GEORGE ONDICK EXECUTIVE DIRECTOR AMVETS DEPARTMENT OF OHIO

STATEMENT OF GEORGE ONDICK
EXECUTIVE DIRECTOR
AMVETS
DEPARTMENT OF OHIO
BEFORE THE
COMBINED HOUSE, SENATE COMMITTEE ON VETERANS' AFFAIRS
ON
REMOTE AND RURAL VETERAN ISSUES
TUESDAY, MAY 29, 2007
KENT STATE UNIVERSITY-TUSCARAWAS
UNIVERSITY DRIVE, N.E.
NEW PHILADELPHIA OHIO 44663
10:00 A.M.

Mr. Chairman and Members of the Subcommittee:
I am pleased to appear today to offer testimony on behalf of Ohio AMVETS related to Department of Veterans Affairs (VA) remote and rural veterans' issues.
In a 2004 study of more than 767,000 veterans by Veterans Affairs researchers shows those in rural areas are in poorer health than their urban counterparts. The findings, reported in the October American Journal of Public Health, validate recent and ongoing VA efforts to expand health care for rural patients.
"We need to think about veterans who live in rural settings as a special population, and we need to carefully consider their needs when designing healthcare delivery systems," said study leader William B. Weeks, MD, MBA, a physician and researcher with the White River Junction VA Medical Center and Dartmouth Medical School. Senior author on the study was Jonathan B. Perlin, MD, PhD, VA's acting under secretary for health.
The study included 767,109 veterans who had used VA healthcare between 1996 and 1999. VA had then just begun setting up Community Based Outpatient Clinics (CBOCs) to provide primary care closer to home for rural veterans. Today there are nearly 700 CBOCs in VA's nationwide system, and recent recommendations from VA's Capital Asset Realignment for Enhanced Service (CARES) initiative call for the establishment of more than 150 additional CBOCs.

Many veterans living in remote areas have found several problems on reaching the VA Medical Centers and VA Clinics; some, due to their inability to obtain transportation, and others due to inability to pay for their transportation. In Ohio, most County Veterans Service Commissions will provide transportation for "qualified" veterans. However, a disabled veteran going for VA Healthcare, may receive from the VA mileage of 11c per mile with a $3 deductible each way. Compare that 11c to a VA employee receiving 48.5c which is considerably more for the same trip and no deductible. Why is there a difference? The Veteran has to pay the same $3.50 for fuel as does the VA employee.
Veterans Affairs Community Based Outpatient Clinics (VA CBOC's or CBOC) were established to change from the centralized idea of admitting many veterans to a hospital for treatment, to smaller, more localized service on a outpatient basis. This seemingly is much better for the

patient, the family and the VA budget. It had worked quite well until the veterans' healthcare outreach was stopped due to budget restrictions.

The VA Health Administration had an outreach program that worked quite well. The VAMCs would send a team (a doctor, nurse, technician and admin clerk) to various remote areas to do the routine healthcare. In southern Ohio, there were many examples: a team went to Pomeroy, 88 miles away from the Chillicothe VAMC, and Jackson, 45 miles away from the Chillicothe VAMC, as well as several other locations. In Jackson, they set up shop in a VSO post. In Pomeroy, they used part of the Holzer Clinic. There were many "outreach clinics" in operation, until the budget problems in January 2003 caused their closing.

The VA policy on establishing VA CBOCs was established so a veteran would not have to travel over 35 miles to obtain healthcare. It was changed to 40 miles. Now the strange thing is in northern Ohio, there are VA Clinics fairly well covering all geographic areas and only one facility is scheduled to close and it is within 40 miles of VA clinics on each side (see attached map showing VISN 10 only so the NW corner of Ohio appears uncovered). This gives us an idea of the problem. In the western portion, the Cincinnati area, there are plenty of VA facilities, many within 30 miles of one another. In remote/rural southeast Ohio, it is a different story. The CBOC program has been curtailed. There are VA CBOCs in Athens, Portsmouth and Marietta, which cover as much area as 20 facilities in other areas of Ohio. Those veterans who depended on outreach visits must now travel 80 or more miles to visit a doctor to get their treatments and then drive back 80 or so miles. For those needing radiation, they are further transferred to Cincinnati in a van. In Cincinnati, they are given their radiation treatment, which causes great nausea, then delivered back to their vehicle for the 80 miles or more drive home. What a way to say thank you for your service to our great nation!!!

The understandable rationale is that VA facilities are set up in areas that will service the largest number of veterans and thus being cost effective. This put us in our present conundrum of providing for veterans in remote/ rural areas. Those veterans served and sacrificed just as much as their counterparts in large populated areas. It is AMVETS' position that we need the VA medical outreach reestablished for those in remote/rural areas of Ohio and the Nation. We owe our rural area veterans this service and more.

The AMVETS is currently providing outreach to veterans in southern Ohio, filing claims on their behalf. With each claim we file, we create another access dilemma for the veterans we serve. Again, it is AMVETS' position that we need the VA medical outreach reestablished for those in remote/rural areas of Ohio and the Nation. I also believe the VA created an Office of Rural Health Care it should be funded, and supported.

I would also like to take the time to reiterate the AMVETS legislative priorities for 2007, they are as follows:

The Department Veterans Affairs (VA) Fiscal Year 2008 Budget - The President's budget request for VA in Fiscal Year (FY) 2008 seeks approximately $86.7 billion for veterans' benefits and services. This amounts to $39.4 billion in discretionary funding and $44.9 billion in mandatory appropriations. In FY 2008, AMVETS requests roughly $43.6 billion in discretionary funding.

Mandatory Funding for VA Health Care - In May 2001, President George W. Bush signed Executive Order 13214 creating the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans (PTF). In May 2003, the PTF issued its final report and recommended that the Federal Government should provide full funding... and that full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding

mechanism. Recent history demonstrates why Congress should pass legislation to make VA health care funding mandatory spending. In FY 2005, VA faced a $1.3 billion shortfall in spending and Congress had to include additional funding in emergency appropriations. For FY 2007, Congress failed to pass the annual VA spending bill and the department is operating under a Continuing Resolution well below FY 2007 requested levels.

Extend Enrollment for OEF/OIF Veterans - H.R. 612 and S. 383 introduced in the House of Representative and the Senate, respectively, would extend from two years to five years, following discharge or release from active duty, the eligibility period for veterans who served in combat during or after the Persian Gulf War. Continued eligibility would allow veterans to receive hospital care, medical services, or nursing home care provided by the Secretary of Veterans Affairs, notwithstanding a lack of evidence to conclude that their condition is attributable to such service. AMVETS fully supports the passage of legislation to extend the two-year priority enrollment for OEF/OIF veterans.

Seamless Transition - In March 2007, GAO testified that the Department of Defense (DOD) and VA were still having problems sharing the necessary medical records the VA needed to determine whether service members' medical conditions allowed participation in VA's rehabilitation activities. Congress should require the two agencies to develop electronic medical records that are interoperable, bi-directional, and standards-based. Congress should also require DOD to conduct mandatory separation physicals for all separating service personnel and also utilize the Benefits Delivery at Discharge (BDD) joint separation exam that was developed and agreed to by both agencies.

Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) - VA operates a network of more than 190 specialized Post Traumatic Stress Disorder (PTSD) outpatient treatment programs throughout the country. Vet Centers are seeing a rapid increase in their enrollment. Equally important, AMVETS is concerned about the lack of awareness and screening among health care professionals for Traumatic Brain Injury (TBI). PTSD and TBI clinically present the same symptoms and the problem for medical personnel is trying to differentiae between PTSD and TBI. VA's approach to PTSD is to promote early recognition of this condition and the same must be done for TBI. In addition, there is no medical diagnostic code specific to TBI. AMVETS is asking Congress to increase funding for PTSD and TBI, with an emphasis on developing improved screening techniques and assigning a new medical code specifically for TBI.

VA Burial Allowance - VA reimbursement benefits were first instituted in 1973 and provided $150 in reimbursements for deaths that were not service-related. In 2001 the plot allowance was increased for the first time in more than 28 years, to $300. The non-service-connected burial allowance was last adjusted in 1978 and now also provides $300. AMVETS supports increasing the non-service-connected burial benefit from $300 to $1,270 and increasing the plot allowance from $300 to $745, an amount proportionally equal to the original benefit. In 2001, Congress increased the burial allowance for service-related deaths from $500 to $2,000. Prior to this adjustment, the allowance had been untouched since 1988. AMVETS recommends increasing the service-related burial benefit from $2,000 to $4,100, restoring the value of burial costs to its original proportionate level.

VA Claims Backlog - The VA Claims Backlog is now over 600,000 outstanding claims and it continues to grow at a rapid rate. VA's estimates that over 263,000 OEF/OIF veterans will seek VA services and most will want to file a claim. At the end of fiscal year 2006, rating-related compensation claims were pending an average of 127 days, which is 16 days more than at the end of fiscal year 2003. During the same period, the inventory of rating-related claims grew by almost half, in part because of increased filing of claims, including those filed by veterans of the Iraq and Afghanistan conflicts. Meanwhile, appeals resolution remains a lengthy process, taking an average of 657 days in fiscal year 2006. Overall, a lack of quality control is central to this issue and VA must establish a long-term strategy focused on attaining quality and not merely achieving quotas in claims processing. AMVETS supports increased funding for VA to hire more Full Time Equivalents (FTEs) in order to address the backlog. AMVETS also supports the practice putting adjudication officers in VA offices aboard active duty military bases.

If you have questions regarding these priorities, or you need additional information, I can be reached at (614) xxx-xxxx Again, thank you for holding this hearing and providing AMVETS the opportunity to present its views.