wasilla, Kenai, the more populated areas, off the road system. They have also opened some outreach clinics. Homer, they use the Kenai CBOC staff to staff that on Mondays and they provide outreach services to those veterans in that area. And also, in Juneau, we expect an outreach clinic to be opened there in the fall. In Juneau, they have a population of about 3,000 veterans and it is designed to go and reach the inter-island ferry system, which is excellent.

And also, we have talked about the Rural Health Care Pilot Areas. There are seven of those areas and they are also on your map. The rural population resides typically around the coast and the inland areas around the river system.

And then what we have found to be most successful is our Yellow Ribbon Reconnecting Veterans Outreach Program, and this was a program initiated by the Alaska National Guard and we did receive a Federal grant of $500,000. The goal is to reach out to the IA recognized villages and the incorporated cities and towns. It is a year program and that will be expiring in July, and we only have, like, 30

more locations, and they are visiting locations today.

But that has been very successful, to go out there and say, where are our veterans, and they want to know how do they know they are a veteran, so we explain that. We take out the paperwork and we help them fill out their paperwork. Many of them have said that, oh, yes, we have received those packages from the Veterans Administration in the mail. We just don't know what to do with it and we don't know what it means. Even if we were to fill out this paperwork, what does it mean for us? So that has been very instrumental, to help them complete that paperwork.

Members of this team understand that if a veteran reaches 30 percent disability, then that enables them to receive travel benefits to travel to one of these VA health care locations. And we work with them on that initial health exam through funds within the Alaska National Guard and creative ways. We reach out to NGOs, veteran organizations that will help fund some of our rural veterans to come into those locations for care, and also to let them know that they are eligible for military gravestones, and that was interesting, to get them out to the rural area and overcome that some of these are post boxes or whatever, and they are eligible for military funeral honors. And they also talk to some of the National Guard retirees that may not have filled out the paperwork for their benefits, and

also to our ATG members to help them fill out applications.

So that has been a very successful effort and we would like to be able to continue that, but it would take another grant. But we get a lot out of that $500,000 grant because we have folks that are really dedicated, part of the community and want to reach out to these folks.

[The prepared statement of General McManus follows:]

Senator Begich. Thank you very much, General.
General McManus. You are welcome.
Senator Begich. Verdie, were you going to speak, or did you have--
Mr. Bowen. If you want me to speak, sir, I am more than--
Senator Begich. I wasn't sure if you had testimony you wanted to give.
Mr. Bowen. Well, I can provide testimony. I had not had time to write one and present one to you.
Senator Begich. Let me hold you there, then, and I will probably have some questions for you.
Mr. Bowen. Thank you, sir.
Senator Begich. Dan?

STATEMENT OF DAN WINKELMAN, VICE PRESIDENT FOR ADMINISTRATION AND GENERAL COUNSEL, YUKON-KUSKOKWIM HEALTH CORPORATION, ALASKA

Mr. Winkelman. Good morning, Mr. Chairman. The Yukon-Kuskokwim Health Corporation has been contracting with the Indian Health Service to provide health care services for over 20 years. Today, in remote Western Alaska, we provide comprehensive health care to 28,000 people, largely Yupik Eskimos across a roadless area the size of the State of Oregon, where the average per capita income in our region is about $15,000 on an annual basis.

Our unemployment rate in our villages is over 20 percent. Gas in our main hub city of Bethel is $5.34 a gallon. In our villages, it is $6 to $8 a gallon, about the same price we pay for a gallon of milk. Many homes in our region are without piped water and sewer, and over 6,000 homes in rural Alaska do not have safe drinking water.

When considering the high energy, food, and personnel costs against an IHS appropriation that does not allow for mandatory medical inflation increase, providing health care to our 58 tribes on a daily basis is an extraordinary challenge, especially when you consider the enormous health disparities in our region.

For example, Alaska Natives' leading cause of death is cancer. The Alaska Native cancer mortality rate is

approximately about 26 percent higher than U.S. Caucasians. While cancer mortality for the rest of Americans is decreasing, it is dramatically increasing for Alaska Natives. Particularly disturbing is our region's high suicide rates. Unfortunately, our age-adjusted suicide rate for teens, 15 to 19-year-olds, is 17 times the national average.

This is the environment where many Alaska Native veterans were born and raised and then return to after serving our great country. For Alaska Native American Indian veterans who serve at the highest rate per capita of any U.S. race, to lack access upon their return from duty to culturally appropriate and quality health care services by the Veterans Administration is a shame.

In Alaska, highly rural veterans must break through several barriers in order to receive care. There are almost no VA facilities in rural Alaska. The existing IHS and tribal facilities managed by Tribal Health Organizations like YKHC are underfunded, according to the IHS, by approximately 50 percent. Lastly, the Alaska VA Health System's Rural Health Pilot Project is not Statewide and needs dramatic improvement.

I have three recommendations. The first is to establish a VA clinical encounter rate for the IHS and tribal facilities. Instead of building new VA health care

infrastructure in rural Alaska, the VA should increase its collaboration with Tribal Health Organizations and use the existing Alaska Tribal Health System infrastructure that already exists for rural veterans' care. The Alaska Tribal Health System provides quality services. We are nationally recognized and we are fully accredited by the Joint Commission. However, due to the IHS's chronic underfunding, it is important that the VA reimburse tribal facilities that provide care to veterans and their eligible family members.

The creation of a VA clinical encounter rate to reimburse IHS and tribally-operated facilities should include multiple types of services, such as primary, emergent, behavioral health, and telemedicine services. Non-native veterans should also be able to access these services through this encounter rate, as well, since in rural Alaska these facilities are the only ones available.

My second recommendation is that in the alternative of establishing a VA clinical encounter rate for IHS and tribal facilities, the committee should review, redesign with tribal input, and redeploy the Statewide Alaska Rural Health Care Pilot Project. The committee should review how the pilot was developed, the extent of tribal participation in the pilot's design prior to deployment, and its scope of services offered versus the actual need, whether the pilot was effectively communicated to our highly rural veterans

and tribal partners, its billing processes, and the number of veterans who, quote, "opted in" and utilized services.

As for the pilot itself, it could have been designed and deployed more effectively. Instead, it seemed to be an afterthought. For example, although care is rendered in tribal facilities, veterans must first self-enroll with a different agency, the VA. We have no control over that enrollment process. This process is called opt in. Why are veterans required to fill out additional paperwork in order to participate in the pilot when they should already be deemed eligible by virtue of their service record? Our veterans deserve better than having to research how they and their eligible family members can opt in for health care services. After all, our veterans opted in when they signed over their lives to serve our country.

Another opportunity for improvement is to do away with limiting the scope of health care services a veteran may utilize within a six-month time period. I do not know anyone, and I am sure you don't, either, who can plan ahead of time when to have their illnesses take place, especially in a six-month time frame. To require our highly rural veterans to jump through additional barriers to receive only limited services is bureaucratic and ineffective to improve access to care.

My third recommendation is to monitor appropriations to

the Office of Rural Health Care to ensure that all rural and highly rural veterans are adequately served. According to a June 3, 2009, letter by Senator Murkowski to VA Secretary Shinseki, Alaska's rural or highly rural veterans were initially going to receive zero dollars of last year's historic $250 million appropriation to the Office of Rural Health. Senator Murkowski wrote, I quote, "I first learned of this project on Friday, May 22, after I expressed concern that none of the $215 million in Office of Rural Health Projects announced that week would have any significant effect on Alaska's access problems."

Obviously, we have received the pilot since then, and, Mr. Chairman, I see I have run out of time. May I have a few more seconds just to wrap up?

Senator Begich. Wrap it up very quickly.

Mr. Winkelman. Thank you. But it is unacceptable for America's most remote rural veterans living in remote bush Alaska to be forgotten by the VA and the ORH, whose mission is to ensure highly rural veterans have access to quality health care resources, especially with such a historic appropriation.

In conclusion, any rural or highly rural veteran should be able to go to any IHS or tribal facility and receive the care they need from that facility and that facility should be fully reimbursed by the VA for providing such services.

In the words of Senator Begich yourself, I think it was last year you said it is all Federal monies, regardless of which Federal agency is providing that care, the IHS or the VA.

And last, I would like to give an example. For a veteran that is living in one of our areas, the reality is that if you are seeking behavioral health care services, it might mean waking up in the early morning hours to leave your home, let us say along the Bering Sea Coast in the Village of Kotlik via a small single-engine plane and flying a half-an-hour to the next village, which is Emmonak, which is near the mouth of the Yukon River, transferring to another small plane, flying another hour and a half to Bethel, and then transferring to a regional airliner to fly the last 400 air miles to Anchorage, all for an appointment the following day. That is a big deal.

Those are some major barriers, and those are the types of situations that we need to improve on, and Congress is entirely in power to solve those problems. Thank you, Mr. Chairman.

[The prepared statement of Mr. Winkelman follows:]

Senator Begich. Thank you, Dan.
Dr. Jesse, were you planning to testify again?

STATEMENT OF ROBERT JESSE, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH OPERATIONS AND MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. Jesse. No, sir.

Senator Begich. Thank you very much. Let me move to Dr. Schoenhard. Thank you very much again for visiting Alaska. Thank you for being here today. I will turn to you.

Mr. Schoenhard. Sir, I do not have any testimony to give but am happy to answer any questions.

Senator Begich. Very good. Verdie, that gives you a few minutes if you want to say any additional comments before I start going through a series of questions here.

Mr. Bowen. Thank you, sir, and thank you very much for inviting me to this committee.

I believe that in Alaska, we have come a long ways. We still have a long ways to go to provide health care to our rural health care veterans. And as I travel throughout the State, I see different issues, and a lot of them really deal with something that Dan just touched on and it dealt with the fact of the travel time it takes to get from one place to another to another in order to get adequate health care.

And sometimes, if the veteran could just stop by either the Native Health Office that is there locally for a simple blood test instead of spending two days or three days to get to Anchorage to do the same thing, it would be a wonderful thing for them.

As I was in Ketchikan a couple of weeks ago, some of those guys were spending three days just to come up for simple blood tests and X-rays that could have been done at the local hospital, and I think that there are probably better ways that we could utilize our money and this is a good point that we should be able to take care of. And I think through partnerships with Indian Health Service and the other local hospitals throughout the State, we will be able to treat every single veteran that we have.

Several things that have been touched on, and this is the last thing I will say, is that most of our veterans, we have a hard time getting them to register within the VA system. I have heard several times today where people have talked about getting everyone registered. I am not really sure what the answer is. The Yellow Ribbon Team by the end of this month will have hit every populated center in the State of Alaska, which is well over 300. In that effort, we were only able to assign 2,000 additional veterans within the VA Health Care System.

I think that more will come as we move along, but if

you look at the State of Alaska's Permanent Fund Dividend Form that is filled out each year by all Alaskans so that they can receive those royalty funds, only 700 have checked the box saying that they are veterans. So I am not quite sure what the answer is to get them to register besides going out and doing one-on-one visits with each and every one of them, like we have pursued.

But the one request I do have for this committee is that the Yellow Ribbon Team that we have in the National Guard goes out and treats all veterans. It doesn't matter what war, whether they are National Guard, whether they are--lately, they have been reaching out to a lot of Vietnam era veterans. They are working on a budget of about $500,000 for their travel expenses currently, and between the State of Alaska and them, we have partnershipped in order to reach all of these communities, and those funds will be up in October. It would be very nice if we can continue on and do follow-up visits next year because we might be able to take that 2,000 to 77,000. That is what should be all of our goal.

Thank you.

Senator Begich. Very good. Thank you very much.

If I can start with first a couple of quick questions, I am going to actually follow up on that regarding people signing up, and I know, General, you with your work with

women veterans, and I know the coordination that you are doing there, even within women veterans, there is a small--I want to say it is about a third of them are signed up or taking advantage. Can you elaborate a little bit of what you think, and maybe following up on Mr. Bowen's comments regarding how hard it is to register. What are you finding specifically in the area with women veterans? I know it is a concern for me. I know it is a concern for Senator Murray. Give me a little bit of thought on that.

General McManus. Well, when we look at our female women veteran population, a lot of them are from the older wars and I think there is a cultural issue there in which many of them, they were in subordinate roles or support roles and their service was not as greatly appreciated when they returned to the States.

And also, a lot of them experienced military sexual trauma, whether it is rape, sexual assault, or harassment. So there was a fear of seeking help through the system, so a lot of them just faded away. However, I think it is different with our current OEF/OIF veterans, that there are mechanisms so that they can report it and receive help.

And a lot of times, women do not recognize that they are veterans, and women have traditionally been in a caregiver role. So I think there is a cultural issue, but there is an education issue. And when we did that women

veterans outreach campaign in November of 2009, last year, we did see an increase in enrollment and use of services. Three hundred women additionally enrolled and 400 seeking services. So I think a routine education system that lets women know they are vets, too, they have earned these rights and these are their benefits, and a lot of them have female-specific health care needs. So now they understand the VA facilities can provide services in those areas, as well.

Senator Begich. Very good. Let me, if I can move over to this side, to either one of you who would answer, is there more that the VA can do? An example was just given how the outreach was done to increase the amount of women who recognize that they have benefits available to them but may not be taking them for a variety of reasons just described. Do you have any thoughts on that? Dr. Jesse?

Dr. Jesse. A couple things. I think the issues that have been brought up are really important. We have historically on the health care side measured access by wait times to clinic visits, wait times--

Senator Begich. How many came through? How long they waited?

Dr. Jesse. How long they waited. And all that is irrelevant if they don't know that they are entitled to services, they can't access those services, they can't get to us, we are not connected to them in one way or another.

Particularly as we move to our sort of our new models of care, if you will, where we are not talking about episodic access as a driving function but actually connectivity, that front-end engagement becomes absolutely crucial.

And so we have an awful lot of effort going on trying to understand this now. Why don't people declare themselves as veterans on forms? Why can we repeatedly send people information and they just don't act upon it? Our assumption is, well, we sent it to you. You should have acted on it. And the simple answer is, people should probably be enrolled when they swear into the military and make that very--we talk about seamless transition and there is a lot of discussion going on between VA and the Department of Defense as to how do we best affect that, and I can only say that, again, this is the Secretary's, one of his top priorities and he understands these issues probably better than any of our leadership in prior years.

So we are trying to understand this. We are trying to make it easier. But there are complex issues here.

In terms of the women's issues, this gets, again, really interesting, because historically, we measure what we do in health care statistically. We look at all of these statistically. But whenever we try and look at women's health issues, the numbers aren't big enough to make sense of the statistics, and what we have really learned from this

is we have to treat each individual as a man of one and really try and understand how we can manage their health care needs in a much more specific manner.

And so the VA over the past several years has done a lot. Every VA facility now has Women's Health Coordinators. We do have an Office for Women's Health Issues that is very proactive in trying to develop these. The issues of military sexual trauma are extremely complex. Just to get them coming forward, I think, is happening because the discussion is coming out into the open. And again, we are willing to accept any help, any advice. We see these as very important issues and are trying to deal with them.

Senator Begich. So obviously if the General has some ideas, she will be able to share them with you and you will--that is good. I will leave that to you two to go forward.

Let me kind of narrow down, if I can, on one, and that is the Rural Health Project. Mr. Winkelman laid out some concerns, and I know you have heard from me more than once on this issue. The idea, and I think you had three suggestions, but I want to take it a little broader, and maybe if, Dr. Schoenhard, if you could respond to this, and that is--I may be a little bold here. The effort and idea is good. I don't think anyone disagrees with that. The implementation is the struggle. And it sounds like, based on the testimony, there might have been some linkages in the

front end that might not have been put together as well and now we are trying to kind of patch it as we move along.

I am wondering if it is better to kind of freeze-frame for a second on it and say, okay, let us sit down with our rural health care providers who have been in the business for years and have figured out how to deliver to the most remote areas in the world, in a lot of ways, health care, and how to restart it rather than, I think, what is happening. The sense I get, and I may be wrong about this, but I hear from so many different people it is almost like we are trying to patch a little issue here and patch a little issue when really maybe we should just freeze-frame it, stop, step back. What is the right approach? Bring some of the people who have been in the field and say, what should we do differently?

Just the fact that you have to go get opt-in through another type of system before you are really in, you know, I can only tell you from my experience, and Dan has much more experience around this, for rural individuals who lived in rural Alaska most of their life, that is just another piece of paper they are not going to do. They are just--I don't want to say give up, but they do less.

Is that too bold of an opportunity, or--I am just trying to--it seems like every time I talk about this issue, it is always like almost starting, then not, then moving,

then not. So give me your thoughts on that.

Mr. Schoenhard. Yes, Senator. I think the numbers on the rural pilot really speak for themselves. We obviously are struggling with getting veterans to sign up for this program. At this point, only 21 percent in the pilot have signed up, and of that, very few have asked for primary care authorizations for mental health consultations. So I think the numbers speak for themselves. We need to improve.

We have hired a company to do a focus group to understand better why we haven't had more success in enrolling veterans, but I welcome what Mr. Winkelman and Mr. Bowen have shared today. We need to sit down and understand together, because IHS has assets on the ground. They are in the communities. They understand well what is needed there, much better than anyone else that would be in a distant location, whether they are with VA or anywhere else. And we should collaborate, and I think your suggestion that we freeze-frame, we were talking a little bit during the break, during the recess--

Senator Begich. That was strategically done. You know that, don't you?

Mr. Schoenhard. Yes, sir.

[Laughter.]

Mr. Schoenhard. We had good conversation, and I would certainly welcome undertaking the discussion of the three

recommendations that were shared and see how we can better serve and better get veterans engaged with IHS in these locations.

Senator Begich. The consultant that you are using, maybe two questions, and you may not know the first one right offhand. Do you know if the list of folks they are consulting with, in other words, getting input from, includes some of the delivery systems within the consortium, the Native Health Care Consortium? Do you know if that is part of the list of who they are kind of--not just veterans, I assume they are talking to in their focus groups, but also the current providers of other health care--do you know if they are doing that?

Mr. Schoenhard. I do not know. My impression is that it is primarily veterans that we have not reached, but I think, hearing what we have heard today, we should reach out and certainly have them also talk to the providers.

Senator Begich. I appreciate that.

Second, is that consultant responsive to you, or who are they--

Mr. Schoenhard. To the VA.

Senator Begich. Okay, to the VA organization. So there is one or two below you that kind of manage that in some form?

Mr. Schoenhard. Yes, sir.

Senator Begich. I would ask this, and I don't know if you can commit to this. I believe in these kind of committee meetings we can make all kinds of speeches or we can get some work done and I would like to get work done. Is there a way that you would be willing to commit your level, some of the folks you just heard some testimony from, to say, we are going to sit down in the next, if it is a month or two, and kind of do the freeze-frame, make sure the consultant is actually touching bases with the right people to hear that input, and then maybe it is just a restart of the program, that you would be willing to say, we will commit to this in an aggressive way, because I think the concept is--I mean, you heard a little bit earlier, I think everyone wants to see this work.

Mr. Schoenhard. Right.

Senator Begich. And the delivery capacity is huge. But it seems like we are just--something is missing in the mix. And I guess in our State, and you have heard me say this before, if you can do it in Alaska, you can do it anywhere. If you can deliver services to the most remote areas in the world in Alaska, the rest of the country will be a piece of cake.

Do you feel that is a commitment you could give now, or do you need to have a conversation back with the VA and more of an administrative discussion before you commit to sit

down with a very short period, maybe it is a month or two, say, we are going to engage at this different level with the consultant and some of the stakeholders, which we would obviously be happy to provide you with some of those names. Any thought from there?

Mr. Schoenhard. Sir, I would not hesitate to make that commitment. I think we should do that.

Mr. Schoenhard. Excellent. Dan, if I can kind of swing back over to you and also to the General, I mean, are you prepared, if there is a time table set up to put the resources on the table, have that discussion, to work through some practical implementations? First, to Mr. Winkelman.

Mr. Winkelman. Yes. You bet, Senator. And there is already precedent for this. There was a Memorandum of Understanding that was signed way back in February 2003 between the VA and HHS and IHS that said they would collaborate together on how to provide better access and how to develop better processes and systems of care for both of their constituents. So there is that agreement that is there. I would suggest that it be used and that there is a high-level meeting to show that there is a commitment with the IHS at the table, the VA at the table, and then also the Tribal Health Organizations that have the compact and contracts that run the health care in Alaska between us and

the Indian Health Service.

Senator Begich. General, any comment from you on that?

General McManus. Yes, sir. We also did a MOU in 2007 working with the VA to prepare for a returning 100 soldiers that were coming out of rural Alaska, 26 villages. And in that, some of the assumptions were that these folks would continue to access care through the Indian Health Services available in their villages. So some of the initiatives surrounded good collaboration between VA Health Care Services and the Alaska Native Tribal Health Care Consortium and providing telehealth services and educating the health aides at the villages to identify some of these illnesses associated with deployments and serving in combat, such as PTSD, and how to best serve them.

Senator Begich. Let me, if I can, maybe--Dr. Jesse, did you have a comment? I wasn't sure if you--

Dr. Jesse. Yes, a couple of things. First is that the VA is committed to working with IHS. I know that there is a refresh of the 2003 MOU in process. I can't tell you exactly where that is right now. We have coming on board actually on July 6 the new Director of the Office of Rural Health, who is at an SES level but comes to us with 20-some years of experience in IHS, which I think will be--

Senator Begich. That will be great.

Dr. Jesse. --extraordinary for developing and

strengthening those relationships. So we are extremely excited about that.

And just one other comment about what Mr. Schoenhard mentioned. He said the numbers speak for themselves. You know, if you look at why we do pilots, it is because we want to be sure we do things right. When we set up the rural pilot in Bethel, there were some bounds around the extent to services that could be accessed. I wasn't privy to that, but my sense is that it was done because we didn't want to overwhelm a system. Well, we have, in fact, underwhelmed the system. You know, we sent letters out to 548 people. We enrolled 20 percent, and only ten have asked for things. Clearly, we haven't done something right, and your comment that there are issues here, clearly, we don't understand, and to step down, to have a stand-down and--I mean, I don't say stop the program.

Senator Begich. Correct.

Dr. Jesse. That was--

Senator Begich. That is why it is kind of a freeze-frame.

Dr. Jesse. --but we need to revisit what is going on here and try and get a better understanding about why people aren't jumping at the service and what we do need to do to open this up, and we would commit to doing that.

Senator Begich. Excellent. I will say this, and I

appreciate that, because I know when you do these programs, sometimes you want to just keep getting down the path, but this is a moment, I think, where we can shift it and reexamine it and probably have a much more successful program. And actually, the fact that you have MOUs tells me that paper is good, but action is better. So it sounds like we have plenty of MOUs. It is just really now it is how do we just collaborate.

And again, I think why we selected this panel the way we did was specific, because I knew the diversity that was going to be here was going to be just right to have this discussion, because it is an important program. Again, if we can be successful in Alaska, I really, truly believe we can do this all across the country in those more remote rural areas that are having a difficult time receiving those services.

Let me end on a couple other quick questions and then I would maybe--yes, I think I am just going to end on a couple more comments here, and that is with respect to the new facilities that Alaska is getting--again, this is specific for the VA--the one in Anchorage, which again, Dr. Schoenhard, thank you for being there. That was a great new facility that I think is going to have a great impact to our veterans, no question about it. Can you--again, this is very parochial, but can you give me any update on the Juneau

1? That has always been kind of in the churn and it seems like it gets pushed, and I am just wondering, how are you doing on that one? And if you don't know, again, you can provide that to the record.

Mr. Schoenhard. If I can check and get that back to you on the record, sir, just to be sure, but we are currently open part-time. We anticipate moving to permanent space by the summer of 2010, but the summer of 2010 is very close, so let me get more specific--

Senator Begich. I was going to say, we are in it.

[Laughter.]

Mr. Schoenhard. Yes. So let me get back with the specific opening there.

Senator Begich. Okay. That would be great.

Dan, if I can ask you one general question, you have heard the discussion about the capacity. Does the consortium, does the Health Care Consortium have--I think I know the answer to this, but I want to just feel comfortable in saying it--if there is a kind of freeze-frame that goes off and it is rejiggered in the sense of a new idea of how to hit the rural health care, does the consortium have the capacity in the areas from the small villages on up to meet probably what you might perceive as the need of the veterans?

Mr. Winkelman. Yes, we do. We have over 200 village

clinics out in the remotest of the remote areas, which is oftentimes what we call home.

Senator Begich. That is right.

Mr. Winkelman. You know, some people like to say it is in the middle of nowhere. I like to say, well, that is my home.

[Laughter.]

Mr. Winkelman. But we have that infrastructure in place and we also have subregional clinics. Many of our Tribal Health Organizations throughout the State of Alaska have really a three- or a four-level tier plan of care, and it starts out in our villages with emergent primary care happening there in the clinics with our community health aide practitioners.

And then if a higher level of care, or there needs to be a referral, it usually goes to some sort of subregional clinic. I know for YKHC, we have five of those and we staff those with mid-level providers. They are usually physician assistants or nurse practitioners. We also have master's level behavioral health clinicians that work with our hospital, as well, and we have care teams around that. We also have dental health aide therapists there, which is essentially a mid-level within the dental structure. And we also have community health aide practitioners with lab and X-ray capabilities, digital X-ray.

And then anything that needs an additional level of care, they are often referred to our hospital, and those are all regional hospitals, as you know and have visited.

And then the fourth level of care is the Alaska Native Tribal Health Consortium in Anchorage, which runs, in conjunction with South Central Foundation, the Alaska Native Medical Center.

And so we have multiple levels of care, infrastructure that is already in place. We are willing and waiting to give all our veterans, whether they are rural or--whether they are native or non-native, to open our doors. Our doors are always open. It is just essentially for a non-native veteran, it is an issue of payment. With the rural native veteran, they are going to be able to come to us and have their payment taken care of by us, so it is not essentially an issue.

Senator Begich. Explain--if I can interrupt you, that was actually a question we had back in Anchorage, and you have just answered, I think, one concern that we had was a non-native veteran entering a facility that is Indian Health Service-funded through the consortium, that someone who is a non-native veteran, as long as there is a payment stream--

Mr. Winkelman. Yes.

Senator Begich. --that handles them, you can take care of them.

Mr. Winkelman. Yes, Mr. Chairman. Our doors in Alaska are open to anyone, regardless of race or whoever they are. But what is really important for non-native veterans who are in highly rural areas in Alaska is that for the first time, they have a reason to go and use our services because there is payment provided by the VA through this pilot program. Now, in areas such as in Southeast Alaska and other areas in Alaska where the pilot is not available, or if they are not opted in and signed up and received their preauthorization, they are not going to be able to do that. But if we can deal with those barriers with a meeting and talk about processes, I think we will be able to see our enrollments go up.

Senator Begich. Very good. Now, my last general question, telemedicine. Would you say your system is a fairly good system, a robust system? How would you measure it?

Mr. Winkelman. I would say our system is probably the best in the United States. We are in the, again, the remotest of the remote areas. I know our Federal partnership, they have various measures--I don't have them in front of me today, but AFHCAN, the AFHCAN Partnership, which is in charge of telemedicine, they have various measures that demonstrate how effective it is and how it can be used.

You know, for instance, we have radiologists that are down in Ohio. Someone can go get a read in the Village of Kotlik or in another village along the mouth of the Yukon River, and through telemedicine we can get them a read in less than a day. It will go from there, it will go all the way down, it will go to Bethel, then it will go from Bethel to Ohio and then back. And so we have really quick turnaround times using that sort of digital process and we are really proud of it. But I think our utilization rates could be higher. That is something that we need to focus on, especially at YKHC. That is something that we are working on right now.

Senator Begich. Very good. Let me end there and just say again, thank you, first to the whole panel. Thank you to the two folks from the VA for your willingness to kind of put this at a higher level, at least in this initial stage of discussion. Like I said, Dr. Jesse, it is not to stop the program, it is to freeze-frame it for a moment to kind of do a little reanalysis, especially while you have a consultant online, which is a very valuable asset. You are spending resources there. You have some Alaskan experience here that is anxious to advise in any capacity it can, and your acceptance to acknowledge that, I think is great, and I just want to say thank you for your willingness to do that.

Thank you to the Alaskans who have traveled a great

distance. Sorry for the humidity. That is an adjustment you will have to make. But I know you are anxious to get back on the plane to get back to home, no matter how small the village may be. But again, thank you all for being here today and testifying in front of the committee.

That ends the committee hearing for the day. It is adjourned.

[Whereupon, at 11:59 a.m., the committee was adjourned.]