James F Ahrens, Chairman, Veterans Rural Health Advisory Committee

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Chairman, Veterans Rural Health Advisory Committee

Chairman Akaka and members of the Senate Committee on Veteran's Affairs, It is my pleasure to testify before you today on behalf of veterans living in rural America.

I currently serve as Chairman of the Veterans Rural Health Advisory Committee. (VRHAC) The 16 members of the VRHAC are appointed by the Secretary of the VA. The mission of the Committee is to advise the Secretary on healthcare issues affecting enrolled veterans residing in rural areas.

I have been involved in the issues of improving health care to those residing in rural America for many years. While I was president of the Montana Hospital Association we developed and implemented the innovative Medical Assistance Facility (MAF) health care delivery model. After ten years of demonstrating its effectiveness, the MAF then became the model for the Critical Access Hospital program. Today there are over 1300 Critical Access Hospitals (CAH's) in the United States. This innovative model of delivering health care has saved and maintained rural America's access to health care.

Access to VA health care services is a critical and growing issue for rural veterans. There is an increasing need for physical and mental health services to be delivered at local access points for the rural veteran. The VA needs to continue to explore and develop innovative ways to deliver these services.

This Committee is very familiar with issues that face Veterans nationwide and in particular veteran's health care access issues in rural areas. Because of your expertise I will not dwell on the problems, but will attempt to provide you with ideas and programs that will enhance the health care of veterans and improve the health care delivery systems in rural America.

Let me begin by enumerating the recommendations of the Veterans Rural Health Committee. These recommendations were recently provided to Secretary Shinseki. as part of the VRHAC's Annual Report to the Secretary. They are as follows:

1. Appoint a robust rural health executive and management team that demonstrates the requisite expertise, experience, leadership, vision, and dedication to addressing the needs of rural Veterans. Utilize contract staff to augment government personnel to ensure access to the broadest range of expertise possible.

2. Engage the VRHAC as a resource in refining the Rural Health Strategic Plan.
3. Initiate an internal outreach initiative to further institutionalize rural health concepts and programs within the VA.
4. Facilitate a formal dialogue between the VRHAC and other VA advisory committees, as well as other significant federal collaborating entities (e.g., Department of Defense and Department of Health and Human Services, Office of Rural Health Policy, et al.)
5. Pursue partnerships with state and federal agencies and local health service providers to increase enrollment of rural and highly rural Veterans and to broaden their understanding of VA benefits and programs.
6. Ensure that access and continuity of care is facilitated as close to home as possible for rural Veterans through delivery of services at VA facilities or through contracted partnerships for primary care and ancillary health services.
7. Reconsider existing VA cost metrics that may act as disincentives for expansion of care into rural and highly rural communities.
8. Leverage the National Health Information Network (NHIN) platform to demonstrate practical, legal, and sustainable health information exchanges in partnerships with non-VA physician practices, community health centers, and other relevant providers in rural areas.
9. Implement an enterprise-wide system that facilities the organization and scheduling of VA Telehealth services.
10. Develop services that leverage mobile phones and the cell phone infrastructure to enhance patient-provider health communications, address health care priorities, and improve efficiency across the VA health system.
11. Conduct studies of rural and highly rural enrolled and non-enrolled Veterans to determine their number, demographics, locations, and unmet health need with a focus on the efficacy of primary care, mental health, and physical rehabilitation services organized through small regional rural facilities.
12. Consistently and proactively deliver training to rural providers serving Veterans and their families with the specific focus on post-deployment health and mental health needs of rural Veterans.
13. In all recruitment and retention efforts for health professionals to serve Veterans in rural and highly rural areas, engage in models of collaboration that add to and to not reduce overall access, comprehensiveness, and sustainability of health services in rural communities.

These recommendations were provided to the Secretary after careful consideration and hours of discussion.

I would now like to share with you some personal recommendations for improving VA rural health care. Let me point that the term “personal” should be taken lightly.
These suggestions are an amalgam of the thoughts of many. Some of these recommendations are similar to the VRHAC recommendations.

1. There should be more health care services in places where Veterans actually live in rural America. 2008 VA enrollment data indicates that most of our rural and highly rural Veterans are in VISNs in the Midwest. Most of our disabled Veterans and many rural Veterans live in the South and the West. This information is included the VRHAC report to the VA Secretary.

2. The VA should utilize more interactive Telemedicine. These expanded Telemedicine activities should focus on rural areas. The recent legislation creating the pilot rural tele-mental health program collaborative between the VA and rural Critical Access Hospitals (CAH's) is a great start. More effort is needed to build upon the existing Telehealth systems located in either civilian rural health facilities or VA facilities.

3. Van transportation networks should be enhanced.

4. The mileage reimbursement rate should be equal to the IRS payment which currently is fifty cents per mile. Consideration should be given to expanding this reimbursement to all enrolled Veterans, including others than those
with service connected disabilities. This would be especially helpful in recruiting friends as drivers for VA patients who can't drive or who can't return home immediately after treatment because of medical issues, e.g. sedation.

5. Enhance and promote the internet utilization of "My HealtheVet" by all possible enrollees.

6. Offer a secure version of VISTA (The Veterans Health Information Systems and Technology Architecture) medical records package to rural practitioners who see Veterans.

7. Make this VA medical record available immediately to providers, who see veterans in Emergencies. Perhaps these records could become available to hospitals and doctors by adding a staffing function to the twenty
four hour emergency suicide hotline. The Committee might consider an amendment to Federal HIPPA Privacy regulations in order to make this happen

8. Increase the availability of flexible scheduling at Community Based Outpatient Clinics (CBOCS). The VA should make provisions allowing local health care practitioners to provide care one or two days a month at the those CBOC's. Rural Veterans appreciate the expansion of CBOC's in rural areas; however care should be taken not to recruit critically needed physicians, mental health providers and other allied health personnel away from existing providers in order to staff these clinics. If a Veteran gains close access to a primary care provider but his family loses access to their primary care provider, the Veteran's burden may increase.

9. There should a closer working relationship between the VA and the Indian Health Service. This relationship is working well in some limited areas, but needs to be expanded. Working relationships should be nurtured between the VA and other federally funded rural health care organizations such as Community Health Centers, CAH's, and Rural Health Clinics etc. The standards of care for federal programs should be operational and respected across all federal programs designed to improve the health care for Veterans and others served by such programs.

10. Mental health services should be readily available to all veterans especially those living in rural communities.

11. All Veterans, including 7's and 8's, should be enrolled in the VA medical system.

12. A new and sustained effort is needed to bridge the services of the VA and private rural health care systems. Resources are needed to educate rural health care providers on how to work within each other's systems and cultures. Rural providers need help in learning how to navigate through the VA and the VA needs more information on the quality of care delivered by rural providers. The VA
Should continue to utilize physicians and other providers through contracts and fee for service arrangements, however this arrangement should be expanded to include ancillary services. There is no reason for a Veteran to be seen in a CBOC for routine care and then be required to drive 1 to 2 hours to another VA facility for an MRI when the MRI service is available in a community facility in the same town where the initial services were rendered.

Mr. Chairman and members of the Committee, I want to thank you for the opportunity to make these points. I hope that by working together we can assist in providing quality health care services to our Veterans living in rural areas. I would be happy to address any questions that you might have at the appropriate time.