

**STATEMENT OF  
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DEPARTMENT OF VETERANS AFFAIRS**

**BEFORE THE  
SUBCOMMITTEE ON HEALTH  
HOUSE COMMITTEE ON VETERANS' AFFAIRS**

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Good Morning/Good Afternoon, Mr. Chairman and members of the Committee. Thank you for this opportunity to discuss ongoing efforts in the Veterans Health Administration (VHA) to provide safe, effective, efficient and compassionate health care to veterans residing in rural areas. Accompanying me today is Ms. Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning and Dr. Adam Darkins, Chief Consultant for Care Coordination.

VHA is committed to providing the highest quality of care to all veterans and understands that although veterans in rural areas face many of the same health concerns as veterans in urban areas, rural area veterans often face additional challenges such as limited finances and fewer specialists. These combined challenges have produced a situation where veterans in remote regions experience a reduced health-related quality of life. I share the Committee's concern for these veterans and would like to take a few minutes to discuss current programs and new initiatives within VA that significantly improve the quantity and quality of health care, while reducing costs and increasing access without the need for new legislation.

**RURAL HEALTH INITIATIVES**

VA has undertaken a number of efforts aimed at addressing delivery of health care services to rural veterans. Central to these efforts are several major initiatives now being implemented throughout the VA system: our Capital Asset Realignment for Enhanced Services (CARES), which provided a framework for

prioritizing new Community Based Outpatient Clinics (CBOCs), and fee-based service with private health care providers; and our telehealth and telemedicine programs, which are using new technology to bring doctors to their patients, rather than patients to their doctors. I will now discuss these efforts and others in greater detail while providing information on key health concerns facing many of our veterans.

### CBOCs / CARES / CHCs

First, I'd like to tell you about our efforts with CBOCs, which are rooted in ambulatory and primary care and have provided VHA its preliminary foundation for enhancing rural access. Early on, VA recognized the value of CBOCs in meeting the primary care needs of rural veterans. In 1995, VA had 102 community based clinics and by 2000, VA had 600 CBOCs.<sup>1</sup> Because we recognize that CBOCs are an important component of the VA health care delivery system, we have continued to establish health care services in community settings where veterans are better able to gain access to health care services. Today, VA has over 700 CBOCs and operates or contracts for care at 100 outpatient clinics located in areas considered rural or highly rural. Between 2000 and 2003, VHA added 67 CBOCs, which brought VA health care to within thirty minutes of another 70,000 veterans. By the third quarter of Fiscal Year 2004, VA was operating or contracting for care at 76 CBOCs in rural or highly rural areas.

CBOCs have been the anchor for VHA's efforts to expand access to veterans in rural areas. Although VHA's CBOCs initially focused on the provision of only primary health care, more recently we have begun to include mental health services as part of the basic core services available to veterans. VHA's CBOCs are complemented by contracts in the community for physician specialty services

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<sup>1</sup> Nomenclature clarification: In 1995, the term used for access points was community based or ambulatory clinic. In 2000, Community Based Outpatient Clinic or CBOC became the commonly used term.

or referrals to local VA medical centers, depending on the location of the CBOC and the availability of specialists in the area.

VA continues to review and implement selected CBOCs through a national approval process based upon the proposals from VA medical centers and the Veterans Integrated Service Networks (VISNs). This process allows decisions regarding needs and priorities to be made in the context of local market circumstances and veterans preferences; it creates uniform criteria and standards that must be met to ensure consistency nationwide.

This process has served VHA well throughout the years. But as demand for VHA health care continued to expand, VA recognized the need to assess the alignment of its capital assets relative to the demand for healthcare. In that context, VA, in June 2002, established the national CARES process. The goal of the CARES process is to assess veterans' health care needs in the VISNs, identify service delivery options to meet those needs for the future, and develop an associated capital asset realignment plan that assures the availability of high quality health care in the most accessible and cost effective manner, while minimizing impacts on staffing and communities and other VA missions. Through the CARES process, VISNs develop plans for capital asset infrastructure that are based on projected demand for services, evolving practices in health care delivery, demographics, and assessments of the existing as well as future capacity of physical plans to deliver accessible, high quality health care.

To further advance VA's efforts to provide quality health care for veterans and ensure an objective, external perspective to the CARES planning process, the CARES Commission was established in December 2003. For over one year, the 16-member Commission, comprised of experts in the health care industry, physicians, nurses, and veteran representatives, including former national and state veterans service organization leaders, carefully evaluated data related to

the demand for VA health care, types of services demanded, and demographics of the veteran population in geographical regions. Additionally, the Commission's analyses included views and concerns from Congressional members, individual veterans, veterans service organizations, medical school affiliates, and local government, community groups and partners and other interested stakeholders. The findings and recommendations of the Commission were submitted to VA in February 2004, and key to the Commission's findings was that it found VA's rationale for prioritizing the implementation of new CBOCs disproportionately disadvantaged rural veterans and was contrary to the goal of CARES. VA took this finding very seriously and in response, revised its national criteria for establishing CBOCs to include emphasis on the importance of access to care for rural veterans, use of CARES travel guidelines to assess access to care, and the availability of mental health services. In addition, VA also created a Directive on Rural Access Hospitals to assure quality services in rural hospitals.

VHA is now in the next phase of CARES. As part of the current CARES business studies in select market areas, Local Advisory Panels (LAP), which are, in part, comprised of representatives from veterans service organizations, governmental agencies, health care providers, planning agencies, academic affiliates, and community organization, which are ensuring that the full range of stakeholder concerns and interests are assembled, publicly articulated, and accurately documented. The needs of veterans residing in rural communities are always an important consideration in the LAP's evaluation. At this time, the Secretary is carefully reviewing the advice and requests from these panels and other interested stakeholders.

In addition to our efforts with CBOCs and CARES, VA continues to look for ways to collaborate with complementary Federal efforts to address the needs of health care for rural veterans. We have strengthened partnerships with a number of agencies providing health care in rural communities, including the Indian Health Service (IHS).

In the last two years, VHA and IHS have entered into a memorandum of understanding (MOU) to promote greater cooperation and sharing between the two health services to enhance health care provision for American Indian (AI) and Alaska Native (AN) veterans. In Fiscal Year 2005, more than 150 activities and programs to improve communication, expand access, ensure organizational support, and improve health promotion and disease prevention were developed and implemented under the auspices of this MOU.

Moreover, VA services are complemented by the services of community health centers (CHCs), which are local, non-profit, community-owned health care providers serving low income and medically underserved communities. For nearly forty years, this national network of health centers has provided primary care and preventive services to communities in need. Most centers try to arrange specialty care for clients with hospitals and individual health providers.

As of January 2006, more than 1,000 CHCs provide health care to community, migrant and homeless veterans and operate in more than 3,600 communities in every state and territory. Over 37,000 health care professionals work in areas designated as underserved or experiencing acute provider shortages. Three hundred sixty-one (361) CHCs are located greater than sixty minutes away from a VHA access point and are providing care to rural veterans.

As VA continues to look for ways to enhance access to health care for rural veterans, targeted partnerships with CHCs to meet specific, locally defined, health care needs in rural locations may provide an additional service delivery option to the array of practices already deployed by VA medical facilities. VHA will consider current policies and next steps that would assist VISNs and facilities to explore this option.

LTC / NURSING HOMES / DAY HEALTH CARE FACILITIES

The demand for Long-Term Care (LTC) in VA, whether in rural or urban settings, has greatly increased due to the aging of the veteran population. VA LTC has evolved from services delivered primarily in geriatric clinics and inpatient nursing home settings to a well-defined spectrum of care, including an array of home and community based care (HCBC) services.

VA believes that LTC services should be provided in the least restrictive setting where services are appropriate to a veteran's health status, functional status, and personal circumstances, and, whenever possible, in HCBC non-institutional settings. This philosophy honors veterans' preferences for care, which helps to sustain ties with their family, friends, and spiritual communities. With these other options, nursing home care can now be reserved for situations in which the veteran can no longer live safely and independently at home.

When nursing home care is needed, especially for a veteran residing in a rural area, VA identifies options for the patient from the broad spectrum of LTC venues available in the veteran's community, including, in many cases, the local State Veterans Home or contracted community nursing home care. VA makes every effort to identify options that maximize the veteran's ability to stay within his community for as long as possible. Newer options of VA geriatric healthcare, including adult day care, respite, hospice, and geriatric foster homes provide more opportunities for the veteran to stay close to home and close to family.

In a few minutes, I will also provide information on our telehealth and telemedicine initiatives and discuss how these advances provide even more options for the veteran population in need of healthcare. These newer telehealth and telemedicine options reinforce our focus on non-institutional health care options and bringing doctors to their patients, rather than patients to their doctors

#### MOBILE VET CENTERS:

The primary challenge in serving rural veterans is to effectively address access to care issues in areas where veteran populations are usually widely distributed over a large geographical area. Some Vet Centers are, by plan, established and maintained in rural areas, e.g., Grants Pass, Oregon; Caribou, Maine; Missoula, Montana; and Cheyenne, Wyoming, to ensure that rural veterans and families have access to readjustment counseling. Staff at rural Vet Centers engages in higher volumes of travel to reach veterans in outlying sections of their catchment areas. Travel is not solely for outreach to inform veterans about services available, but also to actually deliver readjustment counseling to veterans living at some distance from the Vet Center. This is done by establishing Vet Center outstations in rural areas such as Cedar Rapids, Iowa, the Michigan's Upper Peninsula, or Keams Canyon, Arizona on the Hopi Reservation. Outstations are administratively connected to a full sized Vet Center, utilize permanently leased space and are usually staffed by one or two counselors who provide full time services to area veterans on a regular weekly basis. Alternatively, some Vet Center counselors travel weekly to provide group and individual readjustment counseling on a once per week basis using donated space in the community. Such Vet Centers as the Hopi, Navajo, and Sioux/Rosebud Outstation also overcome cultural barriers to care by employing native peoples to staff the outstation. Also essential for Vet Centers serving the rural AI population is to participate in community ceremonies such as Pow Wows.

Other important aspects of the Vet Center for maintaining care for veterans in rural areas is to actively establish and maintain partnerships with other community providers such as state employment services, community substance abuse programs and health care providers such as IHS. Maintaining effective partnerships for referrals and supportive case coordination also may involve extensive travel to all communities within the Vet Centers' catchment area. The Vet Center program also maintains a contract program with over 300 private sector providers under contract with VA to deliver readjustment counseling to veterans living at a distance from existing Vet Centers. Some Vet Centers in

rural areas have telehealth linkages to their support VAMC which provides veterans in more remote areas access to VA mental health and primary care. The Vet Centers in Santa Fe, New Mexico, Logan, West Virginia and Chinle, Arizona on the Navajo reservation are examples of such sites with active telehealth programs. The Vet Centers also maintain some nontraditional hours keeping the Vet Center open after normal business hours or on weekends to accommodate veterans traveling in from greater distances.

### MENTAL HEALTH SERVICES AND SPECIAL NEEDS

Comprehensive and effective mental health care is one of the top priorities for VA. The provision of mental health care in rural settings has historically been a challenge for all health systems and providers, including VA.

However, VA is making changes to address these needs. In Fiscal Year 2005, I began a massive investment to improve access to mental health services throughout the entire VA health care system, in both rural and urban settings. These targeted investments will come to almost \$300 million in just two years, and the intention is to continue supporting newly funded programs in Fiscal Year 2007. Of these funds, VHA has already provided over \$200 million to the VISNs for the expansion of mental health and substance abuse services and included an additional \$35 million through the Veterans Equitable Resource Allocation (VERA) process in Fiscal Year 2005 to enhance our overall mental health service capacity. Almost \$17 million has gone specifically to support adding Mental Health professional staff in CBOCs. Another \$9 million is being used to support expansion of Telemental Health programs to provide expert mental health care in rural areas. Other programs also support rural care, such as the development of Grant and Per Diem programs to serve homeless veterans in rural as well as in urban settings.

Some examples of VA's mental health program initiatives still under way for Fiscal Year 2006, or planned for Fiscal Year 2007, that will benefit rural veterans include:

- Integrating specialty mental health care into primary care and other medical settings
- Continuing to expand access to specialty mental health services at all CBOCs, either by direct staffing, local contracts, or telehealth;
- Developing and piloting a model for rural areas for implementation of the concepts of the Mental Health Intensive Case Management (MHICM) programs.
- Increasing inpatient psychiatry and substance abuse capacity in locations where ten-year forecasts estimate an increased demand for services;
- Providing timely access for homeless veterans to mental health/substance abuse assessments.

Data from 2006, reveal that we are achieving many of our goals, although some of our VISNs have more work to do. For example, Performance Measure data for the second quarter of Fiscal Year 2006, show that 87 percent of the CBOCs with over 1,500 enrolled veterans are now meeting the goal of having at least 10 percent of their visits represent delivery of mental health services. Data on wait times for established patients show that, in the second quarter, all VISNs met the Performance Measure regarding scheduling needed return mental health appointments for established patients within 30 days. We have other data indicating that as a result of our intensive efforts to expand services for rural veterans, veterans have access to service much nearer home. In 1996, VA users of mental health services lived an average of 24 miles from the nearest VA clinic; as of 2005, they now live only 13.8 miles away (just half as far).

These and other Performance Measures in Mental Health help to identify success related to the mental health initiatives and to identify areas for continued

improvement. In relation to the needs of veterans in rural areas, we are especially committed to expanding Telemental Health resources, to provide the most effective opportunity for enabling even the smallest and most rural of the CBOCs to improve the quantity of their basic mental health care and also to improve access to more specialized mental health services when clinically appropriate.

### TELEHEALTH / TELEMEDICINE

Earlier in my statement, I mentioned the unique challenges veterans in rural areas face when accessing health care services, particularly in medically underserved areas. Telehealth provides a means whereby VHA can provide specialist care services to veteran patients, especially those who live in rural areas. Over the past three years, VHA has created the necessary infrastructure to enable routine clinical care services to transition onto telehealth platforms that are robust and sustainable. Robustness and sustainability in terms of telehealth networks means that they are safe, appropriate and effective and this requires the necessary clinical, technical, and business processes are instituted to this end.

VHA is currently implementing a care coordination/home telehealth program (CCHT) to help veteran patients with chronic conditions such as diabetes, chronic heart failure, chronic obstructive pulmonary disease, post-traumatic stress disorder, and depression, to self manage their condition and remain living independently in their own homes. The census of CCHT patients, as of June 21, 2006, is 15,003 veterans with chronic conditions. Enrollment in CCHT programs is currently growing at over 150 patients per week in anticipation of meeting a target of over 20,000 patients by the end of Fiscal Year 2006. Of the patients receiving care, 25 percent are in rural areas and 0.5 percent in highly rural areas. As experience is gained with this mode of service delivery, increasing numbers of veterans in rural and highly rural areas can receive care in this manner.

VHA is implementing a national teleretinal imaging program to assess veteran patients with diabetes for diabetic eye disease. Implementation to 92 sites is planned to be completed by mid Fiscal Year 2007. Of these sites, 29 are CBOCs of which eight are in medically underserved areas (MUA) as recognized by the Health Resources and Services Administration (HRSA). These 29 sites are expected to provide care to 5,335 veterans by the end of Fiscal Year 2008.

VHA will complete the development of a 21 site Polytrauma Telehealth Network by the end of Fiscal Year 2006. This state-of-the-art telehealth network will provide access for combat wounded veterans to specialist health care services that are closer to home. In creating such a national telehealth resource, VHA is establishing ground breaking quality of service standards to ensure that the telecommunications networks upon which this clinical care is provided are appropriately configured and engineered to the tolerances required to support mission critical clinical services.

In Fiscal Year 2005, 14,021 unique patients received care via telemental health in VHA; thus far in Fiscal Year 2006, 13,584 patients have received care. In the remainder of Fiscal Year 2006 and Fiscal Year 2007, VHA is implementing an expansion of telemental health to improve access to services in CBOCs for veterans with mental health conditions. Under the funding agreements with 21 VISNs, an additional 30,040 unique veteran patients will receive 130,450 new mental health encounters in CBOCs. Of 245 CBOCs that will provide these services 213 (87 percent) are in a HRSA designated MUA.

Thus, it can be seen how developments in telehealth within VHA are on a convergent path. Within three years VHA will be in a position to provide veterans in rural areas access to specialist care of a specificity that is unparalleled in any other health care organization in the nation. Achieving this promise requires intense, ongoing work to ensure the clinical, technical and business processes are re-engineered. The telecommunications bandwidth requirements and telecommunication technology infrastructure necessary to support this

undertaking are being assessed and may be a supplemental requirement in future budget requests.

It is vital to address the people processes in new health care developments. VHA's Office of Care Coordination, the office responsible for telehealth development within VHA, has been working closely with the VHA's Employee Education Service to implement national training programs for telehealth.

In January 2004, VHA established a telemedicine training center to develop care coordination/home telehealth services in Lake City, Florida. This center has trained over 2,700 VHA staff. In Fiscal Year 2005, VHA developed a training center for teleretinal imaging in Boston, Massachusetts. Also in Fiscal Year 2005, VHA established a Rocky Mountain Telehealth Training Center for general telehealth in VISN 19 with sites in Salt Lake City, Utah and Denver, Colorado. This center was designated to establish links with the University of Utah, University of Colorado and American Indian and Alaska Native Programs Center at the University of Colorado in Denver. VHA's Rocky Mountain Telehealth Training Center has a scope of operations that covers rural health care delivery.

In 2003, when VHA considered the needs for telehealth training, the particular importance of rural health needs were addressed and incorporated in a request for proposals in 2004. Instead of funding a designated rural telehealth training center, VHA incorporated rural telehealth and health informatics, as applied to telehealth, as a particular responsibility of the Rocky Mountain Telehealth Training Center. VHA's three telehealth training centers are linked through a common steering committee and this ensures that the rural focus is incorporated into the work of all the training centers.

### EDUCATION / RESEARCH / TRAINING

Training and educating the next generation of medical professionals is central to VA's mission of providing exemplary health care to our nation's veterans. While

rural areas typically face shortages of health care professionals, VA is seeking to rectify this through several initiatives and in cooperation with other interested parties.

VA currently offers clinical training in centers devoted to geriatrics, mental health, multiple sclerosis, and other diseases. VA clinical care sites located in rural areas already provide clinical education in a variety of disciplines. Local schools of nursing, universities affiliated with a rural outreach clinic, and Area Health Education Centers provide graduate medical education for residents and trainees. A number of medical schools are considering increasing the size of their student bodies to address the pressing need for rural health care. On June 16, 2006, an article by Carrie Peyton Dahlberg entitled "UC Davis will target rural needs" appeared in the Sacramento Bee, and stated that 40 percent of U.S. medical schools reported a plan to increase their number of admitted students within the next five years to address the nationwide doctor shortage, which is particularly acute in rural areas.

### **CONCLUSION**

Mr. Chairman, providing safe, effective, efficient and compassionate health care to our veterans, regardless of where they live, is the primary goal of the VHA. New technologies and better planning are allowing us to provide the same quality of care in any location. VHA recognizes the importance and the challenge of service in rural areas, and we believe that current and planned policies are addressing these concerns.

The right-sizing of our physical infrastructure as a result of the CARES program, the provision of new CBOCs, collaboration with Federal, State and local health care partners, and new approaches to health care services and advances in technology in telehealth and telemedicine, all combine to make VHA confident that we can provide the best care anywhere and everywhere.

This concludes my statement. Thank you for your time and I will be glad to respond to any questions that you or other members of the committee may have.