

**IMPROVING FEDERAL HEALTH CARE IN
RURAL AMERICA: DEVELOPING THE WORKFORCE
AND BUILDING PARTNERSHIPS**

HEARING

BEFORE THE

SUBCOMMITTEE ON THE EFFICIENCY AND
EFFECTIVENESS OF FEDERAL PROGRAMS AND THE
FEDERAL WORKFORCE

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
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IMPROVING FEDERAL HEALTH CARE IN RURAL AMERICA: DEVELOPING THE WORKFORCE AND BUILDING PARTNERSHIPS

THURSDAY, MAY 23, 2013

U.S. SENATE,
SUBCOMMITTEE ON THE EFFICIENCY AND EFFECTIVENESS OF
FEDERAL PROGRAMS AND THE FEDERAL WORKFORCE,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Jon Tester, Chairman of the Subcommittee, presiding.

Present: Senators Tester, Begich, Heitkamp, and Portman.

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. We will call to order this hearing of the Subcommittee on the Efficiency and Effectiveness of Federal Programs and the Federal Workforce. This morning's hearing is titled, "Improving Federal Health Care in Rural America: Developing the Workforce and Building Partnerships." I look forward to hearing from our witnesses about efforts made by the Federal health care workforce to address the needs of rural America, including veterans and Native Americans.

Today we will discuss some of the challenges of this task, including efforts to recruit and retain a quality Federal health care workforce, and we will highlight opportunities for collaboration, cost sharing and exploring stronger partnerships between agencies and local providers.

As a Montanan and someone who has worked very closely with veterans and the Native American population, I am aware of the challenges in rural and frontier areas of accessing quality health care in a timely manner. Addressing these challenges will certainly require a multifaceted approach. We need to invest in technologies like telemedicine and bring health care closer to home. We need to expand the number of mobile clinics and Vet Centers and improve transportation options for folks that are forced to travel significant distances to receive the health care that they need.

But we also need to address chronic health care workforce shortages in rural communities in agencies like the Veterans Administration (VA) and the Indian Health Service (IHS). Far too often we have seen new facilities sit idle because we cannot recruit enough mental health professionals to a particular area, or we have seen

veterans diverted for care because of nursing shortages at a particular facility.

But this is not a VA-specific problem. It is a rural problem, and it is a national problem. We need government agencies to aggressively and effectively work together to make progress and to ensure they are working in collaboration and not in competition. This collaboration should not only be happening between Federal agencies; it should be happening at the State level, and it needs to be happening in more rural areas.

In these communities the Federal health care workforce needs to leverage its limited resources to empower local partners to more effectively increase access to care. Just because a veteran lives in a place like Havre, Montana, does not make him or her less deserving of timely and quality health care.

We have some great witnesses with us here today, and as we discuss these critical issues in more detail, I look forward to hearing from each of them.

I will now turn it over to Ranking Member Senator Portman for his opening statement.

OPENING STATEMENT OF SENATOR PORTMAN

Senator PORTMAN. Thank you, Mr. Chairman, and thank you for having the hearing today on an incredibly important issue in Montana, in Ohio, and around the country. It is an important topic, and I think the testimony we are going to get today is going to shed light on some of these issues facing rural health care in particular. Thanks to the witnesses for being here, this panel and the coming panel.

One of the most important functions that our Federal Government must fulfill, of course, is the care of our veterans. We need, as we are going to into Memorial Day, to think about that. They are out there defending us, in essence, and their mission continues, when they get home. We have to be sure we are there with them. And there are acute health care problems right now facing over 6 million veterans in rural communities, including a lack of sufficient health care providers and the need to travel, as the Chairman said, significant distances to seek care in many cases.

Like our urban veterans, our rural veterans returning from Iraq and Afghanistan are coping every day with both the visible and the invisible wounds of war. But, unfortunately for those in rural areas, help is not as readily available.

I would like to discuss these topics in the context of traumatic brain injury because it is often referred to as the signature wound, unfortunately, of the wars in Iraq and Afghanistan. The Department of Defense (DOD) now estimates that over 266,000 servicemembers have suffered traumatic brain injuries (TBIs), from 2000 to 2012. At the same time, the Congressional Research Service (CRS), has estimated that over 100,000 servicemembers who have served since 2000 suffer from post-traumatic stress (PTSD). So it is one thing to be able to get our rural veterans treatment for an orthopedic issue or even help maybe on a diabetes management program, but often it is another thing entirely to present the full scope of treatment needed for a veteran suffering from the effects of TBI or post-traumatic stress.

I know our witnesses recognize the scope of the problem, and each of your departments has embarked on a number of initiatives to address those problems. I look forward to hearing more about that today.

I will say I am concerned that we are making internal adjustments and small steps forward, whereas the size of the problem is bigger than that. It is daunting. And the longer we take to address it, the worse it is going to become.

I think the treatments that we are now providing for our veterans are not as effective as they could be, and I think the pilot projects and assessments are important. But I think we have a bigger problem that we need to address, and that is what we will talk about today.

Tragically, we are now losing, we are told, 22 veterans a day to suicide. Fundamental changes are needed to occur from the way VA interacts with our veterans to the model for providing care, and we will talk about that.

When I am back home in Ohio, I regularly talk to our veterans about their interactions with the VA. Some are very positive. Some of the stories I hear from our rural veterans are likely similar to what the Chairman hears in Montana: long drives, even longer drives in Montana probably; expensive drives sometimes to get the kind of treatment that they need; uncoordinated appointments; varying customer service. When a TBI patient who may find it difficult to remember his or her appointments, may find it difficult to follow directions, or even interact with other people, has to drive a couple hours to an appointment, and when he shows up a little late after driving through a blizzard and has to reschedule his appointment for weeks later, we are not setting that person up for success. And, unfortunately, the stories that I have heard are not isolated, and I know, again, in Montana some of the same stories are out there.

So we have to leverage the resources of our Nation for these men and women who have given so much to us. We have providers throughout our country who stand ready to support this population of over 6 million rural veterans if given the opportunity to do so. And connecting our rural veterans with the right treatment I think is something we ought to be focused on, and we will talk about that today.

So, again, thanks to our witnesses. Mr. Chairman, I look forward to the testimony today and discussing these issues.

Senator TESTER. Well, thank you, Senator Portman. I would just like to say thank you for your opening statement, and as we kick off the first hearing on this Subcommittee, I want to say I look forward to working with you to help improve issues, whether it is health care or something else. This is a pretty broad-based Subcommittee.

Senator PORTMAN. Yes, likewise.

Senator TESTER. So I look forward to working with you to get some good things done.

I would like to welcome our first panel of witnesses who have all spent years in public service working to increase access to health care for rural Americans, and they have all dealt extensively with

the challenges of recruiting and retaining a quality health care workforce.

First of all, I would like to introduce Dr. Robert Petzel. He is the Under Secretary of Health in the Department of Veterans Affairs. He has served in that capacity since February 18, 2010. In this position, he oversees the health care needs of some 8 million veterans currently enrolled in the Veterans Health Administration (VHA), the Nation's largest integrated health care system. VHA employs over 272,000 staff members at more than 1,700 sites across this country. Last year, the VA treated 6 million patients during 80 million outpatient visits and 692,000 inpatient admissions.

Welcome, Dr. Petzel. It is great to see you, and we look forward to your testimony and look forward to getting you back in Montana.

Next we have Dr. Yvette Roubideaux, who is the Director of Indian Health Service, IHS, at the U.S. Department of Health and Human Services (HHS). She has served in that capacity since 2009. IHS provides a comprehensive health service delivery system for approximately 2.2 million American Indians and Alaska Natives from 566 federally recognized tribes in some 35 States, and they serve a critical role in my State of Montana.

Dr. Roubideaux, it is good to see you again. We look forward to your testimony.

And last, but certainly not least, we have Tom Morris, who is the Associate Administrator for the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration (HRSA), an agency within the U.S. Department of Health and Human Services. Tom's office serves as a critical research and policy resource on rural health issues, and it administers a number of critical grant programs that enhance the delivery of rural health care. Additionally, his office works very closely with local partners to increase access and to build capacity within those communities. Tom also happens to serve on the Veterans Rural Health Advisory Committee (VRHAC).

Welcome, Tom. It is good to have you here.

OK. We will start with Dr. Petzel. You will have 5 minutes for your oral testimony. Know that your full written testimony will be made a part of the record, so with that, Dr. Petzel, you may proceed.

**TESTIMONY OF ROBERT A. PETZEL, M.D.,¹ UNDER SECRETARY
FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S.
DEPARTMENT OF VETERANS AFFAIRS**

Dr. PETZEL. Chairman Tester, Ranking Member Portman, and Members of the Subcommittee, thank you for the opportunity to speak with you today about how VA recruits, retains, and deploys a quality health care workforce to ensure that veterans can access the health care that they have earned and deserve.

VA is committed to providing veterans with quality, timely, and accessible health care as close to their home as possible. Veterans' mental health is a top priority for VA. As a part of President Barack Obama's Executive Order (EO) to improve access to mental

¹The prepared statement of Mr. Petzel appears in the Appendix on page 31.

health services for veterans, servicemembers, and military families, VA has made significant progress to increase its mental health workforce to meet the needs of veterans.

As of May 14, 2013, VA has hired 1,367 new mental health clinical providers. In addition to that, we have hired 2,063 mental health providers to fill existing vacancies, so over the last 10 months, VA has hired almost 4,000 additional mental health providers. And in addition to that, we have begun hiring a new group of people called peer specialists, and today 261 of them have been hired.

We are aware of the challenges to recruit and retain a quality health care workforce and are implementing a number of creative recruitment strategies to ensure access to care for all veterans. These efforts to increase the awareness of employment opportunities including national advertisements through television commercials, public service announcements. To meet the mental health needs of veterans and their families, VA has also begun to hold facility-based mental health summits with the purpose of building and expanding coalitions with community providers, organizations in the communities, and Federal and State agencies.

VA is dedicated to improving access and quality of care for rural veterans by developing innovative practices to support the unique needs of veterans residing in geographically remote areas.

VA has used a number of programs, including Project Access Received Closer to Home (ARCH) and Patient-Centered Care, in order to provide eligible veterans coordinated and timely access to care through a network of non-VA medical providers who meet VA quality standards.

VA will continue to look for and implement new ways to broaden access through innovative approaches to bringing care to veterans.

Telehealth enhances health care, especially in rural and geographically remote areas, where it can be difficult to recruit health care professionals and where travel distances are excessive.

VA is a national leader in telehealth-based care. In fiscal year (FY) 2012, VHA provided care to half a million patients through video clinical conferencing, store-forward technology, telehealth, and tele-home health. This number is set to rise to 830,000 in 2013.

Specialty Care Access Network Extensions for Community Health Outcomes (SCAN-ECHO), is one initiative that VHA is using to ensure the delivery of specialty care services to improve access to specialists. SCAN-ECHO leverages telehealth to allow health care specialists from a regional center to offer expert advice to providers in rural health care settings.

Another initiative is MyHealtheVet. This offers veterans online access to the VA health care system, and it is designed to give them greater control over their health and wellness. Features of the system include the ability to communicate with providers, refill prescriptions, and to access their electronic medical record.

VA optimizes the delivery of treatments by using technologies and tools such as mobile applications. These mobile applications can help veterans build resilience and manage their daily challenges. The award-winning PTSD Coach mobile app, co-developed

with the Department of Defense, provides an opportunity to better understand and manage the symptoms associated with PTSD.

Prolonged exposure (PE) therapy coach, is a mobile application for patients to use with their therapist during prolonged exposure therapy as a treatment companion.

VA maintains partnerships and continuously seeks to foster relationships with government and nongovernment organizations to bring value to veterans and expand access to the care they have earned and deserve.

VA has a strong history of collaborating with community mental health clinics, including federally qualified centers. These locally developed community partnerships provide mental health services to veterans in areas where direct access to VA health care is limited by either geography or workload.

In response to President Barack Obama's Executive Order, VA, working closely with the Department of Health and Human Services, initiated 15 pilot projects to evaluate how these partnerships can help bring mental health services in areas that are experiencing difficulty in providing direct care. We are committed to building an accessible system that is responsive to the needs of America's veterans. VA continues to implement its rural workforce strategy to recruit locally and utilize the necessary resources, including collaboration, technology, and partnerships, to achieve these goals.

I thank the Subcommittee for the opportunity to appear before you to discuss this important issue, and I am prepared to answer any questions you may have.

Senator TESTER. Thank you for your testimony, Dr. Petzel.

And we will move to Dr. Roubideaux.

TESTIMONY OF YVETTE ROUBIDEAUX, M.D.,¹ ACTING DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. ROUBIDEAUX. Thank you, Chairman Tester, Ranking Member Portman, and Members of the Subcommittee. My name is Dr. Yvette Roubideaux, and I am the Acting Director of the Indian Health Service, and I am pleased to provide testimony on our efforts to develop and support the Federal health care workforce.

IHS's workforce plays a critical role in supporting the overall mission of the IHS as a rural health care system addressing a population with significant disparities in health and access to care.

IHS shares similar challenges faced by rural communities across the Nation. Many of our IHS facilities are in rural and remote locations where recruitment and retention of employees, especially health care providers, present unique challenges.

IHS vacancy rates for health professionals have actually improved over the past few years, but they still remain an issue. For example, dental vacancies were greater than 30 percent, but an increased focus on recruitment and retention reduced those vacancies to approximately 10 percent. However, continued efforts to improve recruitment, retention, and support of our Federal workforce are critical.

¹ The prepared statement of Ms. Roubideaux appears in the Appendix on page 48.

Over the past few years, IHS has implemented a number of reforms to change and improve the agency, and many of these efforts have contributed to better support and strengthen IHS's workforce since many of our reforms were based on input and recommendations from our employees and our stakeholders.

IHS also supports programs such as the American Indians Into Medicine, American Indians Into Psychology, and the Quentin N. Burdick American Indians Into Nursing Programs which help develop students' interest in health professions and encourage them to return to their communities and work for IHS in the future.

The IHS Health Professions Scholarship Program is a key strategy for the agency in developing the future American Indian/Alaska Native (AI/ANs) workforce.

The IHS Loan Repayment Program is one of our most effective recruitment and retention tools for the recruitment of a variety of positions in our workforce.

The IHS has worked to strengthen our recruitment and retention strategies through gathering input from our workforce and our stakeholders to better understand the needs of our workforce. And another important strategy to improve recruitment and retention is to improve the workplace environment at IHS to better support our workforce.

IHS has made improvements in background checks, the hiring process, and credentialing and privileging of providers to ensure that we have a quality Federal workforce.

IHS has also worked to make our salaries more competitive with the private sector, which is especially important for health professional improvement.

IHS has leveraged many partnerships to help develop and support its Federal workforce with other Federal agencies, academic institutions, and tribal communities.

Our partnership with the Health Resources and Services Administration has helped us recruit more health professionals to work in IHS through their National Health Service Corps Scholarship and Loan Repayment Programs.

Our partnership with the VA has helped us improve coordination of care for American Indian and Alaska Native veterans through implementation of our 2010 Memorandum of Understanding (MOU) and our 2012 VA-IHS National Reimbursement Agreement. Those are helping our workforce improve access to quality health care for American Indian and Alaska Native veterans.

Our partnerships with academic institutions are extremely important to our recruitment and retention efforts because of the link it provides to students and new graduates seeking places to serve.

One of our most powerful recruitment and retention strategies is our partnership with our communities. As more of our Federal workforce feels at home and supported by those communities, the likelihood that they will become a long-term member of that community will increase.

In summary, the Federal workforce is essential to the core mission of the Indian Health Service and its delivery of accessible and quality health care services to American Indian and Alaska Native communities. While there is much more to do, we appreciate the

opportunity to testify at this hearing to further discuss opportunities for improvement.

Mr. Chairman, this concludes my testimony. I am happy to answer questions.

Senator TESTER. Thank you, Dr. Roubideaux. We appreciate your testimony.

We will go to Mr. Morris.

**TESTIMONY OF TOM MORRIS,¹ ASSOCIATE ADMINISTRATOR,
OFFICE OF RURAL HEALTH POLICY, HEALTH RESOURCES
AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Mr. MORRIS. Mr. Chairman, Ranking Member Portman, and Members of the Subcommittee, thank you for the opportunity to testify today on behalf of the Department of Health and Human Services, the Health Resources and Services Administration, about the Federal Office of Rural Health Policy.

For 25 years, the office, which was created by Congress, has served as a focal point for rural health activities within HHS. We are charged with advising the Secretary on the impact of HHS policies, regulations, and programs on rural communities. This includes an ongoing focus on issues related to the training, recruitment, and retention of health care professionals in rural communities. We also administer several grant programs related to capacity building from community-based pilot programs to State programs focused on improving the quality and financial performance of small rural hospitals. We welcome opportunities to discuss ways to help rural communities attract and retain needed health care providers. This is a priority for the office, for the Department, for HRSA, and for the Administration.

There are nearly 50 million people living in rural areas. That represents about 16 percent of the population spread across 80 percent of the land mass of the United States. The rural health care system is heavily focused on primary care and chronic disease management, relies heavily on safety net providers like small rural hospitals, federally qualified health centers, and rural health clinics, as well as solo providers and small group practices.

The Office of Rural Health Policy funds several initiatives that focus on building up that rural capacity. This ranges from our work with the 50 State Offices of Rural Health, which we provide grants to, as well as our work through the Rural Hospital Flexibility Grant Program and the Small Hospital Improvement Grant Program, which works to improve question and financial performance for small rural hospitals.

HHS's investment in rural communities, though, goes far beyond the ORHP programs. For example, HRSA administers the National Service Corps, which offers a lifeline to rural communities. They support loan repayment and scholarships for health care providers, and almost half of those providers are in rural areas.

HRSA training programs in primary care, behavioral health, dentistry, and nursing play a key role in training the next generation, and we are also heavily focused on investing in community-

¹ The prepared statement of Mr. Morris appears in the Appendix on page 57.

based residency training for physicians, whether that is through our teaching health center program in which 15 of the 22 grantees serve rural communities or through our work supporting the 23 rural training tracks across the country. Our studies indicate that 70 percent of the graduates of these rural training tracks stay in rural practice, and we are focused on increasing student interest in those programs and also working with communities to start new rural training tracks.

Rural areas also benefit greatly from the HHS and State Conrad 30 J-1 visa waiver programs which place foreign-trained physicians in communities that need them the most. Our office also works with each of the States through the National Rural Recruitment and Retention Network, which placed 1,767 clinicians in rural areas in the past year.

Telehealth plays a key role in increasing the reach of the health care workforce. We have long supported grants to link urban specialists with rural communities in need, and yet we are seeing through our grant programs new and emerging technologies, such as E-emergency care, E-ICU, as well as tele-home monitoring.

Telehealth technology also plays a key role in extending the reach of the limited mental health workforce, particularly in rural areas where psychiatrists and psychologists are often scarce.

We also currently are funding a three-State telehealth pilot that includes Montana and Alaska to link rural veterans to telehealth and health information exchange to enhance their care.

At HRSA, we are also working within the range of Federal partners through the White House Rural Council to train the workers needed to operate and maintain these health information technology systems, whether we are talking about electronic health records, telemedicine, or health information exchange. We expect this to be a key job growth area in the coming years as these technologies continue to be deployed in health care.

Thank you again for providing the opportunity to share HRSA's and the Office of Rural Health Policy's mission with you today and the efforts we have underway to focus on rural working challenges. I am pleased to respond to your questions.

Senator TESTER. Well, thank you, Mr. Morris, for your testimony.

Around 10:30 there will be a vote called, and what we are going to do is stagger it out, so we are not going to adjourn. We will just stagger out, and then when Rob comes back, he can do it; otherwise, if we both have to be gone, we will kick it over to either Senator Begich or Senator Heitkamp. All right? Thank you. Could we put 7 minutes on the clock, please.

Dr. Petzel, the VA has made a commitment to hire 1,600 new mental health care professionals and I think about 300 support staff. You correct me if my numbers are wrong. Where are we at on those hirings both for the clinicians and for the support staff?

Dr. PETZEL. The numbers are correct, Mr. Chairman. In terms of the clinical providers, we have two ways that we look at this. One is the actual positions that were identified that have been filled, and as of the 14th of May, we have filled about 1,356 of that 1,600 clinical mental health providers.

Another way that we look at this is that every quarter we are able to assess the number of clinical providers providing direct care

that we actually have on board. So we went back and looked at what we had on board in May 2012 when we began this effort, and now I have the most recent data from March 2013, and that indicates that we have an additional 1,556 people on board providing mental health care than we did back in May. So we believe that we are well on our way to meeting that goal. And we have basically hired almost all within a few short of the administrative personnel that were part of the 1,900.

Senator TESTER. What are the totals, the 1,556 additional from what they were, what are your total number of mental health—

Dr. PETZEL. I believe that the total mental health that we have on board providing direct patient care is about 18,600. So that would include psychiatrists, psychologists, mental health nurse, clinical mental health specialist nurses, psychiatric social workers, the master's trained counselors and master's trained family therapists.

Senator TESTER. As you well know, in Montana—and I think this could be said for all of rural/frontier America—we have struggled to overcome shortages in mental health professionals for years. So unless we are getting a healthy portion of new hires, which you have indicated we have, we are unable to make up ground with the impacts of PTSD and TBI and the issues of the unseen—we will just call them the “unseen injuries” coming back from war.

You talked about where we are today. Moving into the future are there long-term efforts for assessment? And if so, are there long-term efforts for recruitment that go with those assessments as we move forward to help bring in more young folks into the eye of rural America?

Dr. PETZEL. Well, first of all, Mr. Chairman, there are ongoing recruitment efforts, and these will continue because we have continuing developing vacancies. I am pleased to say that the vacancy rate has actually dropped from slightly over 13 percent amongst clinical mental health providers to a little bit below 11 percent, and that is a significant number when you are talking about almost 20,000 mental health professionals.

We are assessing and will assess actually continuously whether or not we are meeting the access needs and the access standards that we have described. And if we discover that we are not able to do that because we do not have the personnel available, we will continue to add to the mental health workforce.

But I think that it would be useful if I could take 1 minute—

Senator TESTER. Sure.

Dr. PETZEL [continuing]. To describe the other things that we are doing that are relatively new efforts, the most important of which is the use of telehealth and telemental health to deal with the shortage of psychiatrists, which we and everybody has difficulty recruiting into rural areas. I know you are very familiar with that.

We have set up regional centers of psychiatry that communicate with our community-based outpatient clinics and provide consultation and therapy by a telemental health from remote areas such as Spokane, Washington, where we are having difficulty recruiting psychiatrists, into one of these centers in an urban area where we are able to recruit psychiatrists. We have no difficulty recruiting

psychiatrists to New York or Minneapolis or Houston or San Francisco. And these regional centers are proving to be very effective.

The telemental health therapy is very well received by veterans. They like the idea that they do not have to travel great distances. They are not befuddled and frustrated by a 45-minute drive, even across town in an urban area. And that is going to be a major effort in the next 2 years to help us provide the psychiatrist services in remote areas.

Senator TESTER. Well, thank you, and thank you for your work.

Dr. Roubideaux, I want to talk about some of the challenges that may be unique to Indian country as you seek to recruit and to train and to retain quality health care folks. Time and again we hear about administrators who must bring in folks from outside the area as primary care docs, as specialists, as nurses. These are highly skilled but high-paying jobs, especially in Indian country.

I had a group of eighth graders in my office yesterday from down at Crow, and one of the questions they asked me was: How do we get more doctors and nurses from Crow country in the Crow hospital? These are eighth graders, these are 12-, 13-year-old kids that understand what is going on.

Can you talk about the challenges of recruiting in Indian country?

Dr. ROUBIDEAUX. Well, our challenges are significant, and we certainly would like to recruit more individuals from our tribal communities to work in our facilities and to be health professionals. The challenges are of social and economic issues in the communities, schools, and things like that, and then they have to travel far away for their education, and sometimes they do not come back.

So our health professions programs help us recruit and retain American Indians and Alaska Natives to work in our system.

The Indian preference law helps us a lot because about, I would say, approximately three-quarters of our employees right now are American Indian/Alaska Native. The place where we have a difficulty recruiting American Indians and Alaska Natives is in some of the health professions that require training at a distance from the Indian reservation and so recruiting them back to work is a challenge, but our loan repayment programs really help with that.

Senator TESTER. OK. I am going to kick it over to Senator Portman.

Senator PORTMAN. [Presiding.] Thank you, Mr. Chairman,

Dr. Petzel, I wanted to ask a little about using non-VA providers for rural veterans. I know that you have capacity issues—we just talked about that—despite hiring over 1,500 new positions in the last year or so on the mental health side.

Beyond capacity issues, where sometimes you do have to use a private or a fee service, what is the threshold? How far do you require a veteran to go to seek services? How do you define “geographic inaccessibility?” Which I know is one of your criteria.

Dr. PETZEL. Thank you, Senator Portman. We have definitions of rurality that involve both distances—60 miles would be an example—and time—60 minutes—to services. But those are not really used in any great sense when we are evaluating whether somebody should be “fee’d” as we call it, or cared for in the community. Much

of it has to do with the convenience of them being—or inconvenience of them being able to travel. If you have an 81-year-old gentleman who lives even 60 miles from a medical center, it is a burden to ask that individual to travel for a routine clinic appointment. And even for some individuals who are much closer but have to travel across an urban area, that can be a daunting task for somebody who is 81 years old.

So we try to do two things. No. 1, an option is fee'ing that care, that is, providing the care in the local community, and we have two pilots that are running right now looking at that option. But another one that we are doing using in increasing numbers is what we call tele-home health, a video camera in the patient's home, instruments to monitor the patient's weight, electrocardiogram (EKG), blood pressure, and regular contacts with their primary care provider at their clinic or their medical center. It has proven very effective in taking care of patients with multiple chronic diseases, and in not—providing them with the opportunity to not travel to a clinic. We reduce emergency room visits by 40 percent in patients where we have done this and studied it. We have reduced clinic visits by 38 percent. And we have reduced hospitalizations by almost a third by providing this care in the home with constant communication.

Senator PORTMAN. For mental health treatment, is that as effective as it is for other kinds of treatment? We talked earlier about the fact that we have so many of our veterans with PTSD or TBI. So maybe for somebody who is, again, recovering from an orthopedic procedure or somebody who is on dialysis, maybe you can work through some of these issues using some of the telemedicine you are talking about. But how about for mental health? Is it more of a challenge?

Dr. PETZEL. Telemental health is remarkably well accepted. It began actually in the VA on an Indian reservation, on the Rosebud Indian Reservation in South Dakota, almost 10 years ago now, as a study, treating PTSD by telemental health, by a researcher at the University of Colorado. It proved to be very successful and was really the impetus for spreading telemental health around the country. The acceptance rate by this and the satisfaction rate by this is over 90 percent for the patients that use it.

I will tell you an anecdote very quickly. A man lives in New Jersey, has to travel 45 minutes to get to his psychiatrist who works in one of the medical centers there, and he described live on the video camera the experience, 45 minutes through traffic, he is frustrated, he is angry, and he is not the same kind of person that he normally is by the time he shows up for that appointment.

When he does a telemental health therapy episode, he is sitting in his own home. He is comfortable. He has not driven across urban traffic. He is relaxed, and he is an entirely different person. And the therapy session has a dramatically better effect.

It works. It works very well, and we are going to be exploiting this to the maximum over the next several years.

Senator PORTMAN. Do you think that using non-VA providers, particularly for mental health and TBI, is something that you are doing adequately? I notice in the data that you provided the Committee that about 2 percent of VA mental health patients are seen

by non-VA providers every year. DOD, as you know, has a policy with TRICARE that is a little different where they use non-DOD mental health providers for TRICARE recipients on a more regular basis. What is your policy? And, again, is only allowing 2 percent of our veterans to seek treatment by the many providers outside of the VA system appropriate?

Dr. PETZEL. Well, I think that should be expanded, Senator. I have no doubt that 2 percent is not as much as is needed and as could be, and we are, in fact, doing it. The new non-VA care arrangement called PC3 is going to have in it a mental health component, and we will be expanding that.

The issues are making sure that those non-VA providers are facile with PTSD, particularly traumatic brain injury and depression and the things that we see as a result of combat. But we are expanding and we intend to expand our use of non-VA providers.

The pilot that we are doing with the federally qualified health centers I think is an example of that. We have committed to piloting in 15 locations how this works when we have a contract with a federally qualified health care provider. Those are up and running, 15 of them. Five more are going to be added relatively shortly, and I have no doubt that the network is going to expand.

Senator PORTMAN. I notice the data you provided us goes up to 2010, and it does show an increase from 2007 to 2009, actually a decrease in 2010 from 2009. But are you suggesting that your data for 2011 and 2012 and 2013 would show an increase?

Dr. PETZEL. Certainly, Senator, 2012 will show an increase. I do not know about 2011 looks like, but 2012 should certainly show an increase.

Senator PORTMAN. On telehealth or telemedicine, you have given us some important information in your testimony and then in an answer to my earlier question, and I appreciate that. By your own count, you are seeing over a million mental health patients a year now. Clearly a lot more of our veterans need this service. If we assume these patients are dispersed like the veteran population as a whole, that is at least 300,000 mental health patients will be in rural areas or highly rural areas already seeking treatment and likely just as many who need treatment who are not seeking it. Through these health programs that are telemedicine, telemental health programs, how many patients have been connected?

Dr. PETZEL. That is a very good question. Presently it is about 83,000 patients that we have delivered telemental health services to.

Senator PORTMAN. And how many of those 83,000 have to go to one of your community-based outpatient clinics (CBOC) in order to get that service?

Dr. PETZEL. Almost all of them, Senator, would be going to some location where we have telemental health services. There have been a few, but not many, that we have—as the gentleman I described in New Jersey, where we have set this up in their home. That is with the shrinking of—

Senator PORTMAN. That is a pilot program that you think should be expanded?

Dr. PETZEL. It is not a pilot. It is just in its infancy, and yes, it will be expanded. I think that we have demonstrated—these pa-

tients have demonstrated the fact that they are better therapy sessions, better therapy patients when we see them in the context of their home.

Senator PORTMAN. Anything we can do to help you expand that capacity into the home?

Dr. PETZEL. I think we have the resources, Senator. We have the money to buy the equipment. The price has shrunk dramatically, and it is basically just a Web cam now, a high-quality Web cam on a computer. The thing that we need help with around the country, all of us do, is psychiatrists. There just are not enough psychiatrists in this country to meet the country's mental health needs, much less meet the needs of rural veterans, people that are being treated by the Indian Health Service. That is probably one of our largest issues.

Senator PORTMAN. Thank you, Dr. Petzel. I appreciate your testimony. Senator Begich.

OPENING STATEMENT OF SENATOR BEGICH

Senator BEGICH. [Presiding.] Thank you very much. And, Dr. Petzel, thank you very much for your work and your times to Alaska and other work your agency has done, especially around—we call it the “Heroes Card,” but the work you have been doing with Indian Health Services and delivering health care services to rural veterans, especially in roadless areas in Alaska where it is very difficult, as you know, to get access.

I want to ask you a general question, but first I again want to commend you for moving forward. I know our tribes have been very motivated, and hopefully—I have given them the task, after a period of time, to be working with us on any issues that may come up to make sure we continue that process so that a veteran, no matter where they live in rural Alaska, will have access to health care and not worry about having to fly all the way to Anchorage or Seattle, depending on the service they need.

Can you just give me a quick update on how that is working and how you feel the success of that is?

Dr. PETZEL. Thank you, Senator Begich. I want to just mention that I had dinner last night with Katherine Gottlieb from the Southcentral, and I mentioned we were having the hearing, and she said to send her regards.

Senator BEGICH. Very good. Thank you.

Dr. PETZEL. We have had great success, I think, in working with Southcentral and the other tribes in Alaska. The contract that we have for sharing services with Southcentral has been very effective in providing specialty services. We also have some instances where in more remote areas veteran patients are being seen in tribal facilities, obviating the need to travel back to either Fairbanks or to Anchorage.

Then the second issue, the number of people that are having to travel out of Alaska down to Seattle or to Portland for services has shrunk dramatically, and I would say that with very few exceptions we are going to eliminate that need in the not too distant future. I mean, there are some quaternary things such as bone marrow transplants, et cetera, which Seattle is the obvious place to go.

Senator BEGICH. Right, sure.

Dr. PETZEL. But, otherwise, our goal is to not have veterans in Alaska traveling out of Alaska in order to receive care. I think we are making progress, sir.

Senator BEGICH. Fantastic. Let me ask you on the mental health, because, since I have been here, that has been an issue, and I appreciate I think the regulatory change you made to eliminate copays on mental health providers on mental health services. Alaska has been—and you know this, and so it is kind of repeating the obvious—that we have been on the forefront of telehealth and many different avenues from health care to mental health to delivery of just about everything you can imagine through telehealth.

If, let us say, I am an Alaskan who needs services through telemedicine, and my doctor is in Idaho, does that doctor that I am doing telemedicine have to be licensed in Alaska?

Dr. PETZEL. The short answer is no.

Senator BEGICH. OK.

Dr. PETZEL. First of all, in the VA, as in I think every Federal health care entity, you need to have a license in a State, but you do not have to have a license in the State in which you are practicing. So the licensure issue is really not a problem. What you need—the problem, if it arises, is not the credentialing, which is what licensing is about.

Senator BEGICH. Right.

Dr. PETZEL. It is the privileging. You need to have that individual have the right kind of privileges in the right organization. So if a doctor in Boise was doing specialty care for somebody at the Anchorage facility, they would have to be privileged at both Anchorage and at Boise.

We are working to try and smooth out this process of privileging.

Senator BEGICH. Good.

Dr. PETZEL. Credentialing is not an issue. It is——

Senator BEGICH. Thank you for kind of splitting the two issues. I knew there was an issue here, and it is on the privileging situation.

Dr. PETZEL. Correct.

Senator BEGICH. Is there anything legislatively we need to do. I know we did some stuff with DOD on their end, on active, that Senator Kelly Ayotte and I did in an authorization bill a couple of years ago to fix that problem. There were a few more issues they had, but to make sure no matter where an active military member would go, they could get their mental health services delivered from whatever doctor they had at any time. Is there anything legislatively we need to do?

Dr. PETZEL. Senator Begich, I do not know.

Senator BEGICH. OK.

Dr. PETZEL. The privileging issue is something that has to do with the regulating bodies in medical care, the Joint Commission. So the Joint Commission requires that an individual be privileged at the point where they are delivering the care. There is no law, there is not even a Federal regulation that has anything to do with privileging. It is basically a requirement that the Joint Commission has, and we have been working with them to try and find ways to make it easier to have people privileged at various places. But

right now privileged is the right of the medical center or the clinic that is delivering the care.

Senator BEGICH. OK. Very good. Let me again say thank you for all the work that you guys have done in regards to getting what I called the “Heroes Card,” but really delivery for health care for veterans no matter where they live, the services they have earned and deserve. So thank you for that.

Dr. PETZEL. I would like to also just comment on the fact that working with the IHS and tribes in Alaska has just been wonderful. That has been a very good example of Federal collaboration. Thank you.

Senator BEGICH. They are a great group up there.

Let me ask you, Dr. Roubideaux, if I can—again, Dr. Petzel, thank you very much for that.

As you know, we have a significant problem—and, again, I want to echo what Dr. Petzel said. I think our Indian Health Services tribes are doing fantastic work in the delivery of health care. I would argue that we have the best, if not, the top in the country when it comes to delivery in the most harsh climates, conditions, and situations. So I agree that we have some incredible and very innovative approaches that we are making headway in.

But one of the issues—and you have heard me talk about this before, and that is this consistent problem of staffing packages and how do you make sure that you have a vacancy rate of 30 percent in some of your categories, as you described. But the bigger issue is we have, as you know, a hospital in Barrow, one being developed in Kenai, Nome is completed, Matsu, a beautiful facility, the whole top floor is empty because they do not have a staffing package. They cannot deliver the services that the Federal Government contracted with them to do.

You got about \$53 million last year in the CR nationwide. Just the one in Fairbanks TCC will take \$8 million of that.

How are we going to solve this? Because, it is one thing to have a clinic in an urban area, but to get someone hired in a rural area like in Alaska, you cannot do it the day they are open. It does not make any sense.

How are we going to solve this? Because this is honestly unacceptable. We have invested lots of money in these facilities, and then we do not staff them. What is the answer here? Because these are in rural areas.

Dr. ROUBIDEAUX. Well, the answer is for us to work together on the appropriations that will help us get the staffing packages, and I am pleased to report that the President’s budget for 2014 in terms of staffing packages for new and replacement facilities, including joint venture facilities and Federal facilities in Alaska and in Oklahoma, helps us catch up to the amounts that we need to catch up. It has been a difficult budget climate over the past few years, but fortunately through our colleagues and through our working with the tribes, our proposal for \$77 million in new staffing really helps us catch up.

Senator BEGICH. Is that enough?

Dr. ROUBIDEAUX. That is enough to catch up with the need for the facilities that are planned to be open in 2014. And so right now

we are doing our 2015 budget formulation and trying to estimate which ones will be open then as well.

Senator BEGICH. OK. Let me ask one last question, and then I have to go vote. This one, I will use the Matsu facility. They have a top floor that is available. They are going to fill it up. VA has a clinic down the street that is at capacity. It does not have full service, but it is a clinic. Why don't we just take the clinic that the VA has, take the space that is beautiful space, put it in there and have a collaborative effort? It is all Federal money.

Dr. ROUBIDEAUX. Well, the great thing about our—

Senator BEGICH. Is that a good idea?

Dr. ROUBIDEAUX. Because the VA-IHS MOU allows us to do that through sharing of facilities and staff, we have started to do that, and we hope to do more.

Senator BEGICH. VA, good idea?

Dr. PETZEL. Absolutely. We would be delighted if that kind of arrangement worked for both parties.

Senator BEGICH. Fantastic. We want to work with you specifically on that project, so I think that is a huge opportunity to create a great model.

Thank you. I have to go vote.

Senator TESTER. [Presiding.] Yes, you do. Senator Heitkamp.

OPENING STATEMENT OF SENATOR HEITKAMP

Senator HEITKAMP. Thank you, Mr. Chairman, and thanks to all the Members of the panel. Lest you think that this is an unimportant issue to North Dakota, I want to point out that the two Senators whose names were invoked in the testimony were Senator Conrad and Senator Burdick, both from North Dakota and both deeply concerned over a long period of time about the issue of rural health delivery. Whether it is veterans, whether it is our Native Americans, or whether it is just mom and dad on the farm, this is a critical issue for us, and it is a critical infrastructure issue for the development and the continued viability of rural America.

And so I thank the Chairman for bringing this very important issue to the forefront, and I have obviously more questions than what I have time for, and so I would ask for an opportunity to submit some additional questions going forward.

But I want to first make a point. We have heard every bit of your testimony across the board, talking about telemedicine, talking about the need to do things a little differently, expand your capacity by using the technology. Are you so convinced that the technology is available in Indian country or in rural America? The kinds of things that you think you can do in Washington, DC, do you really believe you can do in Hoople, North Dakota? Is there the infrastructure backbone, the amount of technology? And have you looked at those issues going forward when you are promoting telemedicine as a solution?

Dr. PETZEL. Senator, I will take a crack at that first. Ten years ago, the technology was clunky. It required special telephone lines that were often difficult to get into in terms of remote areas. But that whole technology landscape is changing dramatically.

No. 1 is that we can now use a high-resolution Web camera to provide the same kind of fidelity of image, et cetera, that we—

Senator HEITKAMP. I do not mean to interrupt, but is that true in every remote location in the United States?

Dr. PETZEL. Well, we can put that technology anyplace, and we can then use the Internet in order to——

Senator HEITKAMP. What happens if the Internet is intermittent and dial-up?

Dr. PETZEL. If it is dial-up, it works. We have not run into those kinds of difficulties really any place. We have been on Rosebud. We have been providing services of this nature on Pine Ridge. We are going to be providing those services in Devils Lake in North Dakota. And every place we have used it, it has been, No. 1, reliable but I think more importantly it is very well accepted by the patients. When they see that as an alternative to driving 100 miles to Fargo, they will take it in a minute. And they like it, and they get good care with it.

So, yes, I am convinced that this is going to be the wave of the future.

Senator HEITKAMP. Mr. Morris, I would like to hear your response to that, because you are beyond—I mean, your umbrella is a little broader.

Mr. MORRIS. Yes, ma'am. I think there are some challenges in terms of broadband access, which I think is what you are trying to get at, is there enough capacity to use the full extent of the technology that I agree with Dr. Petzel works very well. And we can get back to you for the record with some—I know there has been some analysis of where there are some broadband gaps.

The Federal Communications Commission (FCC) has done some revisions to its universal service program for rural health care that we think is going to be a key tool in sort of that last mile and expanded capacity for those areas, and that was just announced I think within the last couple months.

In addition to that, some of the investments in the Recovery Act through both the Department of Commerce and the Department of Agriculture helped close some of that gap, but there are areas still that are not accessible.

Senator HEITKAMP. I do not think there is any doubt there is still a digital divide in this country, and that is my point. My point is we cannot offer a solution to the remoteness in rural health care and say we are going to solve it with telemedicine, and then not have the highway that is going to take you there. And so I will pledge this. I am chairing on the Ag Committee the Rural Development Subcommittee, and this is an area that goes beyond telemedicine, but this is obviously an absolute critical component of rural development in my opinion.

I have a question for Dr. Roubideaux as well. Obviously Senator Begich and the work that has been done in Alaska is very intriguing to us in North Dakota. We think we have remote locations. We think that we have a great deal of difficulty. And I would tell you that where you hear a lot of praise from him in terms of Indian Health Service, that is not what I hear in my State. What I hear is intermittent services. I hear about clinics shutting down because they do not have the capacity and do not have the staff to even open up on a Friday. That overflow goes to other hospitals.

And so I am very concerned about the long-term commitment and appreciation that you have about the concern that Native Americans in my State have about the quality of their health care.

Dr. ROUBIDEAUX. I want to reassure you that we are absolutely committed to providing health care services to the best of our ability to the American Indians and Alaska Natives throughout the country, including in different areas. And you are absolutely right. There are differences among areas. It tends to track around the difference between the proportion of more direct service programs versus more tribally managed programs. And there are flexibilities around tribal management that are really helping Alaska do some really innovative things. But we still have the Federal trust responsibility and our commitment to the direct service programs in North Dakota and throughout the regions in the country. And so we are still working very hard to try to get these same types of improvements in those programs.

Senator HEITKAMP. And not to prolong it, but I will tell you this: That there are concerns about squashing innovation, especially in the mental health area, within the Indian Health Service because it does not fit with what people may see as traditional models. And I would like to have a longer conversation with you about that going into the future. But we need to be innovative in Indian country in order to provide these services. We need to continue to develop the workforce and the technical expertise of anyone who wants to offer their services, but particularly the programs that we have at the University of North Dakota (UND) to train Indian doctors and Indian nurses.

And if I can just indulge just one additional question on Heroes, I am very interested in looking at modeling the Heroes Health Card program that Senator Begich has been able to get a pilot on. I am very interested in modeling that in North Dakota, and particularly as it relates to Native American veterans. I think anyone who understands Indian country knows that very many Native Americans in terms of a percentage of their population serve in really double, triple, quadruple numbers in the armed services. When they come home, they have access to Indian Health, they have access to Veterans, but neither one seems to work for them.

And so we do not want people who have chemotherapy who are entitled to veterans services to have to get on a bus and drive 10 hours and literally wait in Fargo another 8 hours while the other patients on the bus get their services. As somebody who understands chemotherapy, that is not a healthy thing to do to people.

And so we really believe that North Dakota would be a great additional site, Dr. Petzel, for modeling a Heroes Health Card in the Lower 48.

Dr. PETZEL. We would be delighted to talk with you about that.
Senator HEITKAMP. Terrific.

Dr. PETZEL. And I would just make a comment. In North Dakota and South Dakota, which is where I used to work, 50 percent of the Native American adult males are veterans. That is a huge number.

Senator HEITKAMP. Yes.

Senator TESTER. Thank you, Senator.

I have a question for Tom Morris. Tom, you are Administrator of the Office of Rural Health Policy, and you are a member of the Veterans Rural Health Advisory Committee. You have an informed perspective on a lot of the issues we have talked about today. Could you tell me what the biggest challenges to greater collaboration between agencies like the VA and HHS might be?

Mr. MORRIS. Well, we have had a good partnership with the VA, and their Office of Rural Health I think was created in 2007, and they reached out to us very early on to sort of learn the lessons we learned over the last 25 years about what it is like to sort of be a voice for rural within a large organization. And that collaboration has continued, as you mentioned. I am on the VA Rural Advisory Committee. And I think it has taken a little time for us to understand the unique challenges that the VA has and how that intersection takes place between the VA providers and private providers. But, I think the fact remains that so often veterans who are returning from the previous two wars especially are predominantly rural, and they are coming back to their towns, and they are seeing care both from their local providers and then they may also be going to the VA for some more specialized care.

And so the challenge but also I think the opportunity is how we can both, the private sector and the VA, dually care for those patients, and part of it involves making sure that, as you share patient information or you do telehealth, you meet the privacy and security challenges of the VA's firewall. But I think there is progress being made there through an initiative they have around Blue Button, which is a form of health information exchange.

We have a veterans pilot program right now—and one of the grantees is in your State of Montana, and also Alaska and Virginia—in which we are putting money in to put telehealth equipment into hospitals and clinics, and then reaching out to the VA so that, for instance, a veteran might be able to get their PTSD treatment from a VA provider without having to leave their home community, even if there is not a CBOC or a veterans clinic in that location. And so that program is really still in its infancy. We are recompeting it right now to award another 3 years of grants. And our hope is that that can serve as a pilot for ways that the private providers that care for veterans can also reach out to the VA in their regions and dually care for those patients as effectively as possible.

And then we are in conversations with the VA Office of Rural Health about looking at a number of pilot sites really to focus on this whole notion of health information exchange so that as the veteran sees care in both places, the patient information, the medical record, goes back and forth between both groups.

Senator TESTER. Very good. I would be remiss if I did not ask this question that Senator Begich alluded to, because I have Dr. Roubideaux here and Dr. Petzel here, and it is the collaboration between the VA and the IHS. I would expect you both, since you are sitting side by side, to say it is working great. But what are the challenges that you faced with the collaboration that you have done together? That is the first question to each of you.

And the second question is: Do you have all the policy flexibility you need to be able to do collaboration? In many cases you are

serving the same group of people. So if you could talk about what the challenges have been and then talk about if, in fact, from a policy standpoint if you have the flexibility you need. Whoever wants to go first, go ahead.

Dr. ROUBIDEAUX. Well, I think that we really appreciate our partnership with the VA and their willingness to try to dig in and deal with some of the challenges we face. We are two different systems with two different authorities, and sometimes we have to work through those issues.

There is also the enormous need and the distances that really challenge us as we work together, but I have been requiring my area directors and my Chief Executive Officers (CEOs) to work with the VA over the past 2 years and meet with them, and that is actually going really well. So we are starting to have the conversations we need to have to work through some of the challenging issues. So that relates to the policy issues, and I think the reimbursement agreement was a great opportunity for us to understand each other's authorities and understand some of the innovative ways that we could collaborate and innovative things that we could do. And so I really appreciate our partnership with the VA because they are willing to dig at some of the hardest challenges we are facing.

Senator TESTER. From your perspective, Dr. Petzel?

Dr. PETZEL. I would say that in terms of Washington, and here the collaboration is excellent, the attitude, the desire to make this work for both of us, the desire particularly from our perspective to serve veterans wherever they might be is unparalleled.

The issue for me is generally how this is executed locally, and on both sides. I am not saying it is either the VA or the IHS or the tribes. But it works better in some areas than it does in others. Alaska I think is an example of where it works wonderfully. We have sharing agreements with every tribal organization in Alaska. We are going to have reimbursement pilots in almost all of the State.

In other parts of the country, we have difficulty with our people getting together with the IHS people, and I think that my responsibility is to be sure that the attitude that we evince in Washington is transmitted down to the level where the work is being done.

But I would also agree with Dr. Roubideaux. It is, as I would look at it in the main, working very well. We have a number of places around the country where we do sharing. We have clinics located from the VA's perspective on tribal grounds. The reimbursement agreement I think was a huge step forward, ten pilots piloting that reimbursement agreement to work out the kinks in terms of charges and how bills are paid and patients move back and forth.

There is always room for improvement, Mr. Chairman, and that is in my mind at the local level where we need to be sure that people are doing everything they can do to develop these cooperative relationships in places like Devils Lake, in places like the Crow Reservation, in the Billings clinic, et cetera.

Senator TESTER. Right. OK. Thank you all very much.

Did you have any further questions, Senator Heitkamp?

[No response.]

Senator TESTER. OK. I just wanted to thank you all for your testimony and thank you for the question-and-answer session we have had. This record is going to be open for 15 days, so if there are additional questions—and I know there will be because I will have some myself, and I am sure the others will, too—or additional comments that you want to be put in the record, you certainly can do it over the next 15 days. Thank you all for your service, and thanks for being here this morning.

Now we will go to the second panel, so, Matt Kuntz and Ralph Ibson, if you would come up, and we will get the name tags changed.

I would like to welcome our second panel of witnesses who both have worked tirelessly over the years to advocate on behalf of policies that improve health outcomes and increase access to care for more folks.

We have, first of all, Matt Kuntz. I have known Matt for a while now. He is from the great State of Montana and represents the best of Montana. Born and raised in Helena, Matt graduated from West Point, served with distinction as an Army infantry officer. Matt's advocacy on behalf of our veterans, which is spurred by personal loss, has been recognized by President Obama. Currently he practices law and serves as executive director of the National Alliance on Mental Illness for Montana. Matt took on this role to support, educate, and advocate for all Montanans suffering from serious mental illness and their families. He has done a tremendous job in that capacity, and I am proud of his work and the work of the National Alliance on Mental Illness. Welcome, Matt.

Next we have Ralph Ibson. Ralph is the national policy director of the Wounded Warrior Project (WWP). In that capacity, he heads up research and policy development on health, benefits, and economic empowerment issues for the Wounded Warrior Project. He formerly served as general counsel at the Department of Veterans Affairs and is also a veteran of the United States Army.

Thank you for your service, and welcome, Ralph.

Each of you will have 5 minutes for oral testimony. Know that your entire written testimony will be made a part of the record. So we will start with you, Matt, with your oral testimony.

**TESTIMONY OF MATT KUNTZ,¹ EXECUTIVE DIRECTOR,
NATIONAL ALLIANCE ON MENTAL ILLNESS FOR MONTANA**

Mr. KUNTZ. Thank you, sir. Good morning, Chairman Tester, Ranking Member Portman, and Members of the Committee. I am really honored to be here to testify. As you mentioned, I came into the National Alliance on Mental Illness (NAMI) line of work the hard way, like most of us do, but I am really honored to try to help out as many people as possible, especially our rural vets.

I would like to start out by just saying what the view from Montana is. As you know, it is a very big State with 147,000 square miles, just over 1 million people, with roughly six people per square mile. We have one of the Nation's highest per capita rates of military service, and we are home to over 108,000 veterans, which is about 16.2 percent of the population. Our Indian Health Services

¹The prepared statement of Mr. Kuntz appears in the Appendix on page 63.

needs, we have 12 tribes and 7 reservations with over 66,000 Montanans of Native American heritage.

The scarcity of mental health professionals in Montana is pretty hard to comprehend, and it really is a major difficulty for our families. But the best way to describe it is we have one psychiatrist between Billings and Bismarck, North Dakota. That is a stretch of about 400 miles on the interstate, which is roughly the distance between Boston and D.C. One psychiatrist to cover all that area. There are fill-ins by psychiatric nurses and telepsychiatry, but one warm body.

And I think the other thing that needs to be mentioned because it underlies everything in Montana is the oil development in the Bakken, and our eastern Montana and western North Dakota is overtaxed with pretty much all infrastructure issues, but especially mental health. And it is taking what was a crisis and turning it into something really terrifying.

So I just wanted to give some quick realities of what happens in Montana, especially with our vets, to show interlinked all of these different agencies are. For instance, if there is a veteran in Darby, Montana, who goes into crisis, he would probably be moved 16 miles to Hamilton to stay at Western Montana's private inpatient crisis center. After being there for a day or two, he will then be transported to Helena where the VA's inpatient unit is—that is 100 miles—and then will eventually return to his home community where he will be treated either by the VA through telepsychiatry or by the private health contractor. And that is just how it looks from us.

Some of the things that I think that are really good that are happening in Montana is that the contracting system with the private providers is absolutely essential. The psychiatric nursing program at Montana State is really helping us fill the needs, and telepsychiatry has hit almost a critical mass in Montana, especially with the Centers for Medicare and Medicaid Service (CMS) grant for \$7.7 million for Montana and Wyoming.

Peer services is developing well, and I guess one of the things that I would really like to see more is a residency program. I think that we all talk about how bad we need psychiatrists, but the fact is every State that needs psychiatrists also needs a psychiatric residency program. And if they are able to do some of these things, if they are able to provide the services through telemedicine, maybe there is a way to structure those residency programs a little bit more flexibly as well.

Also, the loan repayment programs, our Nation really relies on our inpatient psychiatrists, and how they should be taken care of in loan repayment is a little bit different than outpatient psychiatrists.

Thank you, Senator Tester, and I am willing to answer any questions.

Senator TESTER. Thank you, Matt. I appreciate your testimony. Next we have Ralph Ibson.

**TESTIMONY OF RALPH IBSON,¹ NATIONAL POLICY DIRECTOR,
WOUNDED WARRIOR PROJECT**

Mr. IBSON. Chairman Tester, thank you for inviting Wounded Warrior Project to testify this morning. With our mission of honoring and empowering those wounded in Iraq and Afghanistan, the mental health of our returning veterans is among our very highest priorities, and I am honored to be here with Matt.

With our focus we see that, despite extensive Federal efforts there remain wide gaps in meeting the mental health needs of this generation of warriors. Let me highlight one critical concern.

Many who served in Iraq and Afghanistan remain reluctant to receive mental health care. Research indicates that half of those who need care are not getting it, and a high percentage of those who elect to pursue care drop out prematurely. Much more progress is needed to reverse these trends, in our view.

Many factors play a role in that process, but in some cases, it also appears to be a function of family issues. And while current law, law that you helped enact, Mr. Chairman directs VA to provide needed mental health services to immediate family members of the Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans, VA has not implemented that provision.

To your focus this morning, Mr. Chairman, nowhere are the gaps in meeting warriors' mental health needs wider than in rural America. VA policy says in essence, and as discussed earlier, that VA facilities must be able to provide veterans needed mental health care, and if they cannot because of lack of onsite staff or geographical inaccessibility, other options must be used, including telehealth or contract arrangements.

But even veterans who live in remote areas often encounter local VA reluctance or even resistance to authorizing community-based care. With limited exceptions, we see only modest VA use of contract arrangements to overcome access gaps. And as indicated, with 55 percent of U.S. counties, all rural, having no practicing mental health clinicians and situations as Matt described in Montana, VA's policy of providing contract care is hardly a comprehensive answer. And with the drawdown of forces in Afghanistan, the access challenge will only grow.

We do see promise in programs mentioned this morning. VA's telemental health capability has seen exponential growth, and we certainly see room for VA to greatly expand use of telemental health to engage more warriors and are pleased that Dr. Petzel agrees, as reflected in his testimony.

A second important programmatic effort was sparked by the directive in the President's Executive Order of last August, that VA hire and train 800 veterans to serve as peer-to-peer counselors. We see that as a model for winning warriors' trust in entering into mental health treatment and staying in treatment. And we also see it as having potential in rural areas. Our one concern is that the initiative is not really targeted at supporting OEF/OIF veterans, where the need is greatest, in our view. That, Senators, as you know, also incorporate a peer-to-peer model, and we see that as a key aspect of the success of that program and are pleased, again,

¹ The prepared statement of Mr. Ibsen appears in the Appendix on page 74.

at Dr. Petzel's acknowledgment that this is a program that needs to expand.

Finally, let me suggest that many OEF/OIF warriors with PTSD and other mental health conditions are also struggling to readjust to a new normal, to uncertainties about finances, career, education, employment. And no single VA program necessarily addresses that full range of issues that many young warriors face. Few, if any, VA programs are embedded in a veteran's community, and yet VA and community each has a distinct role to play. For some veterans, as we see it, community reintegration may take a community-wide effort, and we see a role here for VA. But as yet we see no real centralized effort to harness such partnerships.

With limited exceptions, VA mental health programs are generally not focused or integrated with the adjacent community, and while VA has broad authority to enter into partnership with community providers and Congress just last year in the National Defense Authorization Act (NDAA) strongly encouraged that, we do not see much happening on that front.

Finally, we believe VA should work with communities in providing needed mental health services to wounded warriors. This should include providing training to clinicians on military culture and the combat experience. Simply having more providers or access to providers who do not really understand the experience veterans have been through or PTSD is not itself a real answer.

We look forward to working with the Subcommittee on the important issues discussed this morning, and thank you for consideration of our views. I am happy to answer questions.

Senator TESTER. Well, thank you, Ralph. Thank you both for your testimony. I appreciate it very much.

I am going to start with you, Ralph, on what you just last said, because I think it is an issue that I have heard from the veterans themselves, and that is the training of the clinicians, making sure that when a veteran who has some issues goes and sees a clinician, that they actually have an understanding of what got that person to the point where they are.

How do we best do this? It seems to me that there are several steps involved, and, by the way, you correct me if I am wrong. First you have to build the partnership, and then you have to make sure the folks who are dealing with the veterans understand what the veteran has been through. How is the best way to move forward with that from a VA perspective? Because I think you are spot on, quite frankly.

Mr. IBSON. Well, Mr. Chairman, I think you have really put your finger on an important point or emphasized an important point, and that is that the treatment process has to begin with developing a relationship of trust, and I think essential to that is that the veteran perceive that the provider understands his or her problems, understands where he or she has been. And, the VA has done a heroic job of training its clinicians on evidence-based therapies. I do not purport to be an educator or, to have insight on the best way of training, but I do not see the equivalent focus on helping ensure that those providers really understand veterans. And I do see that even as VA has expanded and has filled many of those vacancies,

hiring 1,300-plus, when veterans encounter a clinician who they perceive does not understand them, they leave.

Senator TESTER. Yes, I agree with that, and that is the worst possible outcome, quite frankly, as far as care goes.

Matt, despite significant investments that have been made to address the complex wounds of war, we continue to see—and you deal with this firsthand—high rates of depression, divorce, domestic abuse, an unacceptably high number of servicemembers, as has already been pointed out today, commit suicide every day. It is overwhelming and at times it is difficult to tell whether we are actually making progress, making a significant impact on what is going on out there.

We need to ensure that the VA is able to identify and treat these folks with their issues in a meaningful way, and we need to ensure that they are appropriately staffed in a rural area like Montana. You talked about Billings and Bismarck, 400 miles away. We have a training staff, but sometimes there is no staff to train in certain areas because there are not mental health professionals there.

As an advocate you have been personally involved with this epidemic. You have seen the investments that have been made. You talked about telemedicine. Are there other things out there that are working besides telemedicine? And is telemedicine working well?

Mr. KUNTZ. Sir, I think telemedicine is working well. It is a great, wonderful thing, and the Tribal Veterans Rep program was one of the first ones that brought it to Montana, and it is valuable. There is no question. I think that one of the other things that I thought was really good was, as you know well, the VA really struggled to staff its inpatient facility in Helena, and it just sat open, and they could not run it due to lack of psychiatrists. And I think that the way that they were able to change their staffing structure to use it with one inpatient psychiatrist, one outpatient, and a couple of nurse practitioners, like that willingness to adapt to what actually happens on the ground in Montana, we do not have three inpatient psychiatrists to run a facility like that. And the VA learned. It took them awhile.

But one of the other things I think is—like the peer support is critical and important, and it also provides much needed jobs for veterans that struggle with these kind of issues. But the retention of the counselors I think in some ways is a bigger issue than actually whether or not they have served. I know many veterans that I talk to just say it is a matter of kind of changing bodies in front of them. And if they open up their soul and describe their combat needs, describe all of their issues going on with them, and then the person is gone, I mean, I talked to one vet that works across the street, and he had three counselors in a year. I think that while we need to focus on getting the perfect, right training and everything—

Senator TESTER. Sure, yes, multifaceted. So what is the issue on retention? Why are they leaving? Is it salary? Quality of life? Are they burning out, getting out of the business? Why are they leaving? Why are we seeing turnover?

Mr. KUNTZ. It is really hard to tell, sir. I think it is different for every one of them. But what shocks me is I guess how in the box

and how constrained they are, I mean, and the limits of what they are given to work with. I do think that they are pretty heavily worked. Hopefully they will be working with peer specialists, but also like they do not even give them business cards sometimes, no voicemail for some of these counselors. And how do you—

Senator TESTER. Right. I got you.

Ralph, do you want to add anything to that as far as what is working and what is not working?

Mr. IBSON. Well, I have seen that same telemental health demonstration that Dr. Petzel alluded to, and I would agree with his assessment, and I would agree as well with Matt's perspective on the retention issue, which I think is not limited to counselors. We attempted about a year and a half ago to survey VA mental health clinicians, across the country and while I would not want to suggest it was a scientific survey, but it was disturbing to see results that suggested serious morale problems at many facilities.

Now, this reflected a period of understaffing, and so I acknowledge that as well.

Senator TESTER. Right.

Mr. IBSON. But many spoke of the system as top-down, as failing to appreciate the importance of allowing clinicians to build that trust relationship, and of imposing performance requirements that were highly focused on evidence-based exposure therapies, which, while having solid evidence base, were not appealing to the veterans. Many of the veterans could not handle dealing on a weekly basis with re-exposure to the trauma they had experienced, and yet that was the directive from on high.

VA has done a survey of its own mental health staff last September on clinician attitudes. I think it would be helpful to see the results of that survey. It would be helpful to understand the factors that drive the 10-percent vacancy data that Dr. Petzel cited. I think a system that honored its clinicians from those peer-to-peer counselors on up would be a system that would be a more successful one.

Senator TESTER. I am going to ask you guys a question that I was going to ask Dr. Petzel, but I did not want to keep him here all day. But I think you guys can answer it in maybe a better way than he could because you are driving the bus at the other end of the experience here.

Licensed professional mental health counselors, marriage and family therapists, they make up about 40 percent of the overall mental health independent practice workforce. In the VA, they make up less than 1 percent. Is there a reason for that? Are they less desirable as counselors? Or is there something out there I am missing?

Mr. KUNTZ. Sir, there may be a reason for that, but I will just say flat out it is not a valid one.

Senator TESTER. OK.

Mr. KUNTZ. We need them.

Senator TESTER. OK. Ralph, do you want to add anything to that?

Mr. IBSON. I would not disagree with that perspective.

Senator TESTER. OK. Good. I want to talk about the gaps that you talked about a little bit, Ralph, in your testimony. There are

some real inhibiting things in our society about people who go in for mental health treatment. There is a stigma attached to it. There can be employment problems afterwards, not because they have issues with mental health, but it is because the employer might not want them to begin with.

What can we do to minimize the stigma, so these folks are more likely to go in and get help when they need it? Because it is curable. We know it is curable. It can be fixed. Or is there anything we can do about it?

Mr. IBSON. Well, I do think there has been a probably 20-year or longer effort to address stigma. I think organizations like NAMI have played an important part in that. But there is evidence that suggests that veterans themselves, warriors of this generation, still are distrustful of mental health care. It is not solely a stigma issue. And I think the peer-to-peer counselors can play an enormously important part in belying those views and drawing warriors into treatment and helping sustain them in treatment.

I agree with, again, Matt's point that we have to honor those warrior employees, make them feel they are an important part of the team and make their working conditions appropriate. But I do think the infrastructure and the policies are in place to close those gaps.

Senator TESTER. OK. Matt, do you have anything to add to that?

Mr. KUNTZ. Sir, I have, I guess, two things. One is I think we need to take the magic out of what this is through research. I mean, a really big problem with the lack of understanding. And we do not understand the brain well enough, and especially these diagnostic patterns. With the Diagnostic and Statistical Manual (DSMs) changing and everything, the best clinicians really struggle to identify what a person has and, I mean, I think because we do not have valid scientific instruments to measure whether or not people have these conditions, they are measured by behavioral health surveys, it just leads to a level of distrust, and people do not have a way of saying, OK, my neuro circuitry is disrupted, so I get help for this.

Senator TESTER. I understand.

Mr. KUNTZ. Anything that we could do to improve that.

The other thing, I think, is we have a lot of different anti-stigma efforts, but they do not really highlight people that had PTSD and depression in the past. We do not read about—or we do not see the anti-stigma things that talk about Winston Churchill's depression, that talk about Abraham Lincoln's depression. Some of the greatest Americans struggled with these conditions, and why don't we bring them up? So I would love to see a little bit more of that.

Senator TESTER. OK, good. I want to talk about partnerships, particularly between the VA and the Wounded Warrior Project, and there may be partnerships between NAMI and the VA that I am unaware of, or maybe there are some opportunities for partnerships that we could make them aware of.

I have been aware of and, quite frankly, been out on some programs like Healing Waters in Montana, and you mentioned a project, Project Odyssey, in your testimony, which is maybe classified in the peer-to-peer program, or maybe it is separate—

Mr. IBSON. Yes, sir, it has a strong element of peer-to-peer support.

Senator TESTER. Yes. If you guys could shed light on programs like that, their effectiveness, and how we might be able to expand on other programs that could—there are programs out there working with animals, horses in particular, dogs, and just kind of talk about opportunities out there to collaborate on peer activities related to the outdoors to relieve stress.

Mr. IBSON. Well, if I could followup, Mr. Chairman, Project Odyssey is one of 18 different programs our organization operates. It is a program that takes warriors out in retreat-like settings. It might be to Montana for an outdoor activity or mountains in Vermont, wherever. But it takes them out in groups that include a trained therapist and focuses on building peer-to-peer relationships to confront in some cases for the first time their post-traumatic stress disorder or other combat-related mental health conditions. It has been very successful in helping veterans confront those issues and get into treatment, to overcome the stigma and barriers. And it is a program that we have run for a number of years and ran in collaboration with VA Vet Center program, and to our disappointment, VA pulled out of it in about 2010. The suggestion was they lacked the authority or felt they lacked the authority to continue.

Since then, Congress last year enacted legislation making it crystal clear that authority exists, and we had hoped that would lead to reinstitution of that partnership. That has not happened yet.

Senator TESTER. Matt, do you have anything to add?

Mr. KUNTZ. Yes, sir. My favorite program for this—I am totally biased because I was involved in helping start it. My sister, Dr. Janna Sherrill, and a veteran from Missoula, Jesse Scollin, started it up. It is called X Sports 4 Vets in Missoula. What it is, they take—it was based on taking veterans river boarding—I believe it was a 6-week program—and it engages them in an extremely high adrenaline activity, and then it was tied in with counseling afterwards, and the level of success in what I saw from that program was just astonishing. And the veteran participation, they not only joined it and they got involved in it, but they took it over themselves and run it. It really is amazing, and it is done in partnership with the Missoula Vet Center, and I know it is a model that could be expanded to other sports and stuff. But the neat thing about this in comparison to some of the other ones is it is not a retreat. It is kind of—it takes them in their community in a sport or something that they can do afterwards and gets them involved with a group of men and women that they eventually form bonds and friendships with, and it also introduces them to civilians like the rafting guide that helped start it.

That was the first civilian that some of these vets have bonded with, and they respected him because he takes a little tiny raft on the Lochsa River, and it really is remarkable. But I have not seen any efforts from the top to try to expand that beyond Montana.

Senator TESTER. Last question, and this is going to be a quick one for you, Ralph. Who funds your Project Odyssey now?

Mr. IBSON. We get donations, typically small donations around the country.

Senator TESTER. All private—

Mr. IBSON. Yes, it is all private sector, no Federal.

Senator TESTER. All right.

Mr. IBSON. We do not take Federal money.

Senator TESTER. All right. Thank you, guys, very much. I want to thank you again for your testimony this morning. I very much appreciate it. I think overall this hearing has underscored some of the important progress that I think we have made, but it also highlighted some additional efforts that we need to make. And I look forward to working with Ranking Member Portman and our witnesses here today on these issues to make sure we address the health care needs of our citizens and they are met regardless of where they live. And in that regard, I just want to thank you two fellows for being here this morning. Again, I appreciate your work.

This hearing record will remain open for 15 days for any additional comments or questions that may be submitted to the record. And with that, the hearing is adjourned.

[Whereupon, at 11:45 a.m., the Subcommittee was adjourned.]

APPENDIX

**STATEMENT OF
ROBERT A. PETZEL, M.D.
UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
U.S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENT
AFFAIRS
SUBCOMMITTEE ON THE EFFICIENCY AND EFFECTIVENESS OF FEDERAL
PROGRAMS AND THE FEDERAL WORKFORCE**

May 23, 2013

Good morning, Chairman Tester, Ranking Member Portman and Members of the Subcommittee. Thank you for the opportunity to discuss how VA recruits, retains, and deploys a quality health care workforce to ensure that Veterans across the Nation can access high quality health care that they have earned and deserve.

VA continues to develop and expand its focus on health and its health care delivery system. As the Nation's largest integrated health care delivery system, VHA's workforce challenges mirror those of the health care industry as a whole. My written statement will describe the challenges VA has faced and the creative approaches we have taken to recruiting, training, and then retaining and supporting our health care workforce to ensure access to care for all Veterans. This statement highlights VA's efforts to focus on rural providers, advances in delivery of mental health care, and how VA has leveraged technology to meet the needs of Veterans. It also describes collaborations between VA's health care delivery system and other entities, including other Federal agencies and academic affiliates.

I. Efforts to Recruit and Retain Health Care Professionals

At VA, we have the responsibility to anticipate the needs of returning Veterans. We have many entry points for VHA health care: 151 medical centers, 827 community-based outpatient clinics (CBOCs), 300 Vet Centers that provide readjustment counseling, the Veterans Crisis Line, as well as VA staff on college and university

campuses and other outreach efforts. In response to increased demand, VA has enhanced its capacity to deliver needed health services and to improve its system of care so that Veterans can more readily access services. Ensuring access to appropriate care is essential to helping Veterans recover from the injuries or illnesses they incurred during their military service, whether they now live in an urban, rural or highly rural area.

VHA routinely uses hiring and pay incentives established under Title 5 and Title 38. Relocation, recruitment and retention incentives are important tools when strategically and prudently used to address our human capital needs. These incentives facilitate the staffing of difficult to fill positions with highly qualified candidates who possess the unique skills and competencies needed, and the retention of employees whose services are essential to fulfill VHA's mission and who would otherwise leave Federal service. VHA assesses staffing needs and utilizes these flexibilities only after verification that incentives are necessary to support the organization's workforce plan and strategic goals. In fiscal year (FY) 2012, nearly \$20 million in recruitment incentives were paid to over 1,742 Title 38 and Hybrid Title 38 employees, while more than \$86 million in retention incentives were paid to 11,157 Title 38 and Hybrid Title 38 employees. In addition to these incentives, VHA has special salary rates for hard to recruit occupations and an additional pay component of executive pay for Nurse Executives and Pharmacy Executives.

The Employee Incentive Scholarship Program (EISP), both a recruitment and retention tool, pays up to \$37,494 for academic health care-related degree programs. Between October 1999 and September 2012, 13,036 VA employees received scholarship awards for academic education programs related to Title 38 and Hybrid Title 38 occupations, and more than 8,688 employees have graduated. Scholarship recipients include primarily registered nurses (78.5 percent), and other health professionals, such as pharmacists and physical therapists. Following completion of the degree program, scholarship participants incur a one to three year service obligation. As of September 30, 2012, less than two percent of the registered nurses who

successfully completed their degree programs left VHA or left clinical practice during the service obligation period.

VHA has implemented an aggressive national recruitment and marketing strategy to increase awareness of employment opportunities. Marketing efforts include national recruitment advertisements through television commercial Public Service Announcements (PSA). These PSAs have been released on *VA YouTube* and were distributed to more than 1,000 media outlets. VHA invests heavily in various marketing campaigns including online media, direct mail, and print advertisements, and has an integrated social media presence on *Facebook* and *Twitter*.

VHA will soon launch a comprehensive national outreach and awareness initiative to target medical residents and trainees who complete medical education in VHA affiliated facilities. These professionals represent a pool of talent that is already experienced and engaged with VHA, and is a viable pipeline to fill mission-critical vacancies. The *Strategic Recruitment Initiative for VHA Health Professions Trainees* will, through Web-based and social media driven marketing, introduce and inform health professions trainees about post-training practice opportunities for consideration across the agency. Another student-focused initiative is the VA Learning Opportunity Residency (VALOR) Program. VALOR provides opportunities for outstanding nursing, pharmacy and medical technology students to gain work experience in VHA health care facilities. During FY 2012, 379 of the 499 VALOR students were nursing students; 43 of those students were located in rural facilities.

II. Challenges Hiring Health Professionals in Rural Areas

VA recognizes that rural communities face challenges in ensuring access to health care providers. VA is working to develop an effective rural workforce strategy to recruit locally for a broad range of health-related professions. These strategies include training, technology, collaboration, and academic affiliations. Nationally, health care is challenged by attracting providers in remote locations. To address these challenges, VHA has engaged a team of 21 professional in-house Physician Recruitment

Consultants. Each is an experienced health care recruitment expert, with both military and private sector health care recruitment experience. This in-house Physician Recruitment Consultants team, working in close collaboration with local Human Resources offices and clinical hiring managers, has proven its ability to recruit for scarce medical practitioners in many rural and highly rural areas. In FY 2012, this team recruited 117 clinicians to rural facilities and in FY 2013, the team has recruited 105 clinicians to date. Targeted recruitment efforts that replicate private sector best practices have helped to fill critical vacancies in locations such as Helena, Montana; Chillicothe, Ohio; Harlingen, Texas; and Fargo, North Dakota.

Academic Affiliations and Training

In order to carry out the primary patient care mission of VHA and to assist in providing an adequate supply of health personnel to the Nation, VA is authorized by Title 38 Section 7302 to provide clinical education and training programs for developing health professionals. VA conducts the largest education and training effort for health professionals in the U.S. Of the 151 VA medical centers and six independent outpatient clinics (IOC), 124 medical centers and three IOCs are affiliated with 126 of 141 allopathic medical schools and 15 of 26 osteopathic medical schools. In addition, more than 40 other health professions are represented by affiliations with over 1,800 unique colleges and universities. Among these institutions are Hispanic Serving Institutions, Historically Black Colleges and Universities, Asian American and Native American Pacific Islander Serving Institutions, and Native American Serving Institutions. The training of health professionals impacts VA's ability to deliver cost-effective, high-quality patient care for Veterans and promotes the recruitment of gifted clinician educators. VA strategically works with universities, colleges and health professional training institutions across the country to expand their curricula to address the new science related to meeting the mental and behavioral needs of our Nation's Veterans, Servicemembers, Wounded Warriors, and their family members.

VA health professions education programs have a major impact on the health care workforce in VA. Approximately 70 percent of current VA optometrists and

psychologists and 60 percent of VA physicians participated in VA training programs prior to employment. VA's involvement in health professions education has shown to be an effective mechanism to support VA's patient care mission.

Rural health care providers and other clinical staff experience significant barriers to accessing relevant continuing education and training necessary to keep their clinical skills current. In addition, the literature indicates that rural providers and other clinical staff report high levels of professional isolation. These factors can contribute to difficulty in retaining skilled health care providers in rural areas. To address these issues, VA is developing locally based training and education programs for rural VA providers, clinical staff, and rural clinic support staff based on local training needs. This initiative will require collaborations with entities that have the clinical or operational expertise to develop or use existing content; innovative methods of training delivery (i.e., video conferencing, Web-based) that are convenient and easily accessible; and educational objectives that address local needs.

To increase specialty care capacity in rural health clinics and to address the issue of professional isolation, VA expanded the Specialty Care Access Network – Extension for Community Healthcare Outcomes (SCAN-ECHO) pilot program to 40 rural VA facilities in FY 2013. SCAN-ECHO leverages telehealth technology to provide specialty care consultation, clinical training, and clinical support from specialty care teams to rural providers so that they can manage patients with chronic conditions closer to home. VA currently has 11 SCAN-ECHO centers with multi-disciplinary teams located at various VA medical centers across the country. The specialty care clinics cover a range of conditions including Hepatitis C, Pain Management, Heart Failure, Chronic Obstructive Pulmonary Disease, Women's Health, and Diabetes. In all, 40 rural VA facilities with over 100 rural VA providers including primary care physicians, nurse practitioners, and social workers are participating in the rural expansion of the SCAN-ECHO pilot program. This program will have a strong evaluation component to help VA assess the program's cost effectiveness in building specialty care capacity in rural areas. In addition, VA will evaluate patient satisfaction, reduction in patient travel, reduction in wait times for a specialty consult, and provider satisfaction in the short term.

and measures of improved patient outcomes and increased retention of rural providers in the longer term.

Providing training opportunities are important investments for creating a Veteran and rural friendly health care workforce. VA is working to integrate rural areas into health care trainee rotations, since evidence shows those who train in rural areas are more likely to practice in rural areas. In VA, the collaboration between the Office of Rural Health and the Office of Academic Affiliations is assisting medical centers in developing training rotations and training expertise in rural and highly rural locations. The Rural Health Training Programs strive to create an environment that supports the recruitment and retention of knowledgeable and dedicated health care professionals who are committed to serving rural Veterans.

Between FY 2010 and FY 2012, VA piloted a program called the Rural Health Training Initiative (RHTI). This pilot sought to positively affect recruitment to rural areas by encouraging trainees to receive their clinical training in rural areas. Over 200 trainees (82 percent Graduate Medical Education, 12 percent Allied Health, 5 percent Nursing) were exposed to rural healthcare at four pilot sites including: W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina; Philadelphia VA Medical Center, Philadelphia, Pennsylvania; Sioux Falls VA Health Care System, Sioux Falls, South Dakota; and Minneapolis VA Health Care System, Minneapolis, Minnesota. All trainees were assigned to rural CBOCs, with the exception of Salisbury, North Carolina, which is a designated rural facility. The pilot led to the launch of the Phase II RHTI in FY 2013. The Phase II RHTI will fund additional physician residents and other associated health and nursing trainees over a three-year period. The seven sites chosen in Phase II include: Nebraska-Western Iowa Health Care System, Omaha, Nebraska; W. G. (Bill) Hefner VA Medical Center; James J. Peters VA Medical Center, Bronx, New York; VA Pacific Islands Health Care System, Honolulu, Hawaii; Salem VA Medical Center, Salem, Virginia; Tuscaloosa VA Medical Center, Tuscaloosa, Alabama; and Maine Healthcare System, Togus, Maine. Implementation of Phase II is currently underway.

In addition, VA supports a very successful geriatric training program for rural providers known as "Geri Scholars." This program trains clinicians practicing out of

rural VA facilities in the most current science in geriatric care and in the principles of implementation science. Each scholar participates in an intensive course in geriatric care and in a one-day workshop in team leadership and quality improvement. The program culminates with each scholar implementing a quality improvement project to improve healthcare for older Veterans within the rural CBOC clinical setting. Recently, the prestigious Duncan Neuhauser Award for Curricular Innovation by the Academy recognized the "Geri Scholars" program for Healthcare Improvement. To date, the program has served all 21 Veterans Integrated Service Networks (VISN), 184 facilities and enrolled 408 VA staff with 104 staff starting the program in the fourth quarter of FY 2013.

VHA oversees the clinical education in VA settings for nearly 120,000 health professions trainees each year. Of these, roughly half are physician trainees (medical students and residents) while approximately 25 percent are nursing trainees and the remaining 25 percent represent trainees in the associated health disciplines. In recent years, VA has increased emphasis and funding of trainees in the associated health professions. In addition to increasing the absolute numbers of trainees in these professions, VA has established new advanced residency programs for physical therapy, physician assistants, and nurse practitioners.

The Federal Healthcare Training Partnership fosters intra-governmental sharing of training resources and infrastructure. Founded by VHA's Employee Education System in 2004, the partnership has grown to include 14 Federal agencies, and now encompasses all agencies that offer clinical care as a primary mission. A diverse and evolving array of training initiatives are shared by participating agencies, including Post-traumatic Stress Disorder courses and suicide prevention clinicians training.

In 2011, VA recognized the Nation's urgent need for preparation and integration of medical, nursing and associated health trainees into interprofessional team based primary care settings. VA funded the Centers of Excellence in Primary Care Education (CoEPCE), and competitively selected five sites to begin transforming primary care education within the context of VA's national Patient-Aligned Care Teams (PACT) implementation. These programs were designed to incorporate a variety of occupations

(trainees in medicine, nursing, psychology, pharmacy, and others) learning and working together to provide patient-centered, team-based care. Through these five educational demonstration projects, VA has quickly become recognized as the national leader in the transformation of primary care education. Initial evidence indicates benefits to VA and Veterans including, strong support of the projects by facility leadership at the five sites; early adoption of the innovations by local academic affiliates; and most convincingly, overwhelming preference of trainees for working in these new "Academic PACTs." VA plans to expand the CoEPCE concept from five to 30 sites by 2019.

The VA Nursing Academy has received significant attention and praise throughout the medical and nursing communities. The VA Nursing Academy has been responsible for increasing the numbers of experienced nurses with Veteran-centric skills available for hire both within and outside of VA. The VA Nursing Academic Partnership Program is now entering a new phase of partnerships between VA facilities and schools of nursing and will establish 18 new partnerships over the next several years. These new partnerships are expected to have a major impact on the training of nurses to respond to the unique needs of Veterans.

VHA also trains roughly 6,400 trainees in mental health occupations per year (including 3,400 in psychiatry, 1,900 in psychology, and 1,100 in social work, plus clinical pastoral education positions). Currently, VA has one of only two accredited psychology internship programs in the entire state of Alaska. VA is committed to expanding training opportunities in mental health professions in order to build a pipeline of future VA health care providers. VA continues to expand mental health training opportunities in nursing, pharmacy, psychiatry, psychology, and social work. Over 202 positions were approved to begin in academic year 2013-2014 at 43 VHA facilities focused on the expansion of existing accredited programs in integrated care settings such as General Outpatient Mental Health Clinics or Patient Aligned Care Teams (PACT). These include over 86 training positions for Outpatient Mental Health Interprofessional Teams and 116 training positions for PACTs with Mental Health Integration, specifically 12 positions in nursing, 43 in pharmacy, over 34 in psychiatry, 62 in psychology, and 51 in social work.

Leveraging Technology

Telemental health empowers VA to provide Veterans quicker and more efficient access to mental health care by reducing the distance they have to travel, increasing the flexibility of the system they use, and easing their access to care that can improve their overall quality of life. This technology improves access to general and specialty services in geographically remote areas where it can be particularly difficult to recruit mental health professionals. Currently, the clinic-based telemental health program involves more than 580 VA CBOCs where many Veterans receive primary care. In areas where the CBOCs do not have a mental health care provider available, VA is implementing a new program to use secure video teleconferencing technology to connect the Veteran to a provider within VA's nationwide system of care. For example, VA recently set up three regional telemental health programs in VISN 7, VISN 17, and VISN 22 to improve access to evidenced-based psychotherapy for Veterans in areas that are underserved because of difficulty hiring qualified mental health staff. VHA has also developed national telemental health programs to provide specialty consultation to general providers to further leverage the mental health workforce. The telemental health program is also expanding directly into the home of the Veteran with the goal to connect approximately 2,000 patients by the end of FY 2013 using Internet Protocol video on Veterans' personal computers.

Empowering Veteran patients with telehealth technology and targeted health communications has proven to be an important way to provide quality care in the daily life of Veterans. With VA's Personal Health Record, My HealtheVet (www.myhealth.va.gov), Veterans are able to play an active role in their health care regardless of their location or age. My HealtheVet is an award-winning Web site that was designed for Veterans, active duty Servicemembers, their dependents, and Caregivers, and gives Veteran patients greater control over their care and wellness. My HealtheVet and its online suite of tools, including Secure Messaging, VA Prescription Refill and VA Blue Button, enables Veterans and their health care providers, clinicians, and staff to be more connected to health care information, anywhere, anytime – outside of a clinical face-to-face encounter.

The VA Blue Button enables Veterans to generate and download an electronic file of their personal health information from My HealtheVet to share with other, more local providers if they chose. This health data is a combination of extracts of their VA electronic health data and patient-generated data stored in their on-line personal health record. With My HealtheVet, patients are provided opportunities and tools to make informed decisions to manage their health care; to securely access portions of their VA health records online 24/7; to print and save their personal health information and their Continuity of Care Document through the VA Blue Button; view VA appointments and access Department of Defense (DoD) Military Service Information (if eligible); refill VA prescriptions; view VA lab results and immunization records; and electronically communicate with their health care teams through Secure Messaging.

In January 2013, VA expanded the types of information that a Veteran with a My HealtheVet Premium account can access, including his/her clinical Progress Notes via VA Notes and the VA Continuity of Care Document, a summary of clinical information from the VA Electronic Health Record in an XML format that is human-readable and machine-readable, which can be exchanged between providers. With My HealtheVet field coordinators onsite throughout VHA, along with targeted communications efforts and materials, Veterans are encouraged to be more "connected" and involved in their health care regardless of their geographic location or living situation. While the health care team cannot be with the Veteran all the time, this new technology assists VA in the delivery of health care to the Veteran, particularly, in rural areas.

Mobile Applications and Technology

VA has made significant progress towards providing all of those in need with evidence-based treatments. Now we are working to optimize the delivery of these treatments by using novel technologies and tools. The multi-award winning "PTSD Coach," co-developed with DoD, has been downloaded nearly 100,000 times in 74 countries since being launched in mid-2011. It is being adapted by government agencies and non-profit organizations in seven other countries including Canada and Australia. This application is notable as it aims to assist Veterans with recognizing and

managing PTSD symptoms, whether or not they choose to engage with VA mental health care providers.

For those who are kept from needed care because of logistics or fear of stigma, PTSD Coach provides an opportunity to better understand and manage the symptoms associated with PTSD as a first step toward recovery. For those who are working with VA providers, whether in specialty clinics or primary care, this application provides evidence-informed tools for self-management and symptom tracking between sessions. Very soon, VA is planning to roll out a version of this application that is connected to the electronic health record for active VA patients.

An additional wide array of mobile applications to support the evidence-based mental and behavioral health care of Veterans will be rolled out over the course of calendar year 2013. These applications are intended to be used in the context of clinical care with trained professionals and are based on gold-standard protocols for addressing smoking cessation, PTSD and suicidality. This is an important step forward, but is dependent upon access to the internet or to phone service in the rural areas.

Technology allows us to extend our reach beyond our clinic walls to those who need help but have not yet sought our services, and to those who care for loved ones who are Veterans. In November 2012, VA and DoD launched www.startmovingforward.org, an interactive Web-based educational life-coaching program based on the principles of Problem Solving Therapy. It allows for anonymous, self-paced, 24/7 access that can be used independently or in conjunction with mental health treatment.

Applications for self-management of the consequences of traumatic brain injury and for crisis management, which are some of the more challenging issues facing Veterans and our healthcare system, will follow later in the year. Mobile applications can help Veterans build resilience and manage day-to-day challenges even in the absence of diagnosed mental health disorders. Additionally, VA has started distributing loaner iPads as part of its VA Mobile Health Family Caregiver Pilot – a 12-month program that will test apps created for caregivers and the Veterans they assist. PTSD

Coach is one of the nine apps loaded on the iPads. The goal of this project is to develop useful tools to support Caregivers and the needs of the Veterans they assist.

Federal and Local Collaborations

When VA cannot meet Veterans' health care needs using available facilities and capacity, VA contracts with community providers to obtain that care. VA coordinates with community providers to address gaps and create an improved patient-centric network of care focused on wellness-based outcomes. Pursuant to President Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Service Members, and Military Families," VA is working closely with the Department of Health and Human Services (HHS) to establish pilot projects with community-based providers. These providers include community mental health clinics, community health centers, substance abuse treatment facilities, and rural health clinics. The effectiveness of community-based providers in helping to meet the mental health needs of Veterans in a timely way is being evaluated. Both the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) of HHS provided contacts for potential community partners.

Pilot projects are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. Some sites include capabilities for telemental health, staff sharing, and space utilization arrangements to allow VA providers to provide services directly in communities that are distant from a VA facility. The pilot project sites were established based upon community providers' available capacity and wait times, community treatment methodologies available, Veteran acceptance of external care, location of care with respect to the Veteran population, and mental health needs in specific areas.

In addition, VA collaborates with Health and Human Services Department-funded Federally Qualified Health Centers and community mental health clinics across the country. These community partnerships were developed locally as a means to provide mental health services to Veterans in areas where direct access to VA health care is limited by geography or workload. The most robust pilot site is in Montana and serves

as a prototype that other facilities may follow. Since 2001, the VA Montana Health Care System (VAMTHCS) has followed a model utilizing contracted care from community mental health centers to address the challenges of the population of Montana's Veterans in need of mental health care but dispersed across such a geographically large area. Montana has a population of 989,415 (46 percent reside in rural areas), a land area of 145,546 square miles and has the second-highest Veteran per capita population. Within Montana's 56 counties, part or all of 54 counties are designated mental health care shortage areas. For non-VA community mental health services, Montana is divided into four regions consisting of a regional mental health center and several satellite offices. Under these VA contracts, Veterans are seen by mental health providers at 45 sites. This allows VAMTHCS to provide mental health services at the local level to Veterans in all 56 counties. In FY 2011, the number of Veterans treated under the contract was 2,221, increasing to 2,388 in FY 2012. The choice of contract provider depends on the type of clinical services required. A contract provider may be utilized for one service while a VA provider may be utilized for a different mental health service. However, decisions are made based on what works best for Veterans.

VHA is responsible for the implementation and program management of the Reimbursement Agreements with Indian Health Service (IHS) and Tribal Healthcare Programs (THP). This program implements a key objective of a 2010 Memorandum of Understanding between VA and IHS, to develop payment and reimbursement policies and mechanisms. The implementation of agreements for reimbursement of certain direct care services provided by IHS or THP ensures the needs of eligible American Indian/Alaska Native (AI/AN) Veterans are met at VA or at IHS or tribal healthcare facilities that have an agreement with VA. Under these agreements, VHA:

- Works in partnership with VA Office of Rural Health and VA Office of Tribal Government Relations to implement MOU objectives;
- Facilitates agreements and local implementation plans with IHS and THPs;
- Resolves policy and operational issues;
- Provides communication and training to internal and external stakeholders; and
- Analyzes and audits claim data and financial processes.

In April 2013, there were 29 signed Tribal Health Program Reimbursement Agreements. For IHS, there is one signed VA-IHS National Reimbursement Agreement, with 10 signed Phase 1 Local Implementation Plans. Phase 2 began in May 2013 and will include a total of 73 Local Implementation Plans for all remaining IHS healthcare facilities.

Additionally, under the auspices of the 2010 MOU between VA and IHS, there are shared opportunities for coordination, collaboration, and resource-sharing for workforce development. In FY 2013, VA increased the number of online clinical trainings available to IHS providers who treat Veterans by more than 200 new courses. Another VA-IHS collaborative team established a new Bar Code Medication Administration pilot and training plan for IHS inpatient facilities. Other Sharing Agreements are in place or being developed between VA and IHS to cover the collaborative use of space, providers, and telehealth equipment.

VA and HHS recently signed a new MOU that will promote the secure exchange of health information between VA and rural health care providers and increase the knowledge and expertise of the Health Information Technology (IT) Workforce. This MOU supports the mutual goals of both agencies to have a highly educated health IT workforce that can support the meaningful use of electronic health record technology in rural communities. The MOU also ensures the interoperability and compatibility of VA and community health IT systems that will ensure better coordination of care for rural Veterans who are dual users of both the VA and the private sector health care systems.

VA is collaborating with the HHS funded Northeast Telehealth Resource Center to develop a telehealth training curriculum for Certified Nursing Assistants (CNA). The CNA Telemedicine Curriculum will be offered to graduates of the CNA course currently conducted by the Augusta, Maine Adult Education program in collaboration with the Togus, Maine VA Medical Center. Many rural Veterans served by VA supplement their VA care with non-VA healthcare services in their communities. CNAs are widely used in community home healthcare and nursing home settings where utilization of telehealth technologies, especially in rural areas, is projected to grow. VA is also collaborating with the U.S. Department of Agriculture, Commerce Department, and the National

Telecommunications Cooperative Association to increase public awareness of the criticality of broadband availability to rural Veterans health care.

For private, contracted care, VHA utilizes the Non-VA Medical Care Program (formerly known as Fee Basis) as one component of healthcare purchased for eligible Veterans from non-VA providers when VA determines that needed services are unavailable within VA facilities or cannot be economically provided due to geographic inaccessibility. Other components of non-VA medical care include sharing agreements and contracts. These contracts establish access and timeliness standards, require medical documentation sharing, and insist upon quality of care being a priority for our Veterans.

Additionally, VHA implemented a three-year pilot program to provide health care services through contractual arrangements with non-VA care providers – Project ARCH (Access Received Closer to Home). This pilot intends to improve access for eligible Veterans by connecting them to health care services closer to home. Five pilot sites have been established across the country: Caribou, Maine; Farmville, Virginia; Pratt, Kansas; Flagstaff, Arizona; and Billings, Montana. On July 29, 2011, health care delivery contracts were awarded to: Humana Veterans in VISNs 6, 15, 18, and 19, and Cary Medical Center in VISN 1. This program became operational on August 29, 2011.

III. Mental Health Care Staffing and Hiring

To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and is increasing the number of staff in support of mental health services. VA has taken aggressive action to recruit, hire, and retain mental health professionals to improve Veterans' access to mental health care. VA is committed to hiring and utilizing more mental health professionals to improve access to mental health care for Veterans. Access enables VHA to provide personalized, proactive, patient-driven health care; achieve measurable improvements in health outcomes; and align resources to deliver sustained value to Veterans.

VA is working closely with our Federal partners to implement President Obama's Executive Order 13625, which reaffirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The executive order strengthens suicide prevention efforts by increasing capacity at the Veterans/Military Crisis Line and through supporting the implementation of a national suicide prevention campaign. It also supports VA in using a variety of recruitment strategies to hire new mental health clinicians and administrative personnel in support of the mental health programs. As of May 7, 2013, VA has hired a total of 1,360 mental health clinical providers and 268 administrative support personnel. As of May 7, VA has also hired 248 new peer specialists. This progress has improved the Department's ability to provide timely, quality mental health care for Veterans.

Despite the national challenges with recruitment of mental health care professionals, VHA continues to make significant improvements in its recruitment and retention efforts. Focused efforts are underway to expand the pool of applicants for those professions and sites where hiring is most difficult, such as creating expanded mental health training programs in rural areas and through recruitment and retention incentives.

For example, specialty mental health care occupations, such as psychologists, psychiatrists, and others, are difficult to fill in some areas and often require a very aggressive recruitment and marketing effort. VHA has developed a strategy for this effort focusing on the following key factors:

- Implementing a highly visible, multi-faceted, and sustained marketing and outreach campaign targeted to mental health care providers;
- Engaging VHA's National Health Care Recruiters for the most difficult to recruit positions;
- Recruiting from an active pipeline of qualified candidates to leverage against vacancies; and
- Ensuring complete involvement and support from VA leadership.

The Department has also used many tools to hire the mental health workforce that have been described above, including pay-setting authorities, loan repayment, scholarship programs and partnerships with health care workforce training programs to

recruit and retain one of the largest mental health care workforces in the Nation. As a result, VA is able to serve Veterans better by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capability to deliver services.

Conclusion

Mr. Chairman, VA continues to be fully committed to building an accessible system that is responsive to the needs of our Veterans across the country while being responsible stewards of the resources appropriated by Congress. VA continues to implement its rural workforce strategy to recruit locally for a broad range of health-related professions. VA will continue to build upon collaborations, use innovative technology, and foster academic affiliations to achieve those goals. We appreciate your support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. VA continues to be committed to providing the high quality of care that our Veterans have earned and deserve. We appreciate the opportunity to appear before you today, and my colleagues and I are prepared to respond to any questions you may have.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

YVETTE ROUBIDEAUX, M.D., M.P.H.,

ACTING DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

**SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENT AFFAIRS
SUBCOMMITTEE ON THE EFFICIENCY AND EFFECTIVENESS OF FEDERAL
PROGRAMS AND THE FEDERAL WORKFORCE**

MAY 23, 2013

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Subcommittee, I am Dr. Yvette Roubideaux, Acting Director of the Indian Health Service. I am pleased to provide testimony on efforts of the Indian Health Service (IHS) to develop and support the Federal health care workforce to address the needs of American Indians and Alaska Natives (AI/ANs) in rural America.

Indian Health Service

IHS is an agency within the Department of Health and Human Services (HHS) that provides a comprehensive health service delivery system for approximately 2.2 million AI/ANs from 566 Federally-recognized Tribes in 36 states. Health care services are provided directly by IHS, through Tribally-operated health programs, through services purchased from private providers, and through urban Indian health programs. IHS facilities include over 600 hospitals, ambulatory clinics and health stations and IHS' Federal workforce consists of approximately 16,000 employees, including health administrators, physicians, dentists, nurses, pharmacists, and other health care professionals. IHS' workforce plays a critical role in supporting the overall mission of the IHS as a rural health care system addressing a population with significant disparities in health and access to care.

IHS Workforce Challenges

IHS shares similar challenges faced by rural communities and health care provider organizations across the nation in maintaining a Federal workforce to address the healthcare needs of rural communities. Many of our IHS facilities are in rural and remote locations where the provision of

care is challenging and the health care disparities are significant. The communities we serve often have significant economic and social challenges that contribute to these health disparities and that complicate the delivery of health care services. Recruitment and retention of employees, especially health care providers, presents unique challenges in these remote and isolated communities. IHS is fortunate to recruit many talented employees from the communities we serve. Recruitment of staff from outside the community requires a different approach given that health care providers may have spent many years living in urban areas during their education and training but may not have considered practicing in a rural environment. There is also a differential between IHS salaries and compensation and the private sector.

IHS vacancy rates for health professionals have improved over the past few years but remain an issue. With an increased emphasis on recruitment reforms, vacancy rates have improved for some of our health professional categories. In the past, dentist vacancies were greater than 30 percent, but an increased focus on recruitment and retention reduced those vacancies to approximately 10 percent. Since 2011, IHS has reduced vacancy rates for physicians from 24 percent to 20 percent, for pharmacists from 6 percent to 4.3 percent, for nurses from 16 percent to 15 percent, and for advanced practice nurses from 19.75 percent to 14 percent. However, continued efforts to improve recruitment, retention and support of our Federal workforce will be critical to further improvements and maintenance of these gains.

IHS Reforms to Develop and Support the IHS Federal Workforce

Over the past few years, IHS has implemented a number of reforms to change and improve the agency. IHS priorities for reform have included strengthening partnerships with the Tribes and

the communities we serve, implementing administrative reforms to strengthen the overall business practices of the agency, and implementation of activities to improve the quality of and access to care for the patients we serve. Many of these efforts have contributed to better support and strengthening of IHS' workforce since many of our reforms, especially those related to better recruitment, retention and support of our workforce, were based on input and recommendations from our employees and our stakeholders.

Recruitment of the Federal workforce, especially for health care professionals, begins with supporting health professional career pathways at various stages in an individual's life. IHS supports programs such as the American Indians Into Medicine, American Indians Into Psychology, and the Quentin N. Burdick American Indians into Nursing Programs which help develop students' interest in health professions and encourage them to return to their communities and work for the IHS in the future. These programs represent critical partnerships with academic institutions that benefit IHS' recruitment efforts.

The IHS Health Professions Scholarship Program is a key strategy for the agency in developing the future AI/AN workforce. The scholarship program supports AI/AN students interested in medicine, nursing, dental, pharmacy, optometry, physician assistant, and other allied health professional careers in their pre-health and health professional training. In exchange for support in health professional training programs, students agree to pay back this support with service working in the IHS system after completion of their training. Many of our current Federal workforce received support from the IHS Scholarship Program, and I am actually the first IHS Director to have received support from an IHS Scholarship in the past.

While the above efforts focus on recruitment of AI/ANs, the IHS Loan Repayment Program is one of our most effective recruitment and retention tools for the recruitment of a variety of positions in our workforce. The IHS Loan Repayment Program provides funding to repay qualifying educational loans in exchange for service in one of our facilities. In 2012, IHS funded 820 awards and anticipates funding over 800 awards in 2013. Many of the individuals who receive loan repayment stay a few years longer than their required service, and some stay with IHS for the rest of their careers.

IHS has worked to strengthen our recruitment and retention strategies through gathering input from our workforce and our stakeholders to better understand the needs of our workforce and enhance our efforts to attract and retain quality administrators and health professionals to help us serve our communities. Input from focus groups and listening sessions has helped IHS develop and update our “Recruitment Toolkit” and our “Retention Toolkit” that contain best practices and tools to support our recruitment and retention efforts. We have also updated our IHS recruitment webpages, increased advertisement of priority health professional jobs on discipline-specific external job boards, and have implemented innovative recruitment activities such as our first “virtual recruitment” online event last month.

Another strategy to improve recruitment and retention is to improve the workplace environment at the IHS to better support our workforce. Our reform efforts have included implementation of the IHS Improving Patient Care program, which is our patient centered medical home initiative that promotes a more customer service focused team approach to care. Participation in this initiative has helped better engage our health professional workforce in activities to improve the quality of and access to care in our hospitals and clinics. Implementation of human resource reforms, including the use of a stronger performance management system also allows IHS to

appropriately hold employees accountable. A stronger emphasis on performance management can help create a more fair and consistent workplace that promotes better retention. Improved transparency and communication with the Federal workforce through electronic tools also promotes more teamwork and alignment with agency goals. IHS has also made improvements in background checks, the hiring process, and credentialing and privileging of providers to ensure that we have a quality Federal workforce.

IHS has also worked to make its salaries more competitive with the private sector, which is especially important for health professional recruitment.

Partnerships to Develop and Support the IHS Federal Workforce

IHS has leveraged many partnerships to help develop and support its Federal workforce with other Federal agencies, academic institutions, and our Tribal communities. These partnerships help us make improvements by sharing information, costs, and activities to promote recruitment and retention efforts.

Our partnership with the Health Resources and Services Administration (HRSA) has helped us recruit more health professionals to work in IHS through their National Health Service Corps (NHSC) Scholarship and Loan Repayment Programs. A few years ago, HRSA and IHS leadership discovered that not all IHS, Tribal and urban Indian health programs were participating as placement sites for the NHSC programs. After both agencies committed to work together on this issue, over 600 IHS, Tribal and urban Indian health programs are now enrolled as official sites for placement of health professionals participating in NHSC scholarships and loan repayment programs. Through this successful collaboration, the number of NHSC clinicians serving AI/AN communities has increased to 318 in April 2013, compared to only 18

in 2009. This is especially important because the types of health professionals eligible for these programs represent critical vacancies for IHS, including physicians, dentists, and behavioral health and mental health professionals.

Our partnership with the Department of Veterans Affairs (VA) has resulted in immediate availability of approximately 700 web-based continuing clinical education courses for health professionals, which helps meet the continuing education needs of our health professionals who often have difficulty finding this type of education from their rural, isolated locations. IHS also has access to the Department of Defense's Joint Medical Executive Skills Institute on-line leadership development training program. Our partnership with the VA to improve the coordination of care for AI/AN veterans who are eligible for both the IHS and the VA through implementation of our 2010 Memorandum of Understanding and our VA-IHS National Reimbursement Agreement are helping our workforce improve access to quality health care for AI/AN veterans. Our partnership with the VA also allowed us to collaborate on expansion of Title 38 pay authorities to IHS to help make salaries more competitive with the private sector.

Our partnerships with academic institutions are extremely important to our recruitment and retention efforts because of the link it provides to students and new graduates seeking places to serve. As mentioned above, our partnerships with academic institutions help us develop a future AI/AN workforce through support in the health careers pathway. IHS also partners with academic institutions to provide opportunities for students and faculty to serve in our facilities. For example, IHS has developed a partnership with the Global Primary Care Residency Program at Harvard Medical School to provide an experiential learning opportunity for primary care physicians in some of our most underserved communities. Our IHS Extern Program is also an important recruitment tool that allows students to gain experience in IHS facilities and to

consider these sites for future employment. IHS also partners with non-profit organizations such as the National Rural Recruitment and Retention Network (3RNet), the Association of American Indian Physicians and other health professional organizations. IHS is also working more with other providers of healthcare in or near their communities since IHS often makes referrals to and purchases care from the private sector. Improved communication has promoted local partnerships that lead to better access to needed care and services.

One of our most important partnerships for recruitment and retention is with the Tribes and the communities we serve. IHS has worked to strengthen our partnership with Tribes over the past few years and to involve them more in how we deliver health care services to their communities. Tribal communities can do much to help with recruitment and retention by welcoming our staff into their communities, helping us develop a culturally competent workforce through education and sharing about their culture and traditions, and through providing us feedback on how to better serve our local customers. One of the most powerful recruitment and retention strategies we have is this partnership with our communities. As more of our Federal workforce feels at home and supported in these communities, the likelihood that they will become a long term member of that community will increase.

Summary

The Federal workforce is essential to the core mission of IHS and its delivery of accessible and quality health care services to AI/AN communities. IHS continues to make improvements in its recruitment and retention activities to support our Federal workforce through our agency reforms, more customer centered tools and activities, and through partnerships with Federal agencies, academic institutions, and the Tribal communities we serve. While there is much more

to do, we appreciate the opportunity to testify at this hearing to further discuss opportunities for improvement.

Mr. Chairman, this concludes my testimony. I am happy to answer any questions that you may have. Thank you.



Testimony of Tom Morris
Associate Administrator
Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services

Committee on Homeland Security and Governmental Affairs
Subcommittee on the Efficiency and Effectiveness of Federal Programs
and the Federal Workforce
United States Senate
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May 23, 2013

Chairman Tester, Ranking Member Portman, and Members of the Subcommittee, thank you for the opportunity to testify today on the rural health workforce. I am Tom Morris, Associate Administrator of the Federal Office of Rural Health Policy (ORHP), which is located in the Health Resources and Services Administration (HRSA), but has a Department of Health and Human Services-wide charge to coordinate and advise the Secretary on health challenges facing the 50 million people living in rural America. HRSA appreciates your interest in our work, and welcomes the opportunity to discuss rural health workforce issues.

HRSA Overview

HRSA's mission is to improve health and achieve health equity through access to quality services and a skilled health care workforce. There are approximately 80 different programs authorized in statute and operated by HRSA.

I am pleased to have the opportunity to talk with you today about the Office of Rural Health Policy and some of the activities associated with our goal of strengthening the rural health workforce and enhancing access to care.

The Federal Office of Rural Health Policy

Established in 1987, the Office of Rural Health Policy (ORHP) serves as a focal point for rural health activities within the Department. The Office is specifically charged with serving as a policy and research resource on rural health issues, as well as administering grant programs that focus on supporting and enhancing health care delivery in rural communities. ORHP advises the Secretary, and other components of the Department, on rural health issues with a particular focus on working with rural hospitals and other rural health care providers to ensure access to high quality care in rural communities.

The Department has maintained a significant focus on rural activities for more than 21 years. There are nearly 50 million people living in rural America. Historically, rural communities have struggled with issues related to access to care, recruitment and retention of health care providers and maintaining the economic viability of hospitals and other health care providers in isolated rural communities. My testimony today will review the steps HRSA is taking to address these issues.

Rural residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban counterparts. Care in rural communities often focuses on primary care and chronic disease management delivered through rural health safety net providers such as critical access hospitals, Federally-Qualified Health Centers, and rural health clinics. The Administration has charged the Office of Rural Health Policy with implementing the Improving Rural Health Care Initiative. This Initiative focuses on four key areas:

- Moving toward a more evidence-based approach in rural programs;
- Improving recruitment and retention of workforce in rural communities;
- Linking HRSA's telehealth programs to ongoing work with rural communities; and

- Collaborating with other partners in HRSA, HHS and across the Federal Government

Within ORHP, there are targeted programs and activities that we carry out in addressing these key areas. We review and provide technical assistance on the Medicare, Medicaid and other key HHS regulations to assess the impact on rural communities. We also staff the National Advisory Committee on Rural Health and Human Services, which advises the Secretary on rural issues. In addition, we support the Rural Assistance Center, a national clearinghouse for information on rural issues. The Office also supports the Rural Health Research Center grant program to both inform its policy role and to support rural-focused health services research. This includes a significant focus on rural Medicare issues, health care workforce issues affecting rural communities as well as research on quality, health information technology and access to care in rural communities.

The Office additionally funds a number of grant programs that focus on capacity building in rural communities. The State Office of Rural Health grant program provides funding to each of the 50 States to support a focal point for rural activities and each State provides matching funds to support this activity. Other programs that ORHP administers are the Rural Hospital Flexibility Grant program and the Small Hospital Improvement Grant program to work with small rural hospitals and Critical Access Hospitals on quality and performance improvement. In addition, ORHP also has a rural health research center which focuses on mental health issues, given what a significant concern this is in rural areas.

Another program supported by ORHP is the Rural Health Care Outreach program, which provides start-up funding for pilot grants in rural communities. This includes the Rural Health Outreach Services, Rural Network Development, Small Health Care Provider Quality Improvement and Delta States Network grant programs. These community-based programs have a new emphasis on metrics and outcomes while building on successful models. ORHP is committed to building an evidence base for rural health care quality.

Rural Health Workforce

Understanding the particular challenges facing rural America, HRSA actively looks at innovative and evidence-based approaches to improving the rural health care workforce through various programs, including:

Rural Training Track (RTT) Technical Assistance Cooperative Agreement: This unique program focuses on a novel resident training model in which the resident does one year in an academic health center, or larger urban facility, and then spends the rest of the residency working in a rural hospital or clinic. Our research shows that approximately 70 percent of the residents who train in these programs continue to practice in rural communities. Through this grant, we provide support to the existing 23 RTTs nationally, while also working to increase medical student interest in this model and help new RTT programs get established. Last year, RTTs had a match rate for their residents of 80 percent (39 students matched to the 49 open positions), an all-time high. Also, four new programs will be opening this July with an additional three more programs scheduled to open in July 2014, pending accreditation.

Rural Health Workforce Network Grant Program: HRSA supports 1,743 students and residents through this pilot program, which focuses on supporting the development of rural health networks' capacity to recruit and retain primary and allied health care providers. We will track this cohort of students to determine how many continue to practice in rural areas.

National Health Service Corps, Nurse Corps, and State Loan Repayment Program: Since 2009, with investments from the Recovery Act and the Affordable Care Act, HRSA has nearly tripled the size of the National Health Service to nearly 10,000 Corps clinicians. Currently, 45 percent of the Corps clinicians are providing care in rural communities. That includes some 900 physicians, 700 nurse practitioners, 600 physician assistants, 500 dental professionals, and 1,200 mental and behavioral health professionals. In addition, HRSA's primary care and nursing training programs play a critical role in supporting the pipeline of future clinicians for rural and underserved communities. Among rural NHSC providers, studies have repeatedly found that half, or more, continue to live and work in non-metropolitan counties several years after they leave the Corps. In fact, a study funded by HRSA and released this past summer found that NHSC clinicians tend to serve for an average of more than 8 years in the same clinical facilities.

Teaching Health Center Graduate Medical Education Program: The Affordable Care Act established the Teaching Health Center Graduate Medical Education payment program, providing \$230 million in fiscal years 2011-2015. This program funds primary care and dental residency programs with a focus on community-based training. This includes a number of rural sites; in fact, 15 of the 22 funded Teaching Health Centers are serving rural communities.

Visas and Rural Physicians: Rural communities also benefit from a number of programs that provide J1-Visa Waivers to foreign-trained physicians in exchange for agreeing to practice in rural areas that need them most. Last year, HHS supported 33 J1-Visa waiver clinicians. In addition, through the State Conrad 30 program, States can recommend up to 30 J1-Visa waivers for clinicians willing to practice in underserved rural areas. The Appalachian Regional Commission and the Delta Regional Authority, which serve predominantly rural areas, also can support J1-Visa waivers. HRSA regularly engages with these entities to develop a strong framework for building alliances and promoting health community models in diverse regions such as rural communities.

National Rural Recruitment and Retention Network (3RNet): HRSA supports the 3RNET, which is a national network of health care recruiters that connects practitioners, who want to practice in rural areas, with rural areas in need of clinicians. In 2012, this organization placed 1,767 clinicians in rural communities. Many of the States participating in 3RNet play a key role in working with communities to identify which program best meets a community's particular needs. They link the clinician seeking to practice in a rural area with the appropriate program to support them, whether it is the NHSC loan repayment program, a State loan program or one of the J1-Visa Waiver options.

Telehealth: For 20 years, HRSA has been investing in telehealth programs. Telehealth improves access to a broad range of care in rural communities by providing video links to specialty care not always available in a rural community. With HRSA support, the Institute of Medicine recently convened a group

of experts to examine the role of telehealth in a changing health care environment. The report from that meeting noted that new and emerging applications of telehealth, such as home monitoring and E-emergency and E-intensive care services, are providing critical support to rural clinicians and the patients they serve. The report also notes that the cost of this technology has considerably decreased in recent years. As a result of this, HRSA has developed a national network of Telehealth Resource Centers to work with providers. These Centers will help them leverage this technology, not only to increase access to care, but also to support existing rural clinicians and improve health care outcomes. Telehealth has been a particularly important vehicle for delivering mental health services to isolated communities.

Mental Health: Access to mental health services can be a particular challenge for veterans in rural areas. In this regard, HRSA is currently supporting a pilot program examining how to use telehealth, and health information exchange, to enhance the coordination of care for veterans in rural areas. Additionally, ORHP is funding projects in Montana, Alaska and Virginia and has a memorandum of agreement in place between HHS and the U.S. Department of Veterans Affairs (VA) to promote the use of technology to enhance care for veterans.

HRSA recognizes that primary care settings have become a gateway for many individuals with both behavioral health and primary care needs. To address these needs, more and more health centers are integrating behavioral health care services into their primary care model. HRSA has expanded access to mental health services in community health centers. In 2012, 70 percent of rural community health centers across the nation offered behavioral health services to their patients in addition to serving as a key access point for primary care.

HRSA's work on this front extends to the National Health Service Corps as well. Designed to extend the reach of National Health Service Corps providers while minimizing patients' travel distances to seek care, the Corps began allowing providers practicing in eligible sites to offer telehealth services to patients at distant sites. This initiative has been particularly significant in increasing access to mental and behavioral health services in rural areas. Nearly one in three clinicians in the Corps (2,919 as of September 2012) is a behavioral health practitioner, including psychiatrists, clinical psychologists, clinical social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurse specialists.

HRSA is committed to cross-agency collaboration and partnerships to help address mental health needs in rural areas. One such example is the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). This initiative promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether treated in specialty behavioral health or primary care provider settings. As part of the CIHS initiative, as well as in the telehealth programs and other initiatives described above, HRSA recognizes and emphasizes the importance of protecting the privacy and security of health information, including substance abuse and mental health information.

White House Rural Council

Rural communities have also benefited from the collaborative work of the White House Rural Council, which was created by the President through an Executive Order in July 2011. The Council, which includes representation from all of the Cabinet-level agencies, is focused on enhancing the ability of Federal programs to serve rural communities through collaboration and coordination across Federal agencies. The Council has focused on enhancing rural economic development and job creation. Health workforce is a key driver of rural economies, where a small rural hospital is often one of the primary employers in the community. Through the work of the Council, HRSA has expanded eligibility for the NHSC Loan Program to Critical Access Hospitals (CAHs) in 2012. This provides another important tool for the 1,331 CAHs across the country. As a result of this change, 173 CAHs are now designated as service sites for the NHSC and 18 clinicians working in CAHs are now receiving loan repayment support.

The Council has also focused on expanding the health information technology (health IT) workforce. The Department of Labor's Bureau of Labor Statistics projects that the number of jobs for Medical Records and Health Information Technicians will grow 21 percent between 2010 and 2020. HHS is working with the Department of Education and the Department of Labor to promote the development of new health IT programs in rural community colleges. Later this year, we intend to support the awarding of up to 10 Rural Health IT Workforce Network Training Grants. These grants will develop a health IT training curriculum and then develop an associate degree program for HIT professionals in rural areas. HRSA will then make those curriculum materials available through the Department of Labor and the Department of Education so other rural community colleges can leverage this investment and start their own programs.

HRSA is proud of our programs and the work in which we are involved to increase access to health care for Americans living in rural areas. Our programs are making a difference in the quality and quantity of healthcare provided.

I appreciate the opportunity to testify today, and I hope this testimony will inform the Subcommittee's future deliberations on the important issue before you. I would be pleased to answer any questions you may have.



Statement of Matt Kuntz, J.D.

Executive Director of NAMI Montana

Senate Committee on Homeland Security and Government Affairs

"Improving Federal Health Care in Rural America: Developing the Work Force and Building Partnerships"

May 23, 2013

I. Introduction

Chairman Tester, Ranking Member Portman and distinguished members of the committee, on behalf of NAMI Montana (The National Alliance on Mental Illness) I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding *Improving Federal Health Care in Rural America: Developing the Workforce and Building Partnerships*. NAMI Montana and the entire NAMI community applauds the committee's dedication in addressing the critical issues surrounding rural health care and NAMI looks forward to working closely with the committee in addressing these and other issues throughout the 113th congressional session.

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

II. The General View From Montana

Montana is the nation's fourth largest state with over 147,000 square miles. Just over a million people reside in Big Sky Country. The very rural nature of the state, with an average of fewer than six persons per square mile, creates unique challenges for our healthcare providers. It is very hard for rural Montana communities to recruit and retain healthcare workers. Our rural healthcare professionals have to walk a tightrope between finding enough patients to make a

living and paying off their student loans while, not being overwhelmed by the workload. It is a difficult balance to strike due to variable patient rates and a shortage of relief for times of overflow.

These challenges are especially difficult for treating serious mental illness because of the complex nature of serious mental illnesses, the level of care required for mental health crises, and the ongoing treatment needs of persons living with these conditions. Our state consistently has one of the highest suicide rates in the country and we are in desperate need of more mental health professionals, particularly in our more rural communities. For instance, there is one psychiatrist between Billings, Montana and Bismarck, North Dakota. That is one psychiatrist to cover over four hundred miles of interstate highway. Providers are trying to find ways to fill the gaps with psychiatric nurses and telepsychiatry, but it is still a desperate situation. The need for psychologists, social workers, and counselors is also dire.

Montana's healthcare system is intrinsically tied to the federal government in a number of ways:

- We are honored to have one of nation's highest per capita rates of military service in the country. Montana is home to more than 108,000 veterans, representing 16.2% of the total state adult population; the second highest population density of veterans in the United States.¹
- Montana is home to twelve tribal nations and seven reservations.² The reservations comprise nine percent of the state's land base. Montana is home to over 66,000 people of Native American heritage. The majority of Montana's native population lives on reservations. Montana residents that qualify for Indian Health Services are served by the Billings Area Indian Health Services which delivers care to over 70,000 people in the states of Montana and Wyoming.

¹ Taken from the State of Montana's recent grant application to HRSA.

² Indian Education for All, "Montana Indians: Their History and Location." (April 2009)
<http://opi.mt.gov/pdf/indianed/resources/MTIndiansHistoryLocation.pdf>

- Montana had just under than 110,000 participants in Medicaid as of December 2012.³
The Montana Medicaid program can generally be classified as hard to qualify for in comparison to other states, but more generous benefits for those that do qualify.
- Over 170,000 Montanans received Medicare benefits in 2011.⁴
- Montana has forty-seven critical access hospitals which qualify for relaxed staffing requirements and cost-based reimbursements Medicare and Montana Medicaid patients.

The federal, state, local and private healthcare programs across Montana rely on each other to succeed. For instance, a veteran who goes into a mental health crisis in Darby, Montana would likely drive or be transported to the emergency room of the private Marcus Daly Memorial Hospital sixteen miles away in Hamilton. The emergency room would refer them to the Western Montana Mental Health Center's crisis center where the veteran would be safe and receive the quality of care to begin to relieve the crisis. In the next day or two, the veteran maybe transported 166 miles by ambulance from Hamilton to the Veterans Administration's (VA) Inpatient Psychiatric Facility in Helena. After a few weeks of treatment, the veteran will likely return home to Darby where they will be able to receive services either through the VA via telehealth or through the VA's contract with Western Montana Mental Health Center in Hamilton. The fiscal streams that fund each level of treatment overlap between federal, state, and private payers.

The baseline need for mental health workers in rural Montana has increased dramatically in the past few years in Eastern Montana due to drilling in the Bakken Formation. The rural communities in this region have experienced a major population boom and the mental health programs and facilities are struggling to keep up. The high wage jobs available in the oil industry make it very difficult to recruit and retain support staff in those communities. Untreated mental illnesses, alcohol, and substance abuses in these areas have the potential to lead to long-term institutionalization in Montana's mental illness and corrections facilities.

III. Highlights

³ "Montana Department of Public Health and Human Services Report to the 2013 Legislature: The Montana Medicaid Program State Fiscals Years 2011 and 2012." <http://www.dphhs.mt.gov/publications/2013medicaidreport.pdf>

⁴ Medicare Resource Center. "About Medicare in Montana." See, <http://www.medicareresources.org/montana>.

A. Veterans Administration Contracts with Private Mental Health Centers

The Veterans Administration of Montana has utilized contracts for several years with community partners across Montana as a tool to increase mental health care access for Montana's veterans who live with rural communities or who choose not to seek mental healthcare services at a VA facility. This contracting arrangement allows the VA to provide in-person counseling services in many of Montana's rural communities.

While the Montana VA and our Veterans Center have been extremely adept at using telehealth services, vans, and other mobile delivery services; the contracts with the mental health centers has provided a consistent level of care for veterans in some communities which would not otherwise be possible. The federal contracts also help improve the financial grounding of the local mental health centers which improves their workforce recruitment and retention.

B. Psychiatric Nursing Program at Montana State

Montana State University received a grant of \$814,021 from the Division of Nursing (DN), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) to establish an advanced degree in psychiatric nursing. This program graduated six advance practice psychiatric nurses in 2012 and will likely graduate thirteen in 2013. Seven students will be beginning studies this fall for the program's Doctor of Nursing Program specializing in psychiatric care.

This program is making an incredible difference across Montana as it brings more and more psychiatric advanced practice nurses into the workforce. These nurses are working with psychiatrists to expand the reach of high level psychiatric care into more communities and are allowing key crisis facilities to open and stay open. It is hard to imagine a more powerful and enduring one-time investment in Montana's mental illness treatment system.

C. Telepsychiatry

Telepsychiatry and other telehealth services are essential to providing effective care throughout Montana. These services have been expanding throughout Montana over the last decade through federal, state, and private investments and they appear to be hitting critical mass. The Veterans

Administration, AWARE Inc., American Telepsychiatry, and other providers have all provided telepsychiatry services to Montanans suffering from serious mental illnesses. The Center for Medicaid and Medicare services recently awarded Healthlinknow, Inc. a \$7.7 million grant to establish telepsychiatry resources to Montana and Wyoming's Medicaid populations. As of this week, over fifty one different facilities in Montana and Wyoming have expressed interest in partnering with Healthlinknow to offer telepsychiatry in their facilities.

The Montana Legislature recently passes a bill which requires all health insurers in the state to cover telemedicine services. State Senator Ed Buttrely brought this legislation and it easily passed both houses with bipartisan support. The federal government's investment in these services combined with a firm legal footing and ever-improving technology has given telepsychiatry momentum in the push to provide more rural Montanans with effective psychiatric coverage.

D. Inpatient Psychiatric Unit at Fort Harrison

In June of 2011, the Veterans Administration completed construction of a \$7 million inpatient psychiatric facility in Helena, Montana. Unfortunately, it took a year and a half until the VA was able to find enough mental health professionals to open the Post Traumatic Stress Disorder wing to treat veterans in mental health crisis.

The VA originally planned on utilizing three psychiatrists to staff the facility, but they had to become more flexible after they could not recruit three inpatient psychiatrists to the facility. The unconventional staffing structure that they designed utilizes one inpatient psychiatrist, the hospital's outpatient psychiatrist; two psychiatric nurse practitioners; and on-call psychiatrists at the Salt Lake City VA Medical Center. In addition, a newly hired staff psychologist oversees all mental health programs in the VA's Montana Health Care System.

The facility is an incredible tool to help improve the lives of Montana veterans with severe post traumatic stress injuries. It is also an excellent example illustrating the federal government's need to have enough flexibility in its system to adjust to the staffing challenges presented by a rural environment.

IV. **Recommendations**

A. Residency and Other Training Programs

Graduate residency programs are one of the most effective methods of bringing doctors into a community. Medical school graduates form ties with the hospitals they perform their residency at and with the communities they reside in and it makes them much more likely to stay in the area. Unfortunately, these residency programs, especially for hard-to-fill positions such as psychiatry, are very rare in rural states. This shortage of rural residency programs only exacerbates the physician shortages in rural areas. For instance, Montana does not have a psychiatry residence program. That makes it extremely difficult for the federal government to fill its psychiatry needs in the VA and Indian Health Services.

The nation is currently experiencing a shortage of residency slots and several federal lawmakers have introduced legislation to add between 3,000 and 4,000 federally funded residency positions over a five-year period. The House version is the “Training Tomorrow’s Doctors Today Act” (H.R. 1201) and Senate version is “The Resident Physician Shortage Reduction Act of 2013” (S. 577).

Federally funded residency programs funded through legislation like this must ensure that some of the residency slots are designated for rural communities. The residency programs may require some design modifications to meet the staffing challenges of rural America, but that flexibility will pay off by reducing long-term costs incurred by the federal government in continuously having to recruit physicians into these areas.

B. Loan Repayment

The federal government’s loan repayment programs are an essential tool to recruiting mental health providers to Montana’s rural communities. However, these programs should be reviewed to ensure that they are broad enough to incentivize healthcare workers to dedicate a portion of their practice to serving individuals in rural areas either through a satellite office or via telemedicine.

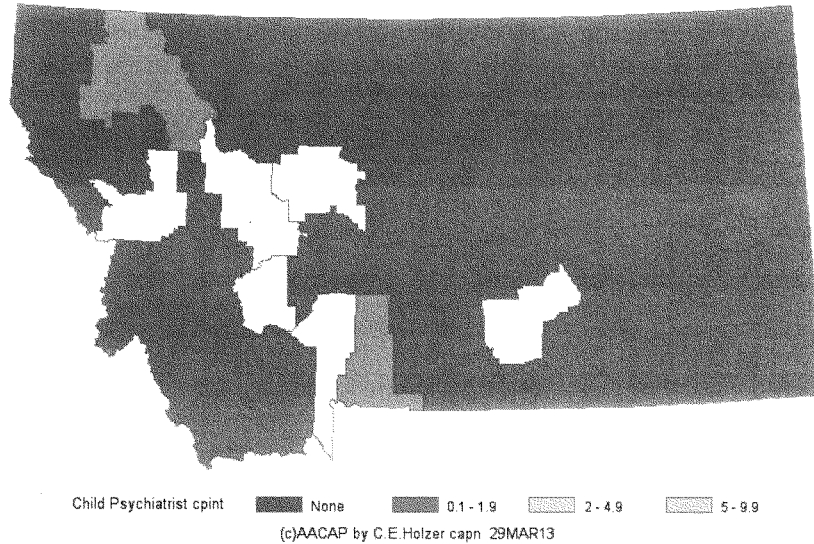
One other issue that NAMI Montana is seeing with repayment programs is that they seem to favor outpatient psychiatrists over inpatient psychiatrists. While both positions are important, the

inpatient positions are extremely hard to fill due to on-call requirements and the stress inherent in inpatient duties. The Veterans Administration's inability to open its inpatient unit in Helena, Montana more than a year after its construction due to a lack of psychiatrists willing to work in an inpatient setting is clear evidence of how challenging it is to fill inpatient psychiatry positions in rural states.

The repayment programs also do not seem to reflect the fact that inpatient treatment facilities in the cities of rural states are an essential tool to caring for mental illness in rural communities. For instance, Shodair Children's Hospital in Helena admitted 800 children in need of psychiatric treatment in 2012 – only 23% of them were from the Helena area. The psychiatrists that work in this facility are an essential tool to treating rural Montana children with emotional disturbances who go into crisis; unfortunately the federal loan repayment programs do not hold them in the same regard as their peers who work with these children in outpatient settings.

There is an effort underway, being led by Rep. Jim McDermott in the U.S. House of Representatives, to get funding restored for the Pediatric Subspecialty Loan Repayment Program. This program targets loan repayments specifically for child and adolescent psychiatrists of up to \$35,000 per year for those who work in medically underserved areas. Our nation currently has about 7,500 child and adolescent psychiatrists with a need for 20,000 so there are families that are routinely told that they must wait an average of 3 to 6 months for their child to see a child psychiatrist. This places a tremendous burden on families. The shortage of child psychiatrists can also lead to a heavy burden on the federal government when some of these children and adolescents go into crisis due to lack of medical care and land in residential treatment facilities that cost hundreds of dollars per day.

Montana: Practicing Child and Adolescent Psychiatrists 2012
Number per county



C. Establish a National Mental Illness Diagnostic Research Center

One of the biggest challenges to the effectiveness of the federal workforce engaged in treating serious mental illness and other brain conditions is the primitive process of diagnosing these conditions. Instead of using concrete scientific tools to determine the illness affecting the inner workings of the brain, psychiatrists and psychologists work off of behavioral questionnaires. It is the equivalent of a doctor trying to determine whether a bone was broken before the invention of X-Rays.

This lack of a biological screening tool for these brain conditions leads to misdiagnoses, improper prescribing, and a general mistrust of the mental illness treatment system.⁵ The

⁵ See example, Alan Schwartz and Sara Cohen, "More Diagnoses of A.D.H.D. Causing Concern," *New York Times* (March 31, 2013) <http://www.nytimes.com/2013/04/01/health/more-diagnoses-of-hyperactivity-causing-concern.html?ref=opinion>.

wobbly status of the mental illness treatment system's diagnostic foundation is staggering when one considers that the total direct and indirect costs of severe mental illnesses exceeds \$300 billion annually.⁶ Many of those costs are absorbed by the federal government through both spending on medical care and for disability payments.

Thanks to public and private funding, researchers are beginning to develop biological indicators for serious mental illnesses and other brain conditions. The promise of these techniques has moved from research journals to broad national media like *Time Magazine*.⁷ It is in the best interest of the country for effective next-generation diagnostic tools to be brought to market as soon as possible. It is also in the best interest of the country to prevent ineffective biological diagnostic techniques from being utilized in our healthcare system.

A National Mental Illness Diagnostic Research Center (NMIDRC) would verify innovative biological techniques for diagnosing serious mental illnesses and other brain conditions. A large percentage of the costs of verification tests are in test design and participant recruitment/management. The MIDRC will be able to reduce these costs through economy of scale by administering multiple tests at the same facility utilizing the same administrative staff. The NMIDRC should be funded with the goal of conducting five to ten verification trials per year. The first several years of testing will most likely focus on disproving new technologies and conducting proof-of-concept tests to refine potentially viable diagnostic techniques for further study.

D. Mental Health Awareness and Improvement Act of 2013 (S. 689)

The Mental Health Awareness and Improvement Act would help address early intervention in mental illness and strengthening suicide prevention programs through:

- Reauthorization of the Garrett Lee Smith Memorial Act, which provides key youth suicide prevention programs targeted to states, tribes, and college campuses;
- Mental health awareness training for school and emergency services personnel so they can recognize the signs and symptoms of mental illness, become familiar with resources

⁶ National Institute of Mental Health, "Annual Total Direct and Indirect Costs of Serious Mental Illness." http://www.nimh.nih.gov/statistics/4COST_TOTAN.shtml

⁷ Alice Park, "Red Alert. New Blood Tests Promise Better Cheaper Diagnoses," *Time Magazine* (February 11, 2013)

in the community for individuals with mental illnesses, and learn how to safely de-escalate crisis situations involving individuals at risk for self-harm; and

- Expansion of the National Violent Death Reporting System (NVDRS) to all 50 states, which would ensure the availability of complete, accurate, and timely information used to design effective suicide prevention strategies.

NAMI-Montana and NAMI strongly support enactment of S. 689 as a step towards addressing the mental health crisis in rural America.

1.

E. Excellence in Mental Health Act (S. 2257)

This legislation will create a new, voluntary pathway for community mental health and addictions organizations to become Federally Qualified Community Behavioral Health Centers (FQCBHCs). Organizations would have to deliver specified services and meet requirements with respect to reporting, standards of care, and oversight. In return, FQCBHC status would offer a foundation for a whole-person approach to health that recognizes community behavioral healthcare organizations' experience and potential in treating complex patients with difficult healthcare needs. Specifically, the Excellence in Mental Health Act would:

- Expand access to mental health and addictions care by supporting FQCBHCs in treating all individuals regardless of their ability to pay, with a comprehensive array of evidence-based specialty behavioral health services that are not available in other settings.
- Reduce the use of emergency rooms for routine care by requiring FQCBHCs to provide specified primary care screening for key diseases like hypertension and diabetes.
- Improve the management of chronic health conditions by requiring FQCBHCs to partner with primary care providers such as Federally Qualified Health Centers to ensure that people with mental health and addictions disorders have access to all needed medical treatments and are appropriately monitored for disease risk.
- Cultivate a robust community mental health and addictions treatment system by requiring FQCBHCs to meet administrative requirements, reporting standards, and treatment objectives.

- Provide a stable foundation for this work by paying FQCBHCs a bundled per-visit rate that shares risk with the federal government.
- Save \$400 million over 10 years by making FQCBHCs eligible for 340(B) drug pricing.

Thank you again for the opportunity to testify in front of this honorable Committee. Your attention to this issue means a lot to me and all of the rural American families affected by serious mental illness. We look forward in helping you come up with solutions to these workforce challenges.



**TESTIMONY
OF
RALPH IBSON, NATIONAL POLICY DIRECTOR
WOUNDED WARRIOR PROJECT
BEFORE THE
SUBCOMMITTEE ON THE EFFICIENCY AND EFFECTIVENESS OF FEDERAL
PROGRAMS AND THE FEDERAL WORKFORCE
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENT AFFAIRS
U.S. SENATE
MAY 23, 2013**

Chairman Tester, Ranking Member Portman, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project (WWP) to testify this morning.

With WWP's mission of honoring and empowering those wounded in Afghanistan and Iraq, our vision is to foster the most successful, well-adjusted generation of veterans in our nation's history. The mental health of our returning warriors is among our very highest priorities.

Gaps in VA Mental Health Care

Given that priority, we continue to be concerned that after more than a decade of combat operations marked by multiple deployments, the systems dedicated to providing mental health care to service members and veterans are still struggling to accomplish their missions. In our experience, wide gaps remain between well-intentioned policies and on-the-ground practices. Perhaps nowhere are those gaps wider than in rural America.

Wounded warriors as a population continue to experience remarkably high rates of post-traumatic stress disorder (PTSD), depression, and other combat-related mental health conditions.

Last year WWP surveyed more than 13,000 service members and veterans wounded after 9/11 to learn more about their physical and mental well-being and progress toward achieving economic self-sufficiency. Among its findings, the survey provides a compelling snapshot of the widespread co-occurrence of combat injury and psychological wounds. With nearly 70% of responding warriors having been hospitalized because of wounds or other injuries,¹ some 69 percent of respondents also screened positive for PTSD.² More than 62 percent indicated they were currently experiencing symptoms of major depression.³ Only 8.5 percent of respondents reported that they did not experience mental health concerns since deployment.⁴ Of those surveyed, PTSD was their most commonly identified health condition.⁵ Asked to comment on the most challenging aspect of their transition, two in five of those surveyed cited mental health issues. Some acknowledged finding help from VA therapists and clinics. But more than one in three reported difficulties in accessing effective care for mental health services.⁶

Others report that the VA was quick to provide medications,⁷ but that it was difficult to get therapy. Still others have been resistant to seeking professional help, particularly at military medical facilities. Overall, warriors' battles with mental health issues – coinciding with alarming rates of suicide among service members -- underscore the urgency and importance of taking action.

The rising suicide rate alone argues for more attention to evidence that a majority of soldiers deployed to Afghanistan or Iraq are not seeking the help they need.⁸ While stigma and organizational barriers to care are cited as explanations for why only a small proportion of soldiers with psychological problems seek professional help, soldiers' negative perceptions about the utility of mental health care may be even stronger deterrents.⁹ To reach these warriors, we see merit in a strategy of expanding the reach of treatment, to include greater engagement, understanding the reasons for negative perceptions of mental health care, and "meeting veterans where they are."¹⁰ VA's vet centers have proven valuable assets in fostering such engagement.

¹ Franklin, et al, 2012 Wounded Warrior Project Survey Report, ii (June 2012). WWP surveyed more than 13,300 warriors, and received responses from more than 5,600. (Hereinafter "WWP Survey").

² Id. at 104. The data reflect measurements of responses to a Primary Care PTSD scale included in the survey.

³ Id. at 45.

⁴ Id. at 57.

⁵ Id. at ii. Questioned about their experience in theater, 82 percent had a friend who was seriously wounded or killed; 78 percent witnessed an accident that resulted in serious injury or death; 76 percent saw dead or seriously injured non-combatants; more than one in five engaged in hand to hand combat; and 61 percent experienced six or more of these types of traumatic incidents. Id. at 15-16.

⁶ Id. at 105.

⁷ Id. at 105. Studies document widespread off-label VA use of antipsychotic drugs to treat symptoms of PTSD, and the finding that one such medication is no more effective than a placebo in reducing PTSD symptoms. D. Leslie, S. Mohamed, and R. Rosenheck, "Off-Label Use of Antipsychotic Medications in the Department of Veterans Affairs Health Care System" 60 (9) *Psychiatric Services*, 1175-1181 (2009); John Krystal, et al. "Adjunctive Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service-Related PTSD: A Randomized Trial," 306(5) *JAMA* 493-502 (August 3, 2011).

⁸ Paul Kim, et al. "Stigma, Negative Attitudes about Treatment, and Utilization of Mental Health Care Among Soldiers," 23 *Military Psychology*, 66 (2011).

⁹ Id. at 78.

¹⁰ Charles W. Hoge, MD, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," 306(5) *JAMA* 548 (August 3, 2011).

Importantly, current law requires VA medical facilities to employ and train warriors to conduct outreach to engage peers in behavioral health care,¹¹ and it is encouraging that VA has begun hiring and training 800 peer to peer counselors this year, pursuant to a Presidential executive order on mental health promulgated last year.¹² (Underscoring the benefit of warriors reaching out to other warriors, our recent survey found that nearly 30 percent identified talking with another OEF/OIF veteran as the most effective resource in coping with stress.¹³) Unfortunately, VA has yet to implement a requirement under current law (or acknowledge its obligation) to provide needed, but time-limited, mental health services to members of the immediate family of OEF/OIF veterans.¹⁴ With access to such services available to family members for only a three-year period beginning with return from deployment on Operation Enduring Freedom or Operation Iraqi Freedom, some are already beginning to lose eligibility for that assistance as a result of VA's inaction.

Against the backdrop of a series of congressional hearings highlighting long delays in scheduling veterans for mental health treatment, the VA last April released plans to hire an additional 1900 mental health staff.¹⁵ While appreciative of VA's course-reversal,¹⁶ WWP has urged that other related critical problems also be remedied. Access remains a problem, particularly for those living at a distance from VA facilities and for those whose work or school requirements make it difficult to meet less-flexible clinic schedules. Mental health care must also be *effective*, of course. As one provider explained, "*Getting someone in quickly for an initial appointment is worthless if there is no treatment available following that appointment.*"¹⁷ Providing effective care requires building a relationship of trust between provider and patient – a bond that is not necessarily instantly established.¹⁸ Accordingly, congressional testimony that many VA medical centers routinely place patients in group-therapy settings rather than provide needed individual therapy merits further scrutiny.¹⁹ We have also urged more focus on the soundness and effectiveness of the VA's mental health performance measures; these track adherence to process requirements, but fail to assess whether veterans are actually improving.²⁰ Unfortunately, the imperative of meeting performance requirements can create perverse incentives, at odds with good clinical care. As one provider explained, "*Veterans face many obstacles to care that are designed to meet 'measures' rather than good clinical care, i.e. having*

¹¹ Public Law 111-163, sec. 304(a); National Defense Authorization Act for Fiscal Year 2013, Public Law 112-239, sec. 730, (January 2, 2013).

¹² Exec. Order No. 13625, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families" (August 31, 2012), accessed at <http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service>

¹³ WWP Survey, at 54.

¹⁴ Public Law 111-163, sec. 304(a).

¹⁵ Department of Veterans' Affairs Press Release, "VA to Increase Mental Health Staff by 1,900," April 19, 2012, available at: <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302>

¹⁶ During a budget hearing earlier that year, Department leaders had assured the Chairman of the Senate Veterans Affairs Committee that -- despite strong evidence to the contrary -- VHA has all the mental health staff it needed

¹⁷ *Id.*

¹⁸ *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Nicole Sawyer).

¹⁹ *VA Mental Health Care: Evaluating Access and Assessing Care: Hearing Before the S. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Nicholas Tolentino).

²⁰ *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Ralph Ibsen), *supra* note 21.

to wait hours to be seen in walk-in clinic as the only point of access, , etc. ”²¹ Prior hearings also documented instances of such measures being “gamed.”²²

WWP has welcomed both VA’s acknowledgment of a “need [for] improvement” in its mental health system,²³ and its report of success in its effort over the last year to hire additional mental health staff. But the impact of that hiring in terms of improving the timeliness of treatment appears to vary markedly from facility to facility. In conferring earlier this month with WWP field staff who work daily with our wounded warriors across the country, we have heard “mixed reviews.” Waiting times have been reduced substantially at some locations, while at others they remain a problem. In one location, for example, warriors are waiting three months to be seen after an initial appointment, and complain that once able to be seen are being afforded group therapy rather than one-on-one assistance, and of being rushed through therapy.

One cannot assume that simply filling mental health positions in the VA necessarily translates into effective mental health care. Consider, for example, the following comments from our field staff regarding warriors’ experience with VA mental health care:

“The biggest [warrior] complaint seems to be... [that providers have] no military background and they don’t ‘get it’ or understand what I am going through and struggling with....[It’s] hard to connect with someone when they haven’t been in your shoes.”

“I ask warriors how they are coming along in their recovery; in more cases than not, warriors do not want to talk about their war time experiences with non-vets.”²⁴

Even as VA is bringing on new providers, several staff reported that facilities are still confronting turnover issues. As one reported --

“Many of the good counselors and psychologists have left [a major VA medical center] because the appointment schedulers continued to disrupt their best efforts to see their patients on a routine basis....At the Vet Centers and CBOCs the scheduling is better but still only reaches a small number of veterans who have access to those facilities....”²⁵

²¹ WWP Survey of VA Mental Health Staff (2011).

²² As one WWP-survey respondent explained in describing practices at a VA facility, “Unreasonable barriers have been created to limit access into Mental Health treatment, especially therapy. Vets must go to walk-in clinic so they are never given a scheduled initial appointment. Walk-in only provided medication management, but Vets who just want therapy must still go to walk-in. After initial intake, Vets are required to attend a group session, typically a month out. After completing the group session, Vets can be scheduled for individual therapy, typically another month out. Performance measures are gamed. When a consult is received, the Veteran is called and told to go to walk-in. The telephone call is not documented directly (that would activate a performance measure)...Then the consult is completed without any services being provided to the Veteran. Vets often slip through the cracks since there is no follow-up to see if they actually went to walk-in. Focus of the Mental Health [sic] is to make it appear as if access is meeting measures. There is no measure for follow-up, so even if Vets get into the system in a reasonable time, the actual treatment is significantly delayed. Trauma work is almost impossible to do since appointments tend to be 6-8 weeks apart.”

²³ VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans’ Affairs, 112th Cong. (2012) (Testimony of Secretary of the Dept. of Veterans’ Affairs, Eric Shinseki).

²⁴ Conference call with WWP alumni managers; May 1, 2013.

²⁵ Id.

Yet even as we hear reports of problems, we hear of facilities that have substantially reduced waiting times and/or where mental health care is described as “excellent.” The watchword continues to be, “you’ve seen one VA, you’ve seen one VA.”

Challenges in Rural America

To the extent that warriors have problems getting needed health care from VA facilities, those problems are magnified in rural areas. Long travel distances are, of course, a formidable barrier. Importantly, VA policy sets systemwide expectations regarding the mental health services that should be available to veterans at VA facilities of varying sizes. The policy states:

“the services that must be ‘available’ are those that must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts, or non-VA fee basis care to the extent that the veteran is eligible.”²⁶

Where VA itself cannot provide a particular needed service at all or cannot provide it to an eligible veteran because of “geographical inaccessibility”²⁷ VA policy calls for VA facilities to provide the needed service through contract arrangements. But we see evidence of significant gaps between policy and practice here, as warriors who live in remote areas often encounter VA reluctance or resistance to authorize community-based care. The following illustration from a warrior’s caregiver is not unusual –

“We live in a smaller community [in Arizona] so our community-based outpatient clinic couldn’t help because they were overloaded and “short staffed” I asked our OEF/ OIF social worker repeatedly for help! It even went as far as [the warrior] running out of his mental health medication in June 2012 and they would not refill until they saw him but the soonest they could would be Feb 2013!! To say I was angry would be an understatement!! I started making various phone calls going up the chain of command!! Finally help came from a lab tech...who suggested I take him to the mental health clinic as a ‘crisis patient.’ We are FINALLY after almost two years getting some counseling on a fee basis.”

A Colorado caregiver of a warrior who is rated 100% service-connected disabled due to PTSD described the experience of living in an area where “we are so remote that we do not even have a traffic light in the entire county” and where “all access to care the VA offers requires travel through a treacherous mountain pass going in any direction of a CBOC... [with] solid snowfall at our high elevation for 8-9 months out of the year.”

²⁶ Department of Veterans Affairs, “Uniform Mental Health Services in VA Medical Centers and Clinics,” VHA Handbook 1160.01 (Sept 11, 2008), accessed http://www.mirecc.va.gov/VISN16/docs/UMHS_Handbook_1160.pdf

²⁷ See 38 USC sec. 1703(a)

"Getting approval for fee basis is a nightmare and most people don't know to even push for it. The only approval we've gotten for fee basis was twice: once for physical therapy, and fee basis screwed up the processing and left us with a bill for the services. I had it re-routed through Medicare just to get it paid for. The other approval was for the sleep study that took two years to process."

Exacerbating access challenges is a historical and growing crisis in the mental health workforce. According to a recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA), 55% of U.S. counties, all rural, have no practicing psychiatrists, psychologists, or social workers and 77% of counties have a severe shortage. The report highlighted issues impacting the dearth of available providers such as high staff turnover, inadequate compensation, stigma, and licensing and credentialing issues. The report also acknowledged deficiencies in the adoption of evidence-based practices and the use of technology, which is especially problematic with the great need for effective trauma-specific approaches for this generation of veterans.²⁸ With the drawdown of forces in Afghanistan, more and more service members will be transitioning to veteran status, with many returning to their homes in rural America. With additional demands from population growth and increased coverage of services, the challenge of access to effective mental health care in rural America will continue to grow.

A Role for Partnerships

VA mental health programs certainly have a role to play in early identification and treatment of mental health conditions. Yet evidence suggests that success in addressing combat-related mental health conditions is not simply a matter of a veteran's getting professional help, but of learning – with help – to navigate the transition from combat to home.²⁹ In addition to coping with the often disabling symptoms, many OEF/OIF veterans with PTSD and other conditions, and wounded warriors generally, are likely also struggling to readjust to a "new normal," and to often profound uncertainties about finances, employment, education, career and their place in the community. While some find their way to VA programs, no single VA program necessarily addresses the range of issues these young veterans face, and few, if any, of those programs are embedded in the veteran's community. VA and community each has a distinct role to play. The path of a veteran's transition, and successful community-reintegration, if it is to occur, ultimately occurs in that community. For some veterans that success may take a community – perhaps the collective efforts of local not-for-profit groups, businesses, a community college, the faith community, veterans' service organizations, and agencies of local government, all playing a role. Yet there are relatively few communities dedicated, and effectively organized, to help returning veterans and their families reintegrate successfully, and other instances where VA and veterans' communities are not closely aligned. The experience of still other communities, however, suggests that linking critical VA programs with committed community engagement can make a marked difference to warriors' realizing successful reintegration.

²⁸ U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, (January 24, 2013).

²⁹ Charles W. Hoge, M.D.; *Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home*, (Globe Pequot Press, 2010).

With limited exceptions, however, VA mental health programs are generally not focused on, or integrated with, the adjacent community. (One important exception is the support some VA facilities have provided veterans treatment courts, in efforts to divert individuals from the criminal justice system into treatment and rehabilitation.) Importantly, VA not only has broad authority to contract, or enter into partnerships, with community providers or other entities,³⁰ but Congress has expressly encouraged the Department to work with communities to expand veterans' access to needed mental health services, expressly inviting it to "partner" with community entities.³¹

It has long been WWP's view that VA should partner with and assist community entities or collaborative community programs in providing needed mental health services to wounded warriors, to include providing training to clinicians on military culture and the combat experience. Our own experience in that regard has been disappointing. At Wounded Warrior Project, one of the 18 programs we offer warriors is our "Project Odyssey," an outdoor rehabilitative retreat for warriors with PTSD that promotes peer-connection and healing with other combat veterans as part of a challenging outdoor experience. We run approximately 50 such retreats around the country annually, and in the past benefitted from a collaborative relationship with VA's Vet Center program, with Vet Center counselors participating in each Odyssey. This was a symbiotic relationship, consistent with the Vet Center's outreach mission, that frequently resulted in warriors becoming Vet Center clients after the Odyssey experience. Unfortunately and inexplicably, VA Central Office officials terminated this partnership in 2010 (seemingly on the basis that there were questions about its underlying statutory authority. Since then Congress has made crystal clear that VA has the authority to provide Vet Center support to recreational programs operated by veterans service organizations to foster the readjustment of warriors. But while we have reached out to Secretary Shinseki to reinstate this relationship, citing the specific authority Congress provided VA to support such programming,³² we have to date received only a noncommittal response.

³⁰ See 38 U.S.C. sec. 8153. Section 8153(a)(1) provides, "To secure health-care resources which otherwise might not be feasibly available, or to effectively utilize certain other health-care resource, the Secretary may...make arrangements, by contract or other form of agreement for the mutual use, or exchange of use, of health care resources between Department health-care facilities and any health-care provider, or other entity or individual."

³¹ "...the Secretary may partner with a community entity or nonprofit organization or assist in the development of a community entity or nonprofit organization, including by entering into an agreement under section 8153 of title 38, United States Code, that provides strategic coordination of the societies, organizations, and government entities...in order to maximize the availability and efficient delivery of mental health services to veterans by such societies, organizations, and government entities." Section 729, National Defense Authorization Act for Fiscal Year 2013, Public Law 112-239.

³² 38 U.S.C. sec. 1712A(g), as added by section 727, National Defense Authorization Act for Fiscal Year 2013, Public Law 112-239. Under that provision, "...[T]he Secretary may provide for and facilitate the participation of personnel employed by the Secretary to provide services under this section in recreational programs that are - (1) designed to encourage the readjustment of veterans described in subsection (a)(1)(C) [of section 1712A of title 38, U.S. Code]; and operated by any organization named in or approved under section 5902 of this title."

Leveraging VA's Workforce and Programs

VA often cites the numbers of OEF/OIF veterans "seen" in VA health care facilities for mental health conditions. But what is less readily acknowledged is the significant percentages of OEF/OIF veterans who drop out of treatment, as well as those who need, but do not seek, mental health care. As a leading researcher described it, "with only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment."³³ The Administration has since formulated a strategy that we believe holds real promise to counter those twin challenges. Its direction to have VA hire and train peers to provide outreach and support to fellow warriors can provide a cadre of warriors who can win other warriors trust and both foster a path to treatment and provide support to sustain warriors who have embarked on treatment. As such, we applaud the White House initiative directing VA to hire and train 800 peer to peer counselors. We understand that VA has made progress, but appears still to be at a relatively early stage of implementation. What is more concerning, however, is that – as it is being implemented, the program has no specific OEF/OIF focus. Rather, as we understand it, individual VA facilities may establish and fill peer positions in any of their mental health programs, without regard to the population served. While we agree that peer-support can be widely beneficial, the most compelling need for this can of help, in our view, is among returning veterans. We recommend that VA peer to peer program either be re-oriented to target the OEF/OIF population or that VA expand substantially the number of veterans it hires and trains to serve as peer to peer counselors. Either step would have a potential multiplier effect throughout the VA system in engaging and sustaining warriors in treatment.

A second key VA program, its Vet Centers also incorporate the critical peer-to-peer component. For this and other reasons, the program has had singular success, in our experience, in reaching and connecting effectively, with wounded warriors. We recommend that VA both improve coordination between its medical facilities and Vet Centers, and that it increase both Vet Center staffing and the number of Vet Center sites, with emphasis on locating new ones near military facilities.

Finally, VA's telemental health capability has seen significant growth, and there is potential for further expansion. A 2008 journal article described the VA as having one of the largest telemental health networks in the world, with over 45,000 videoconferencing and over 5,000 home telemental health encounters annually.³⁴ By fiscal year 2012, the program had grown to providing 217,000 remote mental health visits to 76,000 veterans via clinical video telehealth through VA community-based clinics and 7,100 via home telehealth. 49% of veterans receiving telehealth live in rural areas.³⁵ While VA encourages the use of telemental health and there is emerging evidence for its expanded use to provide mental health services—including individual and group therapy and diagnostic assessment-- some facilities still do not offer these services or

³³ Charles W. Hoge, MD, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," *supra*, note 14.

³⁴ Godleski, et al. "VA Telemental Health: Suicide Assessment," *Behavioral Sciences and the Law*, 26 (3), 271-86. May/June 2008.

³⁵ Interview with Linda Godleski, PhD, Director National Telemental Health Center, VA Office of Telehealth, May 17, 2013

experience barriers to utilizing the modality.^{36 37} Recent studies have indicated that telemental health holds promise in increasing the availability of care, reducing the need for inpatient care, and improving patient outcomes^{38 39} and there is some evidence it might be a more cost-effective model.⁴⁰ There are certainly areas that warrant further careful evaluation.⁴¹ But the advances in telehealth and developing knowledge in the area are encouraging and we urge greater expansion of an approach that could engage more warriors in needed mental health care.

Thank you for your consideration of our views.

³⁶ Department of Veterans Affairs Office of Inspector General, "Evaluation of Mental Health Treatment Continuity at Veterans Health Administration Facilities," (April 29, 2013).

³⁷ Jameson et al. "VA Community Mental Health Service Providers' Utilization of and Attitudes Toward Telemental Health Care: The Gatekeeper's Perspective," *The Journal of Rural Health* 27: 425-432. 2011.

³⁸ Godleski, Darkins, and Peters. "Outcomes of 98,609 U.S. Department of Veterans Affairs Patients Enrolled in Telemental Health Services, 2006-2010," *Psychiatric Services* 63 (4), 2012.

³⁹ Koch. "The VA Maryland Health Care System's telemental health program," *Psychological Services* 9(2):203-5. 2012.

⁴⁰ Shore et al. "An economic evaluation of telehealth data collection with rural populations," *Psychiatric Services* 2007 Jun;58(6):830-5.

⁴¹ Yuen et al. "Challenges and opportunities in internet-mediated telemental health," *Professional Psychology: Research and Practice*, Vol 43(1), Feb 2012, 1-8.

**"Improving Federal Health Care in Rural America: Developing the Workforce and Building Partnerships"
May 23, 2013**

**Post-Hearing Questions for the Record
Submitted to The Honorable Robert A. Petzel
from Senator Jon Tester**

Question 1: Licensed Professional Mental Health Counselors and Marriage and Family Therapists are included on the list of professionals who can serve Veterans. In addition, the Department of Veterans Affairs (VA) has released qualification standards for them. Even though these professionals make up 40 percent of the overall mental health independent practice workforce, they make up less than 1 percent of the VA mental health workforce. Given the dramatic staffing shortfalls, does it not make sense to bring more of these professionals into the VA workforce? Is there a role for Licensed Professional Mental Health Counselors Marriage and Family Therapists to play in meeting the needs of Veterans? Also, I understand these professionals are currently not a part of the VA Trainee Support Program, administered through the Office of Academic Affiliations. Would the VA reconsider including Licensed Professional Mental Health Counselors and Marriage and Family Therapists in this program?

VA Response: VA believes that the hiring of licensed professional mental health counselors (LPMHCs) and marriage and family therapists (MFTs) is an important part of our goal to expand access to mental health services. Language establishing the recognition of LPMHCs and MFTs as mental health specialists within health care programs operated by VA was included in S. 3421, the "Veterans Benefits, Health, Care, and Information Technology Act of 2006" (§ 201 of Public Law 109-461), which was signed by President Bush on December 22, 2006. VA has developed qualification standards and implemented the numerous other requirements for establishing these new occupations. VA facilities have been authorized to hire these new occupations since September 28, 2010.

Since the implementation of the qualification standards, VA has been hiring and continues to actively hire LPMHCs and MFTs. Further, recruitment efforts related to VA's recent initiative to hire 1,600 additional mental health staff have included LPMHCs and MFTs who are eligible for VA employment. VA's enclosed news release, dated April 24, 2012, specifically highlights the inclusion of these professions. VA notes that in May 2012, the Bureau of Labor Statistics indicated there were 149,350 MFTs and Mental Health Counselors in the national mental health workforce. This represents approximately 17.2 percent of the workforce at that time (not 40 percent as was stated in the question).

Developing qualification standards and the appropriate job series for these professions did take time, since the authorizing legislation stipulated that they must be included as

Hybrid Title 38 employees. Each facility has the authority and is responsible for determining the mental health staffing needs for the facility and whether those needs would be best met by a social worker, psychologist, mental health nurse, LPMHC, or MFT. The National VHA LPMHC and MFT Professional Standards Boards are fully functioning and continuously reviewing applicants who have been tentatively selected for hire in VA mental health positions. These two professional disciplines enhance VA's existing interdisciplinary teams within mental health and expand the pool of eligible clinicians from which to recruit. As VA's need for mental health professionals grows, VA expects that the number of LPMHCs and MFTs will also increase.

VA supports the development of training opportunities for students enrolled in LPMHC and MFT master's degree programs, and internal discussions have begun to explore options for LPMHC and MFT training programs in VA. The VHA Offices of Academic Affiliations, Mental Health Operations, and Mental Health Services are collaborating in planning for this expansion of VHA mental health training. The tentative goal is to implement a pilot program in Academic Year 2015.

VHA is consulting with accreditation bodies regarding standards and requirements to develop pilot training programs. Existing VHA LPMHCs and MFTs will be included in the planning process. Specific criteria must be met in order to ensure the quality of the educational program and patient care. These criteria, which are common to all training programs, include: accreditation of affiliated college and university sponsored degree programs; a signed affiliation agreement between the VA and the college or school sponsoring the program; sufficient licensed staff in the same discipline at the local facility to act as core faculty (supervising, teaching, evaluating and mentoring the students); a patient population that meets curricular goals; and an administrative infrastructure to manage the program.

At the present time, the numbers of credentialed LPMHC and MFT clinicians at most VA facilities is insufficient to serve as core faculty; however, some facilities have current supervisory capacity. As the numbers of LPMHC and MTF staff grow, this obstacle will gradually be overcome and training programs for master's degree students in accredited programs can be made available at additional VA facilities.

Part of the planning for the LPMHC/MFT Pilot will be a determination of funding for trainees. Funding for all VA training programs is contingent on several factors, including available funding, the difficulty in recruiting professionals in the discipline in question; and the community standard regarding trainee stipends.

Question 2: During your most recent testimony before the Senate Veterans Affairs Committee, we discussed some of the tools the Veterans Health Administration (VHA) already has, and some of the tools it needs, to more effectively recruit and retain a quality health care workforce. As a result of that conversation, I introduced bipartisan legislation (S.845) with Senator Moran to remove the cap for student loan repayment of health professionals within the VA. The bill would also extend the sunset date of the Health Professionals Educational Assistance Program. Can you highlight the benefits of this legislation? What else can we do to better ensure you have the resources and flexibility you need to address these staff shortages, particularly in rural areas?

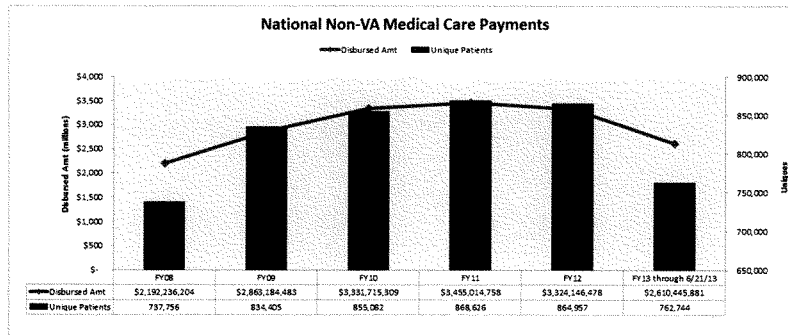
VA Response: VHA supports Section 301, as it would amend 38 United States Code § 7619 to extend authorization of the Health Professionals Scholarship Program through Fiscal Year (FY) 2019, an additional 5 years, to help meet recruitment and retention needs for critical health care providers. This program will help alleviate the health care workforce shortages in VA by requiring scholarship recipients to complete a service obligation at a VA health care facility after graduation and licensure/certification. Additionally, scholarships will enable students to gain academic credentials without additional debt burdens from student loans. Future benefits are gained in reduced recruitment costs, as scholarship recipients will have obligated service agreements to fulfill. These types of obligations secure the graduates' services for up to three years and reduce turnover, and associated costs, typically associated with the first two years of employment.

VHA recognizes the intent of S. 845, Section 1(b), however, VHA already has an established process in place to award amounts in excess of the \$60,000 maximum allowed for Education Debt Reduction Program (EDRP). PL 111-163 – May 5, 2010, Title III Rural Health Improvements Section 301 provides the Secretary the authority to waive the \$60,000 limitation. This incentive tool has been historically underutilized in part because participants are reimbursed the amount they pay their lender annually, placing the burden on EDRP recipients to pay their lender first and then be reimbursed afterward. VHA is currently exploring additional solutions to increase recruitment and retention flexibility to help address critical staff shortages. VHA looks forward to working with key stakeholders to ensure that VHA can continue to attract and retain a highly skilled workforce in hard-to-fill positions, including primary care, mental health, and those in rural areas.

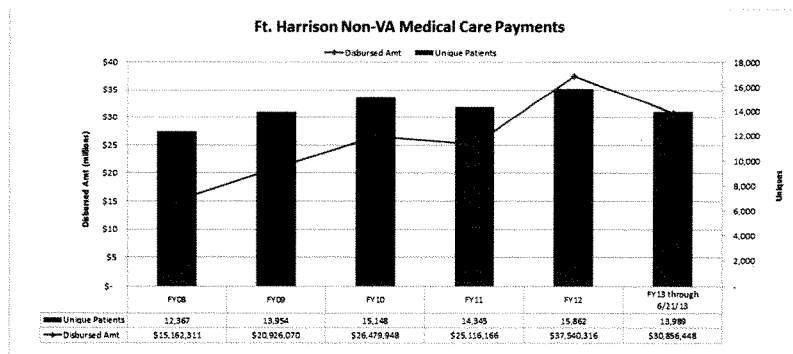
Question 3: As you mentioned in your testimony, the Non-VA Medical Care Program plays an important part in providing care to Veterans in a timely manner. As you know, VA only authorizes Non-VA medical care when VA health care facilities are not feasibly available. While I understand that the National Non-VA Medical Care Program Office (NNPO) is responsible for providing guidance at a national level, I have heard from Montanians that this authority is used very inconsistently across the VISNs. In frontier communities that are hundreds of miles away from the nearest VA facility, the Non-VA Medical Care Program is

often the only option. Looking at data from recent years, has usage of this authority increased or decreased?

VA Response: Looking at data from recent years, usage of this authority has shown an increase from FY 2008 through FY 2011, with a slight decrease in FY 2012. The chart below depicts usage of Non-VA Medical Care since FY 2008, based on numbers of unique patients and disbursed dollar amounts for the care; FY 2013 numbers are current through June 21, 2013:



The following chart provides the same data specific to Fort Harrison, Montana. The number of unique patients increased from FY 2008 through FY 2010, with a slight decrease in FY 2011, followed by an increase last year. FY 2013 data is current through June 21, 2013.



Question 4: Access to emergency care outside of the VA health care system is frequently a challenge for rural Veterans. They are often unable to report to their nearest VA facility because of distance from that facility, the severity of the

emergency, or because they are in urgent need of care after-hours or over a weekend. In many rural areas, the nearest VA health care facility does not provide emergency care, leaving the Veteran to wait until normal clinic hours before they can be treated. Sometimes, that simply is not an option. In those instances, if Veterans receive emergency care outside of the VA health care system, they are required to report that treatment within 72 hours. Given the frequency with which Veterans may be unable to report such treatment in a timely manner, are there any steps that can be taken by the VA to work with these facilities and ensure payment decisions are not neglectful of those considerations?

VA Response: In 2013, the Chief Business Office Purchased Care (CBOPC) initiated the Non-VA Medical Care Coordination (NVCC) model to standardize the front end process and improve future state solutions within the Non-VA Medical Care Program. A portion of this model included the development of the hospital notification progress note utilizing CPRS. This created consistency in the process when VA is notified that a Veteran is admitted to a non-VA health care facility for emergency treatment. Centralized documentation of a Veteran's notification of care at a non-VA health care facility allows a Veteran, family, etc., to inform staff at the VA Medical Center and the notification will be accounted appropriately. The consistent process in documenting notifications for emergency admissions to non-VA health care facilities assists in adjudicating eligibility requirements for medical claims.

When a Veteran experiences an emergency situation, VA always recommends that a Veteran seek care at the nearest emergency department. When a Veteran receives emergency treatment from a non-VA facility, VA recommends that a Veteran or the Veteran's representative notify VA within 72 hours after admission. The reason for the 72 hour recommendation is to facilitate coordination of care between the non-VA facility and VA. Additionally, there are instances where such notification may allow VA to consider the care as "preauthorized" depending on the Veteran's eligibility for contract care under 38 U.S.C 1703 and its implementing regulations (specifically 38 C.F.R. 17.54). If a Veteran, non-VA facility, or Veteran's representative does not make contact within 72 hours, and a claim for reimbursement or payment of the unauthorized non-VA emergency care is filed, VA will consider those claims under our reimbursement statutes 38 U.S.C. 1725 and 1728 to see if the Veteran is eligible for those benefits.

In general, 38 U.S.C. 1728 requires VA to provide reimbursement for non-VA emergency treatment for a service-connected disability, an adjunct condition for any condition when a Veteran is rated permanently or totally disabled due to a service-connected condition, or for any condition of a Veteran participating in the Vocational Rehabilitation program under Chapter 31. Under this statute, a claim must be filed within 2 years after the date of care or services were rendered.

In general, 38 U.S.C. 1725 requires VA to provide reimbursement for non-VA emergency treatment of certain Veterans with non-service-connected conditions. Under this authority, Veterans must meet all conditions of this statute to be eligible for

payment/reimbursement. In addition, the claim must be received by the VA within 90 days of the services provided.

When a Veteran feels a claim is denied inappropriately, they may appeal the decision with the local VA Health Care Facility. The Veteran may file a Notice of Disagreement (NOD), which is a letter expressing dissatisfaction with the decision rendered by the VA and their desire for further review. The VA will review the initial decision when a NOD is filed and must develop the case into a formal appeal, which can be submitted to Board of Veterans' Appeals (BVA) for a final decision.

In order to keep our Veterans informed of emergency care that may be available to them, the VA's Chief Business Office Purchased Care (CBOPC) has developed a Non-VA Emergency Care Fact Sheet and posted it on their public website:
http://www.nonvacare.va.gov/brochures/NonVA_Emergency_Care_FactSheet.pdf.

Question 5: I am aware and appreciative of the efforts undertaken by the VA to work more closely with federally-qualified health centers. Can you discuss efforts by the VA to partner with other rural providers like critical access hospitals and rural health clinics? How about non-profits?

VA Response: There are many examples of VA partnerships and collaborations with Federal and private rural health care providers, rural health clinics, as well as non-profit institutions across the country to increase access for rural Veterans and to provide education and training for rural VA and non-VA health care professionals who provide care to rural Veterans. Some examples of these partnerships/collaborations are cited below:

Partnerships with Non-Profits:

- VA/Area Health Education Center (AHEC) Collaboration. There are a number of VA/AHEC partnerships throughout the country that address health care workforce development through training and education. AHECs are non-profit organizations that serve local communities by working to improve the quality of the primary care workforce in rural areas. In the past year, over 50 VA/AHEC collaborations have occurred across the country. These VA/AHEC partnerships most commonly involve continuing health care education courses and other educational initiatives in the community. However, these partnerships also include the AHEC Veterans' Mental Health Project and operations in VA community-based outpatient clinics.
- VA/Senior Living Independently for the Elderly (SeniorLIFE) Collaboration. The VA Pittsburgh Health Care System is partnering with the SeniorLIFE Washington Program to provide an alternative to institutionalization for rural senior Veterans. This program delivers integrated, interdisciplinary team care for aged 55+ Veterans who require assistance to remain in their

own homes. SeniorLIFE provides in-home medical and nursing care, skilled therapists, adult day health care, and transportation among other services.

- Dementia Care Partnership. The Telephone Assisted Dementia Outreach Clinic at the Tuscaloosa VA Medical Center (VAMC) is partnering with the Agency on Aging of West Alabama to identify community and VA resources for rural Veterans with dementia, their caregivers, and for Veterans who care for family members with dementia. The goals of this partnership include identifying Veterans in rural areas that may benefit from VA services and connecting family caregivers and Veterans caring for loved ones with dementia to community supports such as local Alzheimer's caregiver support groups or other resources that could augment care already received within VA.
- Certified Nursing Assistant Training. The Veterans Health Administration Office of Rural Health (ORH) Veterans Rural Health Resource Center – Eastern Region is collaborating with the newly established Northeast Telehealth Resource Center and Medical Care Development, Inc., a Maine health care not-for-profit, to develop a telehealth training curriculum for Certified Nursing Assistants (CNAs). The telehealth course will be offered to graduates of the CNA course conducted by the Augusta, Maine Adult Education program in collaboration with the VA Maine Health Care System, Togus. CNAs are widely used in community home health care and nursing home settings where rural Veterans receive non-VA health care services via telehealth.

Partnerships with the Department of Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS) Critical Access Hospitals (CAH) and Community Clinics:

- Rural Health Information Exchange (HIE). Up to 70 percent of Veteran patients use both VA and non-VA providers to meet their health care needs. HIE among those providers is necessary to achieve the best possible coordination of care, reduce or eliminate therapeutic or diagnostic duplication, and ensure patient safety. ORH is working in partnership with the HHS Office of the National Coordinator in piloting a program in at least ten rural communities in four states to facilitate HIE between VA and HHS/CMS CAHs, and their associated clinics.
- Rural Behavioral Health Telehealth Partnership. The HHS/Health Resources and Services Administration (HRSA) funds a partnership between the Affiliated Service Providers of Indiana, Inc. (ASPIN), the Richard L. Roudebush VAMC in Indianapolis and the Indiana Rural Health Association to increase access to behavioral health services provided by the VAMC to five rural Indiana communities. The partnership placed telehealth equipment in each of these five mental health care sites and

schedules Veterans for appointments with VA mental health providers. The sessions use secure Clinical Video Telehealth to deliver care from the VAMC to Veterans at the community mental health care sites.

- Rural Positron Emission Tomography - Computed Tomography (PET/CT) Scans. The Clarksburg VAMC entered into a healthcare resources sharing agreement with a private rural hospital to purchase a PET/CT scanner for placement and operation at the United Hospital Center. This sharing agreement offers priority scheduling to Veterans and also provides services to local citizens. This opportunity benefits VA from a cost savings perspective and shares sophisticated medical technology with a rural non-VA hospital in the local community. Most importantly, this relationship has improved Veteran access to PET/CT services and rural Veterans are no longer required to travel long distances to receive this type of care.
- Rural Veteran Spinal Cord Injury (SCI) Collaboration. The VA Long Beach Healthcare System (VALBHS) SCI Center is a regional SCI Center with a commitment for outreach to rural Veterans with SCI. The VALBHS regularly sees rural SCI patients in local VA facilities, and uses telehealth to treat patients in faraway private rural clinics in Montana.

Additionally, VA works closely with nonprofit community-based agencies to eliminate Veteran homelessness in both urban and rural areas. VA's on-going prevention, rapid re-housing and transitional housing programs, together with its collaborative permanent supportive housing through the Department of Housing and Urban Development (HUD) – VA Supportive Housing (HUD-VASH) program provide wide-ranging services in rural areas. VA realizes the importance of partnering with community-based non-profit organizations to reach the rural homeless Veteran population. Rural homeless persons are often referred to as the "hidden homeless" as many of these individuals reside in the woods, campgrounds, abandoned farm buildings, and buildings not intended for human habitation. Much of the rural at-risk homeless population reside in substandard housing or are doubled up in temporary housing arrangements. Additionally, rural community-based homeless service providers often lack adequate capacity and infrastructure to address rural homelessness.

For example, the Supportive Services for Veteran Families (SSVF) Program provides grant funding for community agencies to assist Veterans and their families with preventive supportive services. Of those grants awarded in FY 2011 for operations conducted in FY 2012, approximately 5 percent of the SSVF grants serve Veteran families in rural areas exclusively, while an additional 32 percent of grants serve a mix of rural and urban areas. In FY 2012, VA awarded funding for operations in FY 2013. Approximately 10 percent of the community agency grantees provide services exclusively in rural areas. Additionally, over 45 percent of these grantees included a rural component in their services. VA is expanding access to services both by increasing available resources and by specifically targeting rural areas. In the past year, VA has increased funding available through its SSVF grant program from \$100 million to \$300 million. Additionally, the FY 2013 SSVF Notice of Funding Availability

lists "Veteran families located in a rural area," as one of the target populations for SSVF funding.

Community agencies funded under VA's Homeless Providers Grant Per Diem (GPD) Program provide transitional housing for Veterans who are homeless. In FY 2012, 16.8 percent of those GPD Programs were in rural areas. As of April 2013, 26.6 percent of those GPD programs indicated that they provided transitional housing for Veterans in rural areas.

The HUD-VA Supportive Housing (HUD-VASH) Program offers homeless Veterans permanent housing opportunities through HUD's Housing Choice vouchers, linked with wrap-around VA case management services. Vouchers are distributed through local Public Housing Authorities in both urban and rural areas. From FY 2008 - FY 2012, HUD allocated 5,260 of the approximately 48,000 HUD-VASH vouchers to rural areas. In FY 2013, HUD allocated approximately 10,000 vouchers nationwide, thus as of November 2013, increasing the total number of active HUD-VASH vouchers allocated since 2008 to over 58,000. Of the vouchers allocated in FY 2013, approximately five percent were distributed to serve rural areas. Vouchers are allocated based on relative need.

Finally, VA understands that the rural homeless Veteran population has pressing and unique needs. To that end, VA continues to explore the potential use of video-teleconferencing and related technologies in the care of rural homeless Veterans. Connecting people through technology can reduce costly and inconvenient travel and prevent isolation for remote VA staff, Veterans, and VA's nonprofit community-based partners.

Question 6: The Senate Veterans Affairs Committee recently held a hearing on VA Outreach and Community Partnerships. A recurrent theme at this hearing was the unprecedented level of support by the American people willing to help our Veterans. At the hearing, we heard about qualified and well-established community organizations that have a difficult time assisting federal agencies in serving the Veterans and families in their communities. In your testimony, you mentioned the steps VHA has taken to promote collaboration at the federal and local level. I appreciate that and commend you for your work. Could you discuss the VHA's collaboration with private, faith-based, or non-governmental organizations whose sole mission is to serve our Veterans?

VA Response: VA recognizes that the Federal government cannot alone provide the comprehensive resources and services needed to assist with the support and reintegration of our Nation's Veterans. VHA has always collaborated with a variety of private, faith-based, and non-governmental organizations at both the national and local levels. VA also realizes that more can be done. Toward this goal, Dr. Robert A. Petzel, Under Secretary for Health, charged every VA medical center to host a Community Mental Health Summit between July 1 and September 15, 2013, in order to identify

community-based programs and services in local areas across the country to support the mental health needs of Veterans and their families.

Through these Community Mental Health Summits, VA seeks not only to increase awareness in the community regarding the unique health needs of Veterans and available VA programs and services but also to enhance partnerships between VA and complementary community-based programs and organizations. VHA facilities received a Community Mental Health Summit toolkit that contained templates for planning the events and reporting on their outcomes. A Web page was developed to provide the public with information about each facility summit, including a point of contact to request additional information.

In addition, VA's partnerships with community based organizations provide the backbone to VA's efforts to end Veteran homelessness. VA provides grants to consumer cooperatives, public and non-profit private community providers through the GPD Program and the SSVF Program. VA also partners with community-based organizations through its Health Care for Homeless Veterans (HCHV) contract residential treatment program and through the HUD-VASH Program.

GPD Program

The GPD Program provides funding through grants to public (e.g., state, local, and Tribal governments) and non-profit private organizations to develop and operate transitional housing and supportive services for homeless Veterans. The GPD Program currently has over 15,000 operational transitional housing beds. Beds are in every state, the District of Columbia, Puerto Rico, and Guam. During FY 2012, over 41,000 unique Veterans received services from the GPD program, which included over 2,800 women. In 2012, over 12,000 Veterans exited the program to permanent housing.

Also, there are four GPD transitional housing projects in the state of Montana with a total of 68 beds. There is also one stand alone GPD service center. The GPD projects in Montana provided services to 198 unique Veterans in FY 2012, including 8 women Veterans. There were 49 Veterans exiting these projects to permanent housing during that year.

SSVF Program

The SSVF Program provides supportive services grants to private non-profit organizations and consumer cooperatives to coordinate or provide supportive services for very low-income Veteran families. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk of homelessness due to a housing crisis. In FY 2012, SSVF awarded \$100 million in funding to 151 community-based organizations serving Veterans families in 49 states, the District of Columbia, and Puerto Rico. In FY 2013, VA expects to award nearly \$300 million in SSVF supportive services grants. In FY 2012, the first year of SSVF program operations, community-based grantees assisted over 35,000 homeless and at-risk Veteran families participating in SSVF. This participation rate significantly exceeded VA's projected expectation to serve 22,000 in the first year of operation.

The Volunteers of America (VOA) Northern Rockies currently serves central and east Montana. Through April 2013, VOA has served 97 participants. Of the 97 participants, 58 participants have been discharged from SSVF with 46 participants (79 percent) placed in permanent housing.

HCHV Contract Residential Treatment

The HCHV Program provides a gateway to VA and community supportive services for eligible Veterans who are homeless. This includes ensuring that chronically homeless Veterans and/or those with serious mental health diagnoses can be placed in community-based programs that provide quality housing and services that meet the needs of these special populations. Local VA facilities collaborate with local groups by offering competitive contract solicitations to community-based providers to provide contract residential treatment services and housing. Dedicated community partners are essential to the success of this program. During FY 2012, HCHV provided funding for 3,287 beds through 299 contracted community providers in all 50 states, the District of Columbia, and Puerto Rico. In FY 2012, over 11,500 unique Veterans received residential services from the HCHV program with over 3,800 Veterans exiting the program to permanent housing in FY 2012.

In Montana alone, during FY 2012, the HCHV Program provided residential services to 138 unique Veterans, and 46 Veterans exited the HCHV Program to permanent housing. There are currently 57 HCHV contract residential treatment beds operated through two contracted community providers in the state of Montana.

Montana has also been very active in hosting Homeless Veteran Stand Downs, that are 1 to 3-day events that provide homeless Veterans a variety of services and allow VA and community-based service providers to reach more homeless Veterans. Stand Downs give homeless Veterans a temporary refuge where they can obtain food, shelter, clothing, and a range of community and VA assistance. In many locations, Stand Downs provide health screenings, referral, and access to long-term treatment, benefits counseling, ID cards, and access to other programs to meet their immediate needs. There were 15 Stand Down events in Montana for calendar year 2013.

Department of Housing and Urban Development-Department of Veterans Affairs Supportive Housing (HUD-VASH) Program

Through the HUD-VASH Program, HUD provides permanent housing support through Section 8 Housing Choice vouchers and VA provides wrap-around case management and supportive services. VA recognizes that merely housing a Veteran and, in some cases, the Veteran's family is not sufficient. Community partners are needed to provide a full array of supportive services and help meet the needs of the Veteran family. VA collaborates extensively with a number of community-based providers. These community groups provide a wealth of services to HUD-VASH Veterans, including:

- Homeless street outreach
- Utility and security deposits
- Furniture and other household necessities

- Transportation tokens
- Employment assistance
- Free or low cost dental care
- Veteran support groups
- Local advocacy for ending Veteran homelessness

The HUD-VASH Program has developed productive partnerships with Home Depot and Community Solutions' 100,000 HOMES Campaign and "Boot Camps." Home Depot has found a number of ways to assist HUD-VASH Veterans, including: small cash grants and donations of needed household items, access to "Team Home Depot" repair or home improvement, and the provision of housing development grants to nonprofits.

Furthermore, VA's collaboration with Community Solutions and the 100,000 HOMES Campaign have facilitated working relationships with local governments and community groups to "register" and create a community list of homeless individuals. These local lists are developed as a way to identify the most vulnerable homeless individuals in the community. Community Solutions also works to match those needing housing to available housing resources and supportive services to rapidly move those individuals into permanent housing. Community Solutions has also developed "Boot Camps" for targeted communities to work together on barriers to rapidly house these individuals by developing simpler, streamlined processes, and established mutually agreed upon benchmarks to demonstrate progress and outcomes.

**Post-Hearing Questions for the Record
Submitted to The Honorable Robert A. Petzel
from Senator Rob Portman (OH)**

Question 1: Your capabilities to deal with Traumatic Brain Injury (TBI) are particularly advanced at your polytrauma centers at places like Palo Alto and Minneapolis. How are you connecting rural Veterans to those sorts of TBI rehabilitation teams?

VA Response: The Department of Veterans Affairs (VA) has built the necessary capacity to provide specialized medical rehabilitation services for Veterans with TBI and polytrauma across its health care system through the nationwide Polytrauma System of Care, in collaboration with Primary Care, Mental Health Care, and Extended Care Services.

The Polytrauma System of Care uses a stepped-care model to ensure access to the appropriate level of services for the Veteran: 5 Polytrauma Rehabilitation Centers serve as hubs for acute inpatient medical and rehabilitation care, research, and education; 23 Polytrauma Network Sites provide inpatient and outpatient rehabilitation services; 87 Polytrauma Support Clinic Teams focus on outpatient rehabilitation and community re-integration; and 39 Polytrauma Points of Contact have capacity for comprehensive TBI evaluations and more limited interdisciplinary team treatments.

Polytrauma System of Care locations and levels of care reflect the geographic distribution of the Veteran population with TBI and clinical resources available at specific VA medical centers. Access to the appropriate level of care and care coordination is secured through case management (i.e., every Veteran receiving TBI rehabilitation services is enrolled in case management) and utilization of the electronic medical record.

VA further leverages technological advances to facilitate access to specialized rehabilitation care and to connect rural Veterans with Polytrauma System of Care teams. A Polytrauma Telehealth Network was developed early on for the Polytrauma System of Care teams providing high-speed, high-quality video conferencing capabilities necessary for distance evaluations, treatments, and consultations. Since then, the system has been enhanced with other elements of virtual care including e-consultations, secure messaging, and video-telehealth to the home. VA is also invested in developing mobile applications for self-management of certain chronic conditions, some of them related to TBI.

Question 2: I understand similar teams can be found within the civilian healthcare system. Can you tell me how many civilian rehabilitation teams have been utilized to treat Veterans outside the polytrauma centers? Have you integrated the capabilities into a telehealth network?

VA Response: VA provides access to a broad continuum of rehabilitation services, from acute inpatient rehabilitation to sub-acute and transitional rehabilitation, outpatient

care, adult day programs, home-based care, and community living centers. When VA cannot meet Veterans' health care needs using available facilities and capacity, VA uses fee-based services (non-VA medical care) from non-VA providers.

In Fiscal Year (FY) 2012, 8,288 Veterans with TBI received non-VA medical care, inpatient and outpatient medical and rehabilitation services at non-VA facilities, at the cost of \$29.3 million to VA. Approximately 474 non-VA facilities provided inpatient care for Veterans with TBI. Additionally, VA has engaged 46 non-VA facilities in the care of Veterans enrolled in the Assisted Living Pilot for Veterans with TBI.

A Polytrauma Telehealth Network has been in operation since 2006 supporting the Polytrauma System of Care teams with high-speed, high-quality video conferencing capabilities necessary for distance evaluations, treatments, and consultations. Since then, the system has been enhanced with other elements of virtual care including e-consultations, secure messaging, and home video-telehealth. VA is also invested in developing mobile applications for self-management of certain chronic conditions, some of them related to TBI.

Question 3: How many rehabilitation physicians does the VA employ currently, how many of those are engaged in TBI diagnosis and training, and how many of those are integrated with telemedicine initiatives to reach rural veterans?

VA Response: VA currently employs 597 rehabilitation physicians. In addition to specialized TBI care, rehabilitation physicians provide a broad spectrum of medical services for a range of disabling conditions that cannot be separated in the corporate database.

VA has deployed a sustained educational campaign to educate and train all employees, and, more specifically, rehabilitation providers about the mechanisms and consequences of TBI. Within VA, over 60,000 health care providers have completed education and training on TBI in the last 4 years through national conferences, satellite broadcasts, and Web-based training. VA's Talent Management System network currently offers 35 TBI related trainings on demand, and collaborative VA/Department of Defense TBI Grand Rounds are broadcasted nationally every month. The more experienced teams in the Polytrauma System of Care also offer TBI mini-residencies, in-person or through telehealth, for providers in need of specialized training.

Rehabilitation specialists, including physicians, are increasingly engaged in telemedicine initiatives that reach out to rural Veterans. Over 46 Polytrauma System of Care programs provide clinical video-telehealth services, and other programs are involved in some other type of virtual care. Telerehabilitation services are currently expanding to include standardized protocols for remote TBI evaluation, prescription of devices for in-home monitoring of TBI symptoms, and a mobile application for self-management of concussion symptoms, which is currently under development.

Question 4: What is the process for non-VA hospitals and providers to file a claim with the VA for compensation? How does this process differ than other federal government programs such as Medicare and Medicaid? If the process is different, why is it different? Do you keep metrics on the backlog on these claims, and if so, how has this backlog changed over the past 10 years?

VA Response: VA accepts and encourages electronic health care claims that satisfy criteria established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, paper claims are also accepted. Non-VA hospitals and non-VA medical providers are required to complete the appropriate form, CMS 1500 and/or CMS 1450 (UB-04), provide the codes or the treatment rendered, and submit the claim to the Non-VA Medical Care Office that issued the authorization or the VA facility nearest to where the emergency occurred. This process is no different than other Federal Government program that provides payment for hospital care and medical services, including Medicare and Medicaid.

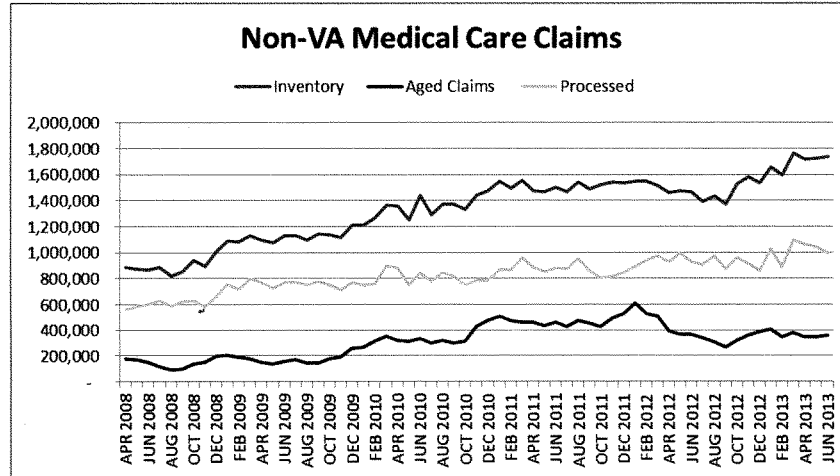
Since 2008, VA has been maintaining and tracking claims data. This data includes metrics for claims inventory levels, aged claims inventory, and claims processed. These metrics are defined as follows:

- Claims Inventory - The total number of claims received plus any claims pending (not processed) from prior months
- Aged Claims Inventory- The number of claims within the claims inventory that have aged more than 30 days past the date the claim was received
- Claims Processed - The number of claims that have been paid, denied, or rejected

The chart below depicts non-VA medical care claims data since April 2008. Data supporting this chart can be found in the imbedded Excel workbook titled *NVC Claims*. Since 2008, non-VA medical care claims processing has been trending upward. Since April 2008, there has been a 77 percent (1.2 percent monthly) increase in monthly claims processing, a 96 percent (1.5 percent monthly) increase in inventory levels, and 101 percent (1.6 percent monthly) increase in aged claims inventory levels. Claims processing, claims inventory, and aged claims inventory figures will increase or decrease for a variety of reasons including, but not limited to:

- Facility Non-VA Medical Care staffing levels
- Non-VA Medical Care referral activity
- Community provider billing activity
- Emergency care needs

To meet or exceed VA's goal, 80 percent or more of non-VA medical care claims inventory must be less than 30 days old. VA's Chief Business Office for Purchased Care (CBOPC) monitors this metric on a weekly basis. As of July 1, 2013, 80.82 percent of non-VA medical care claims inventory was less than 30 days old.



NVC Claims.xlsx

Question 5: What metrics are used to determine which non-VA hospitals are utilized for particular patients?

VA Response: The determination of which non-VA facility to use is a local decision that is based on the clinical need of the Veteran and the availability of clinical resources; local and national contracts, and sharing agreements.

Question 6: What can be done to ensure that referrals are being extended to any hospital that meets quality patient care and satisfaction indicator thresholds?

VA Response: A prospective non-VA medical care provider can contact their local Non-VA Medical Care Office to be added to the VA Medical Center's (VAMC) list of Non-VA Community Providers. Once the non-VA medical provider has been added to the VAMC's Non-VA Community Providers Listing, the determination of which hospital will be used is a local VAMC clinical decision based on the level of care, access, and specialized services required to treat the Veteran.

When a Veteran is approved to receive preauthorized non-VA medical care, they are allowed to choose a non-VA medical provider of their choice. In some instances, a Veteran may request assistance from VA to help them find a provider. When

requested, the VAMC may provide the Veteran a list of providers with whom VA has worked with in the past.

Please note, VA is prohibited from paying non-VA medical providers, including hospitals, if they are on the Department of Health and Human Services' List of Excluded Individuals and Entities (LEIE).

Question 7: Specifically in the Cleveland metropolitan area, are all four major health systems in Greater Cleveland considered for referrals when the Stokes Medical Center has need of patient care beyond the capacity of the VA network?

VA Response: Yes, all facilities in the Cleveland metropolitan area are considered when a patient is authorized to receive non-VA care. Specifically, two of the metropolitan hospitals are used due to physical location and close proximity of these facilities. The other two locations are used when needed or requested by a Veteran patient.

Question 8: What is the process for a hospital to be designed as a referral facility when VA hospitals exceed their capacity? I am aware of at least one Ohio Hospital that has had problems determining how the VA identifies and selects outside hospitals for referral. What steps can non-VA hospitals take to be considered as referral facilities when VA hospitals exceed their capacity?

VA Response: As noted above, a prospective non-VA medical care provider should contact their local VA facility, request to be added to the list of non-VA medical care community providers, provide key information concerning their facility, and register in VA's payment system. The Non-VA Medical Care Program's public Web site contains instructions on "Becoming a Non-VA Community Provider." These instructions are located at: http://www.nonvacare.va.gov/docs/provider-resources/ISMP_Becoming_a_non-VA_Community_provider.pdf

When a Veteran is approved to receive preauthorized non-VA medical care, they are allowed to pick a non-VA medical provider of their choice. In some instances, a Veteran may request assistance from VA to help them find a provider. When requested, the VAMC may provide the Veteran a list of providers with whom VA has worked.

Question 9: How many VHA employees work official time 100% of the time?

VA Response: Of VHA's approximately 288,000 employees, there are about 250 union representatives on 100 percent official time – less than 1 percent.

Question 10: Of the employees who are on 100% official time, do any of their positions of record reflect positions the VA is currently seeking to fill, "hard to fill" positions, or positions which the VA has a critical need to fill? Could this result in any service disruptions to veterans?

VA Response: In some cases, union representatives occupy hard-to-fill positions. Employees in hard-to-fill positions are not precluded from becoming union representatives because the Federal Service Labor-Management Relations Statute does not permit the Government to deny a union representative official time on the basis that his or her position is hard-to-fill.

Question 11: Have any personnel assigned to mental health treatment for our veterans been on 100% official time over the past 10 years? How might official time affect VA's efforts to treat our veterans?

VA Response: VA is unable to report whether any personnel assigned to mental health treatment have been on 100 percent official time over the last 10 years as VA has not and currently does not compile this information. VA has no means by which it can easily retrieve or collect this information.

**Post-Hearing Questions for the Record
Submitted to The Honorable Robert A. Petzel
from Senator Mark Begich**

Question 1: As you work toward coordinating telehealth between agencies, what definition of “telehealth” do you use? Does this have any limitations? How does the definition of “telehealth” at each agency jive with state definitions?

VA Response: The Department of Veterans Affairs (VA) uses telehealth to increase access to care for Veterans and works across Federal agencies at the local and national level to achieve this. VA participates in the U.S. Cross Federal Workgroup on Telehealth (FedTel), which is a multi-agency telehealth collaboration group, coordinated by the Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS). HRSA defines telehealth as “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.” The HRSA definition is compatible with VA’s operational definition of telehealth, which is “the use of information and telecommunication technologies to provide clinical care in circumstances where distance separates those receiving services and those providing services.” VA uses the term telehealth because it provides care at a distance in over 40 clinical specialties by clinicians from different professional groups, and it encompasses clinician education.

The definition of telehealth varies across states. The contrast between VA’s definition of telehealth, and that of state definitions, in relation to developing and coordinating telehealth, mainly relates to the term “telemedicine.” VA also defines the term telemedicine (a subset of telehealth) as “the provision of care by a licensed independent practitioner that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the practitioner and the patient.” States vary widely in their definition of telemedicine and have differing approaches to state licensure of clinicians involved in using it. As a national system this state level variability does not affect VA’s ability to use telehealth.

Question 2: Tell me how else the agencies are collaborating, generally amongst agencies to promote better delivery of care.

VA Response: There are many examples of VA partnerships and collaborations with Federal and private rural health care providers, rural health clinics, as well as non-profit institutions across the country to increase access for rural Veterans and to provide education and training for rural VA and non-VA health care professionals who provide care to rural Veterans. Some examples of these partnerships/collaborations are cited below.

Partnerships with Non-Profits

- VA/Area Health Education Center (AHEC) Collaboration. There are a number of VA/AHEC partnerships throughout the country that address health care

workforce development through training and education. AHECs are non-profit organizations that serve local communities by working to improve the quality of the primary care workforce in rural areas. In the past year, over 50 VA/AHEC collaborations have occurred across the country. These VA/AHEC partnerships most commonly involve continuing health care education courses and other educational initiatives in the community, but they also include the AHEC Veterans' Mental Health Project and operations in VA community based outpatient clinics.

- VA/Senior Living Independently for the Elderly (SeniorLIFE) Collaboration. The VA Pittsburgh Health Care System is partnering with the SeniorLIFE Washington Program to provide an alternative to institutionalization for rural senior Veterans. This program delivers integrated, interdisciplinary team care for aged 55+ Veterans who require assistance to remain in their own homes. SeniorLIFE provides in-home medical and nursing care, skilled therapists, adult day health care, and transportation among other services.
- Dementia Care Partnership. The Telephone Assisted Dementia Outreach Clinic at the Tuscaloosa VA Medical Center (VAMC) is partnering with the Agency on Aging of West Alabama to identify community and VA resources for rural Veterans with dementia, their caregivers, and for Veterans who care for family members with dementia. The goals of this partnership include identifying Veterans in rural areas that may benefit from VA services and connecting family caregivers and Veterans caring for loved ones with dementia to community supports such as local Alzheimer's caregiver support groups or other resources that could augment care already received within VA.
- Certified Nursing Assistant Training. The VHA Office of Rural Health (ORH) Veterans Rural Health Resource Center – Eastern Region is collaborating with the newly established Northeast Telehealth Resource Center and Medical Care Development, Inc., a Maine health care not-for-profit, to develop a telehealth training curriculum for Certified Nursing Assistants (CNA). The telehealth course will be offered to graduates of the CNA course conducted by the Augusta Adult and Community Education program in collaboration with the VA Maine Healthcare System, in Togus. CNAs are widely used in community home health care and nursing home settings where rural Veterans receive non-VA health care services via telehealth.

Partnerships with the Department of Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS) Critical Access Hospitals (CAH) and Community Clinics

- Rural Health Information Exchange (HIE). Up to 70 percent of Veteran patients use both VA and non-VA providers to meet their health care needs. HIE among those providers is necessary to achieve the best possible coordination of care, reduce or eliminate therapeutic or diagnostic duplication,

and ensure patient safety. ORH is working in partnership with the HHS Office of the National Coordinator in piloting a program in at least ten rural communities in four states to facilitate HIE between VA and HHS/CMS CAHs, and their associated clinics.

- Rural Behavioral Health Telehealth Partnership. HRSA funds a partnership between the Affiliated Service Providers of Indiana, Inc., the Richard L. Roudebush VAMC in Indianapolis and the Indiana Rural Health Association to increase access to behavioral health services provided by the VAMC to five rural Indiana communities. The partnership placed telehealth equipment in each of these five mental health care sites and schedules Veterans for appointments with VA mental health providers. The sessions use secure Clinical VideoTelehealth to deliver care from the VAMC to Veterans at the community mental health care sites.
- Rural Positron Emission Tomography - Computed Tomography (PET/CT) Scans. The Clarksburg VAMC entered into a healthcare resources sharing agreement with a private rural hospital to purchase a PET/CT scanner for placement and operation at the United Hospital Center. This sharing agreement offers priority scheduling to Veterans and also provides services to local citizens. This opportunity benefits VA from a cost savings perspective and shares sophisticated medical technology with a rural non-VA hospital in the local community. Most importantly, this relationship has improved Veteran access to PET/CT services and rural Veterans are no longer required to travel long distances to receive this type of care.
- Rural Veteran Spinal Cord Injury (SCI) Collaboration. The VA Long Beach Healthcare System (VALBHS) SCI Center is a regional SCI Center with a commitment for outreach to rural Veterans with SCI. The VALBHS regularly sees rural SCI patients in local VA facilities, and uses telehealth to treat patients in private rural clinics in Montana.

Additionally, VA has taken a number of steps to integrate Federal efforts in the delivery of services to homeless Veterans. VA understands that ending Veteran homelessness is an incredibly complicated task that requires assistance from a number of Federal partners. Although nearly all VA homeless programs include some Federal interagency collaboration, the most pronounced efforts of interagency collaboration are found in the Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) Program, HUD-VA Homeless Veterans Prevention Demonstration, Supportive Services for Veteran Families (SSVF) Program, and Veterans Justice Programs (VJP).

VA and HUD work collaboratively on the HUD-VASH Program where HUD provides permanent housing through a Section 8 Housing Choice voucher paired with VA wraparound case management services. From the outset of the HUD-VASH Program, VA and HUD have worked closely to determine voucher allocations.

As VA works to end Veteran homelessness, VA and HUD are co-facilitating Veteran “boot camps” to improve homeless Veteran services in select communities. These boot camps bring HUD and VA staff along with providers from target communities experiencing high rates of homelessness among Veterans. Their goal is to end Veteran homelessness through better coordination, adoption of best practices, and by maximizing the effectiveness of all available resources. VA staff and HUD staff work closely together on a frequent basis. VA and HUD have jointly produced Satellite Broadcasts and other virtual live meetings using different technologies to ensure that information is shared with VA field staff, HUD field office staff, and Public Housing Authorities. HUD maintains a Web site for the HUD-VASH Program. VA and HUD also assist with questions from the field, resolve difficulties between VA field staff and Public Housing Authority staff (usually related to process concerns), and jointly provide new information to the field (such as a letter from both Departments). Furthermore, although VA and HUD have always shared data, VA and HUD are making a concerted effort to improve data sharing. To promote effective data sharing, VA and HUD developed a data sharing agreement to provide Veteran identifying information to facilitate HUD’s efforts to verify their data individual by individual. This data sharing collaboration makes VA and HUD data more accurate, equipping Federal officials with the tools to make informed, strategic decisions regarding VA’s efforts to end Veteran homelessness.

VA also collaborates with HUD, Department of Labor (DOL), and local community agencies through the HUD-VA Veterans Homeless Prevention Demonstration (VHPD). Through VHPD, homeless and at-risk Veterans in five communities receive support in the form of housing assistance and supportive services to prevent them and their families from becoming homeless, or reduce the length of time they and their families are homeless. VHPD provides services in the following locations: MacDill Air Force Base in Tampa, Florida; Camp Pendleton in San Diego, California; Fort Hood in Killeen, Texas; Fort Drum in Watertown, New York; and Joint Base Lewis-McChord near Tacoma, Washington. In Fiscal Year (FY) 2012, VHPD provided services to over 730 Veteran families, of which 26 percent were female and 37 percent were Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn Veterans. In FY 2014, this three-year prevention demonstration is scheduled to conclude. The end of VHPD will not terminate services for homeless or at-risk Veterans who are still in the program at the end of FY 2014; rather, VA staff in conjunction with HUD will ensure that all currently enrolled Veteran households are stably housed or transitioned to a program that will continue to provide the required services.

The SSVF Program relies on a number of collaborative Federal partnerships to ensure that VA is effectively preventing homelessness and rapidly rehousing homeless Veterans. The SSVF Program provides supportive services grants to private non-profit organizations and consumer cooperatives to coordinate or provide supportive services for very low-income Veteran families. The SSVF Program currently has 151 operational nonprofit grantees that are involved in a number of efforts to improve agency collaboration. For example, SSVF Program grantees are required to enter all service data into HUD’s Homeless Management Information System. Through the use of a shared data system, community agencies can better coordinate services and

understand the needs of those they serve whether they are served by VA's SSVF Program or a HUD-funded program. A common data standard also allows Federal officials to better understand the impact of homelessness on the costs and outcomes of programs serving homeless Veterans that draw from support across multiple systems. Additionally, VA and HUD recently issued joint policy guidance clarifying SSVF Program participants' eligibility for HUD-funded homeless programs.

In addition to HUD, VA's SSVF Program collaborates with a number of Federal agencies. SSVF grantees utilize a payment system designed and operated by HHS' Division of Payment Management. The SSVF Program and the Department of Labor's Homeless Veteran Reintegration Program (HVRP) have participated in training grantees from their respective programs and encourage cooperation between the SSVF Program and HVRP by including collaboration as scoring factors in recent Notices of Funding Availability (NOFA).

VA also has worked with the Department of Justice (DOJ) to strengthen the SSVF Program's emphasis on the importance of legal services for homeless and at-risk Veteran families. This emphasis was reflected in the SSVF Program's most recent NOFA where it states, "Grantees are encouraged to provide, or assist participants in obtaining, legal services relevant to issues that interfere with the participants' ability to obtain or retain permanent housing." DOJ has in turn worked with local legal providers to encourage partnering with SSVF Program providers. VA regularly offers training to SSVF Program grantees on how to access mainstream resources from other agencies to strengthen services delivery and improve outcomes. This coordination is further reinforced by grant opportunities where applicants for SSVF Program funding must demonstrate plans for community collaboration.

VA also collaborates extensively with Federal partners through VHA's VJP. For example, the Federal Interagency Reentry Council, chaired by Attorney General Holder, convenes agencies whose programs have an impact on individuals reentering their communities after incarceration. VJP has provided VA's staff-level representatives to the Council since its inception in 2011. The Legal Aid Interagency Roundtable (LAIR) is another productive interagency collaboration in which VJP participates. A joint effort by the White House Domestic Policy Council and DOJ's Access to Justice program, LAIR helps Federal agencies use existing resources and authorities to facilitate access to legal aid for the populations they serve. Access to Justice staff provide ongoing technical assistance to VA as it develops partnerships with providers of pro bono legal services, 42 of which are now serving Veterans in VA medical centers around the country. Finally, VJP staff work closely with the Department of Defense to plan for implementation of its pilot program, Service Member Justice Outreach (SMJO). Modeled on VA's Veterans Justice Outreach program, SMJO is intended to enhance access to needed mental health services for Servicemembers facing military discipline.

Finally, VA is leveraging its relationship with the United States Interagency Council on Homelessness (USICH) and other strategic partners to collaborate with multiple Federal agencies to meet the varied and complex needs of Veterans experiencing

homelessness. Currently, through an initiative entitled Veterans Access to Mainstream Benefits Plan, VA is partnering with nine Federal agencies to provide a multitude of services including but not limited to: providing affordable housing, both in urban and rural settings; connecting Veterans to social security benefits for those Veterans who are disabled; improving employment opportunities for Veterans willing and able to work; improving local transportation access and options for Veterans and their families; making sure Veterans' children have access to early care and education; and sharing data regarding returning Servicemembers who may be at-risk of homelessness. Through this collaboration, Veterans experiencing homelessness will have access to a comprehensive array of services provided by VA and its Federal partners.

Question 3: I have been asking this since I have been here, it seems that the federal government should be looking more closely at one reimbursement rate; this is something I asked for during the debate of the Affordable Care Act with the Alaska Health Care Federal Task Force I created. Is there any movement towards a more uniform rate?

VA Response: VHA hosted representatives from several federal agencies including Centers for Medicare and Medicaid Services (CMS) and the DoD in the fall of 2011. The purpose of this meeting was to discuss the possibility of creating a single Federal blended rate for health care services in the state of Alaska. While these interagency efforts have not continued since that meeting, VA has continued to evaluate changes to existing regulations that would result in VA Alaska payment rates becoming more standardized with the rates currently used by TRICARE.

In addition, VA has entered into reimbursement agreements with numerous Alaska Tribal Health Programs to increase access to care for Veterans residing in Alaska.

Question 4: In your testimony you talk about the struggle to hire psychiatrists. It has come to my attention the VA Psychiatrists are underpaid because they are in the wrong table for base pay (lowest pay table). Is this the case and is the VA paying wages comparable with other federal healthcare entities?

VA Response: Public Law 108-445 allows VA to construct a pay system that outlines specialty and administrative pay ranges, allowing for the enhanced recruitment and retention of VA physicians and dentists. The Physician and Dentist Pay Steering Committee reviews numerous national data sources that reflect compensation values of each physician specialty or assignment. The determination to place the psychiatry specialty on the Physician and Dentist Pay Table 1 with a salary range of \$97,987-\$195,000 was based on a thorough analysis of comparable national salary data.

Currently VA has seven (7) pay tables (attached) for physicians and dentists. The physician specialties are grouped into five clinical pay ranges (Pay table 1-4 & 7), that reflect comparable complexity in salary. Two additional pay ranges apply to VHA Chiefs of Staff (Pay Table 5) and physicians and dentists in executive level administrative assignments at the facility, network, or headquarters level (Pay Table 6).



Final Approved Pay Ranges For Physician

VA identified and utilized salary survey data sources which most closely represent VA comparability in the areas of psychiatry practice setting, employment environment, and hospital/health care system. The national salary data for Psychiatrists from the 2011-2012 Association of American Medical Colleges (AAMC), Hospital & Healthcare Compensation Service (HHCS), Medical Group Management Association (MGMA), and Sullivan Cotter & Associates (SCA) are as follows:

- AAMC reports Professor level equivalent salary of \$239,900
- MGMA reports Mean level equivalent salary of \$214,327
- HHCS reports Mean level equivalent salary of \$188,375
- SCA reports Mean level equivalent salary of \$189,426
- VA reports Mean level equivalent salary at \$183,213

After careful analysis of these national salary data, in May 2012, the Under Secretary for Health approved a blanket exception for psychiatry for Pay Table 1, Tier 1 from \$97,987-\$195,000 to a maximum amount of \$250,000; this exception allows requested increases to the Pay Table 1, Tier 1 range to be approved at the VISN level, instead of centrally, thereby providing a broader, more competitive salary for potential recruitment and greater retention of psychiatrists. This exception to increase psychiatry up to \$250,000 allows VA to be competitive for the recruitment of psychiatrists to provide mental health services to a greater number of patients in multiple locations including medically underserved areas. Along with the increase to a maximum of \$250,000, VA has implemented an aggressive, multi-faceted, sustained national marketing and outreach campaign for psychiatry to include targeted recruitment to rural and highly rural markets.

Question 5: I understand that the Department is about to embark on a new contract care initiative, "PC3" (Patient-Centered Community Care) that will be far greater in scope than the Project HERO and Project ARCH pilots. Given that PC3 will cover the entire VA health care system, I want to make sure that some of the concerns surrounding HERO and ARCH, as well as PC3 are addressed before awards are made to contractors. Why did the Department decide to expand these pilots to a national scope rather than expand its in-house capacity to address rural health care needs through tools already in place such as fee basis, telehealth, telemental health, recruitment and retention incentives for VA primary care providers and psychiatrists who are in short supply in many rural VA facilities, as well as the many activities of the Office of Rural Health such as Rural Resource Centers and VISN rural consultants?

VA Response: Project HERO was a 5+ year pilot project in four Veterans Integrated Service Networks (VISN) to test approaches for purchasing care from community providers through contracts that implement operational standards and require high

quality clinical services, medical documentation sharing, and timely access to care (the dental contract was in place from January 2008 through September 2012; the medical contract ran from January 2008 through March 2013). Project Access Received Closer to Home (ARCH) is a 3-year pilot program to evaluate how to improve access to quality health care for rural and highly rural Veterans by providing these services closer to where they live through contractual agreements with non-VA medical providers. PC3 is not an expansion of either pilot; rather, it incorporates lessons learned from both pilots to improve non-VA medical care. PC3 offers another option through which non-VA medical care can be purchased. PC3 is designed to work in concert with and supplement VA's internal capabilities and does not limit VA's ability to invest in internal capabilities to serve rural Veterans.

The PC3 contracts will provide inpatient and outpatient specialty care and mental health care for eligible Veterans when the local VAMC cannot readily provide the services, such as when there is a lack of available specialists, there are long wait times, or there is an extraordinary distance between the local VAMC and the Veteran's home. The contracts will include inpatient specialty care, outpatient specialty care, mental health, newborn care, and limited emergency care. The contracts will not include primary care, dental care, nursing home care, long term acute care hospitals, homemaker and home health aide services, chronic dialysis treatments, and compensation and pension examinations. The PC3 contract was awarded in September 2013.

Question 6: What steps is the Department taking to include veterans, employee representatives and other key stakeholders in the bidding and implementation phases of PC3?

VA Response:

Veterans – VA meets with Veterans Service Organizations (VSO) bi-monthly. Since June 2011, PC3 has been a recurring agenda topic for these meetings. The ongoing conversations provide an opportunity to inform VSOs of progress with PC3 and ensure they are able to provide input.

Employee Representatives – When invited, VA meets with the labor unions during their quarterly meetings. PC3 has been a standing agenda topic for these meetings since September 2011.

Industry – VA hosted Industry Days for any interested stakeholders to attend. The Industry Days included a presentation and the opportunity for interested stakeholders to ask questions and meet one-on-one with VA.

- Minneapolis, Minnesota – November 17-18, 2011
- Atlanta, Georgia – November 29-30, 2011
- Portland, Oregon – December 14-15, 2011

In addition, VA held two conference calls with Industry (January 10 and May 3, 2013) and provided the following opportunities for input/communication:

- Issued a Request for Information (RFI) that was open for any organization to respond (November 14, 2011).
- Issued a draft Request for Proposal (RFP) that included opportunities to submit questions (October 10, 2012).
- Responded to questions on the RFP, which included five rounds of questions (February 11, February 26, March 18, April 26, and May 7, 2013).
- Provided an e-mail address to the public, Congressional staff, and VSOs to allow any interested party to contact the Contracting Officer directly.
- Placed interested parties who registered through FedBizOpps or contacted the Contracting Officer on a list to receive e-mail announcements with acquisition updates.

Congress – VA had the following communications with Congressional members and staff:

- Briefed the House and Senate Veterans Affairs Committees, Senate Appropriations Committee, Senate Budget Committee, and House Appropriations Committee.
- Testified at hearings for the House Veterans Affairs Committee and its Health Subcommittee.
- Briefed individual Members of the House and Senate.
- Provided Non-VA Medical Care 101 training for House and Senate (non-Committee) staff, which included PC3.

Question 7: What actions has the Department taken to ensure that smaller providers who have historically contracted directly with individual medical facilities will be able to compete on a level playing field for the five regional contracts that PC3 will award?

VA Response: Current contracts will remain in place until the period of performance is complete. To ensure that any other contracts provide definitive benefits above and beyond those offered by PC3, future contracts for services covered under PC3 will be reviewed and approved prior to solicitation. Contracts for staffing within VAMCs to provide care internally are not impacted by this approach.

PC3 offerors must be able to provide all services stated in the RFP to be considered for a contract award. Those interested parties unable to meet these requirements were encouraged to partner with other companies.

Question 8: When do you expect to make these awards? Why has there been a five month delay in making these awards? (First solicitation posted December 2012).

VA Response: The Request for Proposal (RFP) was released in December 2012. After receiving and evaluating the proposals, the amended RFP was issued on April 26,

2013 and industry submitted their proposals on May 28, 2013. On September 4, 2013, the contracts were awarded, with a 6 month implementation period.

The time period between solicitation posting and contract award occurred as a result of time allowance for offers to be submitted, solicitation amendments which were necessitated by new ideas and comments from stakeholders and industry to ensure the best product for our Veterans and VA, evaluation of proposals submitted, exchanges with offerors, submission of revised final proposals, and final contract administration actions (e.g., responsibility determinations).

Question 9: Will there be uniform national guidelines in place for assigning veterans to the networks of non-VA providers that will be established under PC3? What type of oversight is planned to ensure that referrals of veterans to non-VA providers will comply with the statutory requirements that non-VA care will only be utilized when it is not available within the VA?

VA Response: VA will utilize the following guidelines for purchasing care when a VAMC cannot provide it in-house.

- When a VAMC cannot provide the needed care in-house or the care is not feasibly available to the Veteran, VAMCs will first look to provide specialty care in-house or at another VAMC.
- When not feasible to provide the care in-house (that is, within the VA health care system), the VAMC will consider its options for purchasing the care. Consideration will first be given to the availability of sharing agreements with DoD or with Academic Affiliates under VA Directive 1663.
- If none, the VAMC will obtain the care through local contracts (if they exist and if they prove definitive benefits above and beyond PC3 contracts).
- Once these options are ruled out as not viable, the VAMC will purchase care through the PC3 contracts.

Local VAMCs are responsible for tracking their usage of non-VA medical care through various means. VA's Chief Business Office for Purchased Care (CBOPC) will monitor contract usage and work with VAMCs if anything is out of the norm. Finally, the VA Office of Inspector General conducts oversight of contract usage.

**Post-Hearing Questions for the Record
Submitted to The Honorable Robert A. Petzel
From Senator Heidi Heitkamp**

One of the challenges in rural areas like North Dakota is that many veterans live considerable distances from VA hospitals. While the VA has worked to address access to care through the establishment of clinics, I am interested in what additional steps could be taken to improve access to health services for veterans in rural communities.

Question 1: What steps are being taken by the VA to integrate care for veterans into local health care systems?

VA Response: Fargo Department of Veterans Affairs Health Care System (VAHCS) works proactively with the local and regional health care systems. For example, Veterans Integrated Service Network 23 mental health and homeless leadership, along with Fargo VAHCS staff, attended the Homeless Continuum of Care for North Dakota in June 2013. These meetings serve as a means to identify gaps in mental health services with VA as an active partner in these discussions. In May 2013, several members of the Fargo VAHCS team attended the Substance Abuse and Mental Health Services Administration policy academy located in Baltimore, Maryland for training to identify priorities and establish strategies to improve services for North Dakota Veterans, Servicemembers, and their families. We are also actively working with Indian Health Service (IHS) as part of the VA-IHS Reimbursement Agreement to pay for direct care services provided to eligible American Indian/Alaskan Native (AI/AN) Veterans at IHS clinics and hospitals. This gives AI/AN Veterans another option to receive care closer to home and in an IHS-managed clinic if preferred.

In addition, non-VA care may be approved for Veterans in the local community when VA is not capable of furnishing the care or service required. Outreach activities for Veterans located in rural areas, on Native American Reservations, or who are homeless, occur year round. These activities allow Veterans who may not otherwise be able to access health care benefits, to enroll, make appointments, ask questions, and receive education regarding health care benefits. VA continues to expand contracting and partnerships with local agencies and facilities.

Question 2: What could be done to enhance telehealth services to meet the needs?

VA Response: To meet the needs of Veterans, Fargo VAHCS is expanding same-day access, via telehealth, through our primary care-mental health integration (PC-MHI) program. Tele-psychiatry and telehealth are examples of services Fargo VAHCS implemented to increase access care to Veterans in rural areas in North Dakota. Services provided include evaluation and diagnostic assessment, medication management, evidence-based psychotherapies, supportive therapies, posttraumatic stress disorder groups, behavioral health coordinator groups, and individual sessions focused on education and disease management.

VA is taking further steps to extend access, beyond its established clinics, through the use of secure clinical videoconferencing with Veterans at home in rural communities. The main barrier to VA providing telehealth services to serve Veterans in rural communities relates to services into homes and local communities where there are telecommunications connectivity concerns.

Question 3: Can you please provide a status update on efforts to open the VA clinic in Devils Lake, North Dakota?

VA Response: On September 26, 2013, VA awarded a lease for space and construction of the VA Primary Outpatient and Telehealth Clinic (POTC) in Devils Lake, North Dakota to Mercy Hospital, 1031 7th St. NE, Devils Lake, North Dakota. The POTC will provide one-half day telehealth services with a part-time physician and on-site staffing by nurses to allow Veterans to be seen by a health care professional 5 days a week. Direct access to specialists at the Fargo VAHCS will be available through telehealth. The clinic is expected to open in early Spring 2014.

The Devils Lake POTC will offer an opportunity for community collaboration on clinic space, STAT laboratory and x-ray studies, short-term pharmaceutical needs, and the potential for development of a clinical Rural Telehealth Practicum. VA currently plans for the clinic to be open 5 days, for a total of 20 hours a week, with an increase in hours as workload and demand dictate. The clinic may also afford an opportunity to consider interagency agreements or contracts, as appropriate with IHS or a North Dakota technical college or university nursing program to provide an innovative telehealth practicum in rural health care.

**Post-Hearing Questions for the Record
Submitted to Dr. Roubideaux
Indian Health Service**

**“Improving Federal Health Care in Rural America”
May 23, 2013**

Senator Jon Tester

- 1. Does Indian Health Services (IHS) collect data on how many of the health care providers in its facilities are members of the tribe they serve? If so, what do these numbers tell us?**

Answer: The Indian Health Service does not collect information on the tribal membership of its providers as a part of its human resources management system or in the provider data present in its medical record systems. While some AI/AN health professionals include in their career goals a wish to return to their own Tribal communities, some also choose to work elsewhere.

- 2. Can you highlight some of the efforts underway by IHS to recruit tribal members? Do you have programs or formal relationships with tribal colleges and medical schools to help train your workforce?**

Answer: IHS has adopted several recruiting strategies intended to recruit tribal members. The IHS Health Professions Scholarships provide support to American Indian and Alaska Native (AI/AN) students in health professions training programs in exchange for service in Indian communities. The Indian Health Professions programs offer grant funding priority to universities that train AI/AN nurses and psychologists through the Indians into Nursing and Indians into Psychology grants. Efforts to train the existing workforce are conducted at the Area and local levels. Several IHS Areas and local facilities have agreements with local tribal colleges to provide training for local staff. In addition, hiring activities are conducted in accordance with statutory requirements for Indian preference in hiring decisions, which helps promote hiring of qualified AI/ANs and strengthens Federal support of Self-Determination for Tribes in health care for their community. 25 U.S.C. § 472

- 3. I appreciate all of your work in recent years to negotiate and finalize agreements with the VA to enhance care for tribal veterans. Under these agreements, the VA will reimburse IHS for direct care provided to eligible veterans receiving services from IHS. Can you provide an update on the implementation of these agreements at the national and local levels? Have you encountered any specific challenges?**

Answer: For some American Indian and Alaska Native (AI/AN) Veterans, the complexity of navigating two health care systems may prevent optimal use of the Federally-funded health services for which they are eligible. VA and IHS continue to

work together to address the input we receive from Tribes and to improve services to AI/AN Veterans.

IHS and VA signed the IHS VA National Reimbursement Agreement in December 2012 and are making progress implementing this agreement at Federal facilities in the Indian health system:

- As of May 2013, Implementation Plans were finalized for the ten Phase I sites and all ten sites began billing and awaiting payment from the VA.
- The VA approved and installed its payment structure (costs center) at the Veterans Integrated Service Network (VISN) 20 Network Payment Center. All health care claims will be processed at one VA location.
- The IHS/VA implementation team is providing “one on one” training to all sites to provide them with process and system training to submit clean claims to the VA.
- Various IHS/VA workgroup discussions occur weekly via conference calls to coordinate, monitor and implement billing and collection activities. In April 2013, IHS, including both Headquarters and the Area Office, and VA met in the Portland Area. Both agencies worked directly at VA’s processing center, testing processing claims.
- IHS has dedicated personnel to work with VA on this activity and has direct communication with IHS Federal facilities and the appropriate VA VISN. IHS staff are assigned at the local level to work with VA and patients to assist eligible AI/AN Veterans in enrolling in the VA health care system and educate them on the process and benefits available to the patients. IHS HQ is in the process of coordinating a National Partnership Training which will include training sessions focusing on education on VA enrollment and eligibility processing for business office staff.
- Seventy one IHS sites are targeted for implementation after the completion of the initial Phase. An implementation plan template was agreed on and finalized by IHS and VA.
- The IHS and VA staff are working well together and making good progress on implementation of the reimbursement agreement. There have been no major challenges during the implementation phase.

**Post-Hearing Questions for the Record
Submitted to Dr. Roubideaux
Indian Health Service**

**“Improving Federal Health Care in Rural America”
May 23, 2013**

Senator Heidi Heitkamp

There has been a great deal of attention to the crisis in the Northern Plains with regard to child safety as highlighted by the recent child protection/social service challenges on the Spirit Lake reservation in North Dakota.

- **What is IHS doing to respond to this crisis in terms of data-gathering and administrative, logistic, and clinical interventions?**

Answer: The IHS national efforts to effectively address this public health problem include professionals in the IHS working in collaboration with communities, law enforcement, social services, and other entities to respond to, support, and treat child victims of maltreatment (abuse and/or neglect). IHS provides direct services, advocacy, and interagency coordination; participates in multidisciplinary child protection teams in the Area; and collaborates with other Federal agencies to provide services to AI/AN children and families. The Domestic Violence Prevention Initiative (DVPI), comprised of 65 projects nationwide, is aimed at the prevention of family violence, child abuse and neglect. The IHS launched its Tribal Forensic Healthcare Training Project in June 2013 which provides both web-based and live, in-person training for: Pediatric Sexual Abuse Examiner and Pediatric Sexual Abuse Clinical Skills, among others. Two monthly webinar series are offered - one on the topic of child maltreatment. The IHS Child Maltreatment Policy is currently being revised to outline uniform clinical care guidelines that comprehensively address the identification, evaluation, management, and prevention of suspected child abuse and/or neglect.

The Aberdeen Area (AA) developed a policy on the reporting and tracking of suspected child abuse and neglect. This is implemented at the Spirit Lake Health Center. The AA will be working with the Information Technology (IT) program to develop an electronic method of collecting this data. Clinical intervention has been focused on providing behavioral health care for children and families through the IHS behavioral health programs. The Spirit Lake IHS works in consultation with Tribal Programs and multidisciplinary teams to ensure patients receive services. Training on childhood issues related to safety have been conducted during the Annual Behavioral Health Conference (April 2013), and will be addressed in the upcoming Bullying Conference (July 2013) and in the Takoja Niwiciyape; Giving Life to the Grandchildren training (October 2013). Prevention activities are carried out within the Tribal communities through presentations, trainings, and health fairs. IHS also provides funding for tribal projects aimed at child safety such as the American Indian Life Skills Curriculum.

IHS has been working to address the issues in Spirit Lake in the areas of more effective reporting, ensuring adequate access to treatment, and continued partnership with the Tribe and community. Child Abuse reporting training occurred in October 2012 to employees at the Spirit Lake Health Center (SLHC). Policies and Procedures were updated to specify the system for reporting and tracking of the reports from the SLHC. For 2013, 24 reports of suspected abuse were made to the BIA Social Services (SS) and 11 referrals were received from BIA SS to the Spirit Lake Behavioral Health Department. The Director of Behavioral Health position was filled in December 2012 with a clinical psychologist. Tele-psychiatry is being added to increase access. The Area Division of Behavioral Health reviewed 256 files that were transferred from the Tribal SS to the BIA SS to give an indication of any referrals that may be warranted. Due to the age of the case files no referrals were identified at that time. Current referrals will be made directly to the SLHC. The SLHC Behavioral Health staff are members of the Child Protection Team to further facilitate referrals and promote case management. The SLHC staff attends the Spirit Lake Tribal Coalition meetings between the Tribe, IHS, BIA and County Social Services. SLHC Behavioral Health Staff have engaged in education efforts with the BIA and Tribal community on education about abuse issues and mental health care.

Native Americans are represented in the military in relatively higher percentage than any other ethnic group. Hence, many Native combat veterans are and will be returning to their tribes and communities.

- **What steps has IHS taken, perhaps in conjunction with the VA, to address the mental health needs of these veterans and their families?**

Answer: The IHS and VA responded to tribal requests for increased collaboration and signed a Memorandum of Understanding (MOU) in October 2010 to improve coordination of services for American Indian and Alaska Native veterans eligible for the VA and IHS. The VA and IHS identified key areas for collaboration in the MOU. Joint working groups have been established to specifically address key strategies to improve the health status of American Indian/Alaska Native (AI/AN) Veterans through the delivery of accessible and quality health services. One of the workgroups is focusing on mental health issues and its accomplishments include the following:

Suicide Prevention: Increased collaboration/outreach activities between the IHS Areas and VA suicide prevention coordinators. Seven of 12 Areas have met with suicide prevention coordinators. This activity is two-fold:

- Monitor and increase outreach activities (44 specific activities across all Areas, with over 3,000 participants);
- Continue to develop community capacity to recognize and respond to someone at risk for suicide.

Post-Traumatic Stress Disorder (PTSD):

- Produced a DVD training module on PTSD and American Indian Veterans to address services and begin collaborations at the local level to increase communication between agencies. The DVD will be disseminated to IHS Tribal and Federal sites for training of clinicians beginning FY 2014.
- All information is also shared between the PTSD and Suicide Prevention Workgroups to ensure outreach activities are occurring on American Indian and Alaska Native Reservations. Resources and information is sent to IHS Meth Suicide Prevention Initiative (MSPI) and Domestic Violence Prevention Initiative (DVPI) Project recipients to ensure broad range coverage.
- The IHS Tele-behavioral Health Center of Excellence provided the following education events to further increase knowledge and provide training in PTSD and American Indian Veterans to IHS and Tribal clinicians:
 - 02/02/2012 Assessing and Treating PTSD in Primary Care
 - 10/26/2012 PTSD Native American Veterans
 - 02/22/2012 Historical Trauma and Native Men: A Focus on Veterans Part I
 - 03/08/2013 Historical Trauma and Native Men: A Focus on Veterans Part II

As you know, the University of North Dakota is home to several programs, including Indians into Medicine (INMED), Recruitment/Retention of American Indians into Nursing (RAIN) and the Indians Into Psychology Doctoral Education (INPSYDE) Program, which work to recruit and train American Indians in the fields of medicine, nursing and psychology. In particular, the Indians into Medicine program is a viable means to address the shortage of health care providers in tribal communities. However, funding for this and the other programs has remained flat for a number of years.

- **What can IHS do to further strengthen these programs?**

Answer: IHS plans to strengthen its partnerships with the INMED Director, presidents of local universities and colleges, Tribal Leaders and the INMED board. The Aberdeen Area (AA) Recruitment Office plans to establish stronger ties with the INMED program by holding two on-site visits annually, one in the spring and one in the fall. This will allow recruitment efforts to be continuous. In addition, the Area plans to share data with students regarding vacancies, set up student rotations at our facilities for summer jobs, bring in former graduates who currently serve in the Aberdeen Area for inspirational purposes, and be involved with student and leadership activities.

The AA Recruitment Office plans to encourage students to shadow staff at the Service Units to foster interest in the field of health care. Information regarding the IHS loan repayment program will also be shared with students at the INMED Program.

**Post-Hearing Questions for the Record
Submitted to Dr. Roubideaux
Indian Health Service**

**“Improving Federal Health Care in Rural America”
May 23, 2013**

Senator Mark Begich

- 1. As you work toward coordinating telehealth between agencies, what definition of “telehealth” do you use? Does this have any limitations? How does the definition of “telehealth” at each agency jive with state definitions?**

Answer: “Telemedicine,” “telehealth,” and “e-health” are terms used interchangeably by many individuals, states and healthcare systems. The American Telemedicine Association (ATA) provides the most authoritative reference with respect to these terms, and most subject matter experts use the ATA’s definitions.¹

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology.

Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telemedicine and often no separate coding required for billing of remote services. ATA has historically considered telemedicine and telehealth to be interchangeable terms, encompassing a wide definition of remote healthcare. Patient consultations via video conferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education, consumer-focused wireless applications and nursing call centers, among other applications, are all considered part of telemedicine and telehealth.

While the term “telehealth” is sometimes used to refer to a broader definition of remote healthcare that does not always involve clinical services, ATA uses the terms in the same way one would refer to medicine or health in the common vernacular. Telemedicine is closely aligned with the term health information technology (health IT). However, health IT more commonly refers to electronic medical records and related information systems while telemedicine refers to the actual delivery of remote clinical services using technology.

- 2. Tell me how else the agencies are collaborating, generally amongst agencies to promote better delivery of care.**

¹ www.americantelemed.org/practice/nomenclature.

Answer: Staffs at the Department of Veterans Affairs (VA) and the Indian Health Service (IHS) have been working on twelve strategic objectives to improve American Indian/Alaska Native Veteran's health services and coordination of care under the VA-IHS Memorandum of Understanding (MOU) signed in October 2010.

For example, Strategic Objectives 2 and 7 of the MOU focus on coordination of care, and sharing programs and services. The joint efforts of IHS and VA target specific strategies designed to improve delivery of accessible and quality health services. Specific accomplishments include:

Shared Facilities/Services:

- The Chinle VA/IHS partnership is operational and providing medical and mental health services within an IHS facility located within the Navajo Nation in Arizona.
- Cherokee, NC Indian Hospital has made a satellite space available for Home Based Primary Care Team on the reservation; VA staffs participate in medical staff meetings/other meetings to promote working relationships between both systems.
- Warm Springs Service Unit in OR is developing a system for IHS providers to have access to review VA medical Record at the Portland VA of shared patients.

Suicide Prevention:

- Increased collaboration/outreach activities between the IHS Areas and VA suicide prevention coordinators. Seven of 12 Areas have met with suicide prevention coordinators. This activity is two-fold:
- Monitor and increase outreach activities (44 specific activities across all Areas, with over 3,000 participants)
- Continue to develop community capacity to recognize and respond to someone at risk for suicide.

Post-Traumatic Stress Disorder:

- Produced a DVD training on PTSD and American Indian Veterans to address services and begin collaborations at the local level to increase communication between agencies. The DVD will be disseminated via Adobe Connection to IHS Tribal and Federal sites for training of clinicians beginning FY 2014.
- All information is also shared between the PTSD and Suicide Prevention Workgroups to ensure outreach activities are occurring on American Indian and Alaska Native Reservations. Resources and information is sent to IHS MSPI and DVPI Project recipients to ensure broad range coverage.
- The IHS Telebehavioral Health Center of Excellence provided the following education events to further increase knowledge and provide training in PTSD and American Indian Veterans to IHS and Tribal clinicians:
 - 02/02/2012 – Assessing and Treating PTSD in Primary Care
 - 10/26/2012 – PTSD in Native American Veterans
 - 02/22/2012 – Historical Trauma and Native Men: A Focus on Veterans Part I
 - 03/08/2013 – Historical Trauma and Native Men: A Focus on Veterans Part II

Strategic Objective 3 of the MOU focuses on health IT. Major Tasks include sharing of technology; interoperability of systems; developing processes to share information on

development of applications and technologies; and developing standard language for inclusion in sharing agreements to support this collaboration. Activities include:

- Actively consulting on Electronic Health Record (EHR) Certification and Meaningful Use requirements.
- Actively consulting on Meaningful use for the Medicare and Medicaid EHR Incentive Programs for the Centers for Medicare & Medicaid Services (CMS).
- Meeting to design system changes to VistA and Resource & Patient Management System in preparation for the transition to International Classification of Diseases (ICD)-10.
- Meeting to define the scope, needs and support agreement for leveraging VA experience with bar code medication administration for its potential use in IHS and Tribal hospitals.
- Meeting regularly with VA and the Department of Defense (DoD) to plan for the integrated EHR (iEHR), for which VA, DoD, and IHS staffs are designing the EHR interface and care management functions. These activities will allow IHS and VA to share medical records securely to better coordinate care for American Indians and Alaska Native Veterans that receive care in both health care systems.
- Participating, along with VA in health information exchange through the Nationwide Health Information Network (NwHIN), which is a group of Federal agencies and private organizations that have come together to securely exchange electronic health information. NwHIN "onboarding" (process to join the Exchange) is underway in IHS and should be complete for all Federal facilities by the summer of 2013. Through NwHIN Connect, IHS and Tribal providers will be able to download summary of care documents for any VA patient (or, for that matter, any patient whose private-sector provider participates in Health Information Exchange), and vice versa. Also, as part of Meaningful Use, IHS will be adopting the Direct Exchange protocols, which will allow IHS providers to deliver patient records to any trusted entity such as a VA hospital or provider. This is scheduled for implementation in 2014.

3. **I have been asking this since I have been here, seems that the federal government should be looking more closely at one reimbursement rate; this is something I asked for during the debate of the Affordable Care Act with the Alaska Health Care Federal Task Force I created. Is there any movement towards a more uniform rate?**

Answer: The Interagency Access to Healthcare in Alaska Task Force Report dated September 17, 2010, notes these concerns and points to continued work among Medicare, TRICARE and the VHA to engage in projects to related to more common payment methods for similar services. However, we also note that the statute governing how payment rates are established and updated for each government program differs.

If a patient's healthcare needs exceed the capabilities or capacity of directly-operated IHS or Tribal programs, the patient may be referred for care purchased from private providers under the Contract Health Services (CHS)/Purchased/Referred Care (PRC) program. When referring a patient for CHS/PRC care, IHS and Tribes seek to maximize limited resources by securing the most favorable prices from private providers. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized CHS/PRC and urban Indian programs to pay no more than "Medicare-like" rates for referred services (inpatient) furnished by Medicare-participating hospitals. Under this statutory authority, IHS and Tribes

need pay no more than “Medicare-like” rates for inpatient care provided by Medicare-participating hospitals, thus establishing rate uniformity with Medicare. “Medicare-like” rates have helped to unify reimbursement rates for *inpatient* care with Medicare inpatient rates. When purchasing *outpatient* services, IHS seeks to maximize access to care for its beneficiaries by negotiating the most favorable rates possible with private providers.

Consistent with the MMA, IHS uses Medicare-like rates for inpatient care. The different payment systems in the Federal Government reflect different patient populations that have disparate needs and who receive treatment in different types of settings. For example, Medicare beneficiaries are generally aged 65 and above, and this patient population have a distinct mix of health needs and covered services that may differ from the population types paid under TRICARE or the VA systems. Additionally, the statute governing how payment rates are established and updated for each government program differs. Noting the task force report, we share an interest in payment rates that are adequate and support good access to care under all these Federal programs. We are open to suggestions from stakeholders for improving payment methods in ways that may make payment more uniform across programs.

4. **I am glad to see the IHS/VA MOU’s finally being implemented. I would like you to give me your summation of the MOUs and how we can improve them.**

Answer: Historically, Federal Memoranda of Understanding (MOUs) have been developed between Federal and/or private entities such as agencies, operating divisions, universities, and other organizations to broadly set up parameters for the entities to work together toward defined accomplishments or goals. When formulating the IHS-VA MOU in 2010, IHS and VA built upon decades of collaboration, as well as an MOU signed by the two agencies from 2003. The IHS-VA MOU outlined five goals and 12 strategic objectives.

IHS sees the MOU as an important sign of the commitment between the two agencies to improve coordination of care for American Indian and Alaska Native veterans eligible for both IHS and the VA. By establishing a structure for staff to work together on areas of interest, both agencies can track progress towards the common goal of providing healthcare to AI/AN veterans. In October 2012, at the two year anniversary of the 2010 MOU signing, the IHS and VA held a review meeting. The main finding of this review was that while progress was made on the strategic objectives, VA and IHS agreed to work on more specific outcome measures for each of the 12 strategic objectives of the MOU and will continue to assess and document progress on an annual basis.

**Post-Hearing Questions for the Record
Submitted to Tom Morris
From Senator Jon Tester**

**“Improving Federal Health Care in Rural America: Developing the Workforce and
Building Partnerships”
May 23, 2013**

Question 1

As you well know, one of the Office of Rural Health Policy’s chief areas of focus is “improving recruitment and retention of workforce in rural communities.” I know you have approached the issue innovatively and that you have launched a number of initiatives. For instance, in your testimony, you cite the positive results from the Rural Training Track program – and note that approximately 70 percent of the residents who train in this program continue to practice in rural communities. Can you share some of the lessons learned from this or similar programs? Are there any initiatives that have been particularly effective? And can they serve as a model for the VA and other agencies to address rural workforce challenges?

Answer: The Rural Training Track (RTTs) family medicine residency program is an innovative model in which the resident spends one year training in a larger facility and then the final two years in a smaller rural community setting. This exposure to rural areas helps expose residents to the benefits of rural practice and can play a key role in educating the next generation of rural physicians. Over the last three years, we’ve provided a grant to the National Rural Health Association to support the existing 24 RTTs while also working to increase student interest in these training opportunities and expand the number of RTTs nationwide. What we’ve learned is that the Rural Training Tracks are a successful model for addressing local physician workforce needs. They provide a great training experience for a resident that helps them understand the unique challenges and rewards of rural practice. By making local physicians part of the training model, they also provide career enrichment for local clinicians by making them part of the teaching experience, linking them to the formal medical education environment. We also know that almost two-thirds of the graduates of these programs stay in rural practice. Although this model has been around for more than 20 years, it has not spread widely as much of the residency infrastructure tends to be linked solely to larger hospital settings. In recent years, we’ve seen more interest in training family medicine residencies in community-based settings and we believe the RTT model is well suited to provide that. Through our grant, we have worked with more than 10 communities interested in starting new RTTs and we expect up to four new programs to earn their accreditation later this year. One of the potential factors driving this interest is that residents training in a RTT program can be counted for Medicare Graduate Medical Education (GME) payments beyond the full-time equivalent (FTE) cap for the hospital. An urban hospital with a RTT can include in its FTE count residents in the RTT in addition to the residents subject to the FTE cap for Medicare direct GME payments.

We've also seen growth in the number of students seeking to match to RTTs. In calendar year 2012, the RTTs had their highest match rate of 84 percent.

The RTT model is heavily dependent on partnering and collaboration between the parent hospital and the rural site and the RTTs that have thrived have been those that believed this was an appropriate and innovative way to train residents and help address rural workforce challenges. Some RTTs have had to close in recent years due to lack of institutional support from their parent urban hospital. Financing can also be a challenge, but new RTTs can qualify for Medicare support, which represents a step toward expanding this model in a sustainable manner. In terms of applicability of the RTT model for VA, it is important to note that VA does not have the legislative authority to grant waivers to an institution for its GME cap or to grant financial incentives to sponsoring hospitals. However, in partnership with HRSA, VA could offer its rural community-based outpatient clinics as training sites for expansion of the RTT.

Question 2

As you know, the role of rural health clinics has been critically important in states like Montana where we do not have enough primary care providers in rural and frontier communities. Can you discuss the role played by these clinics? Have workforce issues prevented us from increasing the number of these facilities?

Answer: Rural Health Clinics (RHCs) play an important role in the rural safety net and can often be the only source of primary care in a rural area. The Rural Health Clinic Act was enacted in 1977 to address the shortage of physicians practicing in rural areas by including nurse practitioners, physician assistants, and nurse midwives in their workforce. The program grew slowly in its first couple decades, but there are now about 4,000 RHCs in the United States. Most RHCs are located in a health professional shortage area (HPSA), with the rest located in a Medically Underserved Area or a Governor's designated shortage area. A recent study from the University of Southern Maine noted that 86 percent of independent RHCs offer free care or a sliding fee scale to the uninsured and that 97 percent of those surveyed were accepting new Medicaid patients.

About half of the current RHCs are independent while the other half are provider-based, meaning they are owned and operated by a rural hospital. Health care professionals working at RHCs can qualify for the HRSA State loan repayment program through the National Health Service Corps and many do take advantage of that. Other RHCs often depend on the various state-administered loan programs and J1-Visa waiver programs to help address workforce needs. Some RHCs may struggle to ensure that they have at least one nurse practitioner or physician assistant on staff, as required under statute; however, many providers continue to apply for certification under the RHC designation so there is still great interest in this program.

Question 3

In your testimony, you briefly discussed the work of the White House Rural Council to enhance the ability of federal programs to serve rural communities through the collaboration and coordination of federal agencies. Can you elaborate on the work of this Council? From a health care perspective, what have been its most significant deliverables for rural communities?

Answer: The White House Rural Council brings together over 25 Federal departments and agencies to enhance collaboration and cooperation within government to promote economic strength and quality of life in America's rural communities. The Council also has convened stakeholder meetings and summits which bring public and private organizations together to develop strategies to maximize the impact of their collective investments in rural communities. The Council's work recognizes the importance of accessible, high-quality health care to the economic strength of rural communities.

Under the leadership of the Council's Chairman, Department of Agriculture Secretary Tom Vilsack, the Council has sponsored several initiatives to enhance the Federal government's engagement with rural communities. As was mentioned during the testimony, through the work of the Council, in 2012 HRSA began a 3-year pilot program to expand eligibility for the National Health Service Corps (NHSC) Loan Repayment Program to include certain health care providers working at Critical Access Hospitals (CAHs). Already, 173 CAHs have been approved as NHSC service sites and 18 clinicians working in CAHs are receiving loan repayment support.

Much of the Council's most significant work has been creating partnerships across Federal agencies. New Memoranda of Understanding were signed between HHS and several other departments and agencies which allow these organizations to work more closely together to improve health care for all critical populations in rural communities, including veterans, as well as train and develop a diverse health information technology (IT) workforce.

In support of the Council's initiative to development of a rural health IT workforce, HHS and the Department of Labor signed a Memorandum of Understanding to link community colleges and technical colleges that support rural communities with available materials and resources to support the training of health IT professionals. HHS and the Department of Education have conducted outreach to rural community colleges to discuss federal resources available to expand training for students interested in health IT. Already, more than nine thousand students have already completed the Community College Consortia curriculum, and another four thousand are actively enrolled.

HHS and the Department of Veterans Affairs also promoted this training curriculum to rural Veterans who sought to expand their career skills, providing testing vouchers and support to rural Veterans who took the training and sought to test for basic health IT competencies. HHS is also awarding \$4.5 million in grant funding to support 10 to 15 Rural Health IT Community College Training Networks later in FY 2013.

The Council is also working on increasing access to capital for implementing and improving health IT infrastructure through a Memorandum of Understanding with the Department of Agriculture. Several Rural Development funding programs can support health care facilities as they upgrade connectivity, purchase electronic health record technology, install other necessary hardware and software, and train their employees in health IT.

**Post-Hearing Questions for the Record
Submitted to Tom Morris
From Senator Mark Begich**

**“Improving Federal Health Care in Rural America: Developing the Workforce and
Building Partnerships”
May 23, 2013**

Question 1

As you work toward coordinating telehealth between agencies, what definition of “telehealth” do you use? Does this have any limitations? How does the definition of “telehealth” at each agency jive with state definitions?

Answer: The Office for the Advancement of Telehealth, located within the Office of Rural Health Policy, defines telehealth as “the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.” Other agencies may define telehealth differently, either to more directly reflect program needs or because the definition is specified in statute.

Question 2

Tell me how else the agencies are collaborating, generally amongst agencies to promote better delivery of care.

Answer: There are a range of activities underway to better coordinate health care services. The Affordable Care Act included a number of provisions that support this effort. The Center for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) have worked closely together on a number of initiatives through the Center for Medicare and Medicaid Innovation.

HRSA and CMS are working closely together to support patient-centered medical homes in community health centers. HRSA, the Agency for Healthcare Research and Quality (AHRQ) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have worked closely with the Innovation Center in its development of the Health Care Innovation Awards. CMS and HRSA have also worked together to identify ways to reduce regulatory burden for rural health care providers and a number of provisions addressing those concerns was included in a proposed rule issued in January 2013 that is expected in the near future. In addition, HRSA met with CMS project officers and grantees to connect the HRSA Telehealth Resource Center grantees with the CMS Innovation Award Grantees to leverage the resources of each organization. To support the significant focus in the Affordable Care Act on improving health care quality and outcomes, the Department created the Partnership for Patients, a public-private initiative aimed at reducing patient harm and improving patient quality, which is administered by CMS and includes many HHS and other governmental agencies as partners who are collaborating to achieve the goals of the initiative. This includes identifying new methods of care to prevent hospital-acquired conditions while also focusing on preventing potentially preventable readmissions. The Community-Based Care Transitions program provides funding to

test models for improving care transitions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from inpatient hospitals to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measureable savings to the Medicare program. Participants in the Community-Based Care Transitions program include community-based organizations (CBOs) that provide care transition services across the continuum of care through arrangements to effectively manage transitions and report process and outcome measures on their results. The move to help eligible providers become meaningful users of electronic health records and to be able to exchange that patient information, with appropriate consent and privacy protections, along the continuum of care also involves collaboration across HHS as well as the Departments of Defense and Veterans Affairs, and the private sector, as we work toward health information exchange. The ability for clinical information to follow the patient from setting to setting is critical to improving quality and driving more efficient care.

HHS is also working to promote better delivery of care by improving access to primary care, including through the expansion of the National Health Service Corps and the Nurse Corps (formerly known as the "Nursing Education Loan Repayment Program" and "Nursing Scholarship Program" as authorized under section 846 of the Public Health Service Act). The NHSC is also collaborating with other programs in HRSA, such as the Teaching Health Center program in order to effectively increase the number of primary care providers.

Question 3

I have been asking this since I have been here, seems that the federal government should be looking more closely at one reimbursement rate; this is something I asked for during the debate of the Affordable Care Act with the Alaska Health Care Federal Task Force I created. Is there any movement towards a more uniform rate?

Answer: The different payment systems in the Federal Government reflect different patient populations that have disparate needs and who receive treatment in different types of settings. For example, Medicare beneficiaries are generally aged 65 and above, and this patient population has a distinct mix of health needs and desired services that may differ from the population types paid under TRICARE or the VA systems. Additionally, the statute governing how payment rates are established and updated for each government programs differ. That said, we note the task force's finding that Alaskan providers are interested in a uniform Federal rate.

Question 4

How successful have congressional efforts, through the Affordable Care Act, been at bolstering the National Health Service Corps (NHSC)? Is this resulting in more boots on the ground in health professional shortage areas (HPSAs)? How many more providers are benefiting from the NHSC?

Answer: The Affordable Care Act appropriated a total of \$1.5 billion in new dedicated funding for the NHSC over five years starting in FY 2011 and allowed for programmatic changes such half-time service to better support the varied recruitment and retention needs of underserved communities in rural, frontier, and urban areas. This funding has allowed for the successful

expansion of the NHSC, which has nearly tripled its Field Strength from 3,601 in FY 2008 to 9,908 in FY 2012. NHSC providers must serve in Health Professional Shortage Areas and are meeting the primary care needs of over 10.4 million patients. Approximately 45 percent of the Corps clinicians are currently providing care in rural communities.

Question 5

As you may know, the Federal Health Care Task Force I got included in the Affordable Care Act traveled to rural Alaska to look at the question of rural health care and how to work more collaboratively. There were some recommendations, though many were not followed up on. Do you anticipate any more follow through on these recommendations?

Answer: CMS collaborates extensively with other agencies for many initiatives, and we acknowledge the importance of the recommendations in the Task Force's Report to Congress and the work invested in the creation of those recommendations. Current Medicare initiatives relate to some of the Task Force's recommendations. For example, the Task Force recommends that Federal payers consider enhanced reimbursement rates for primary care providers in underserved areas. Under the Affordable Care Act, CMS established the Primary Care Incentive Payment Program, in which eligible primary care physicians may receive an extra incentive payment for primary care services furnished from January 1, 2011 through December 31, 2015. Also, Medicare physicians who furnish services to beneficiaries in areas designated as primary care geographic Health Professional Shortage Areas by HRSA are eligible to receive a 10 percent bonus payment. The Medicare HPSA bonus is paid quarterly and is based on the amount paid for professional services. Additionally, Medicare has engaged in a vigorous effort to review existing regulatory burden on providers, especially those in rural areas and has recently proposed policies that will reduce the regulatory burden on providers and eliminate duplicative requirements; these new rules should especially benefit providers in rural areas.

We further note that the Federal Health Task Force recommended that agencies should consider modifications to facilitate increased regulatory flexibility and simplification. CMS has addressed this in recent rulemaking proposals. In our February 7, 2013, proposed rule, "Medicare and Medicaid Programs; Part II—Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction," we discuss proposals on decreasing regulatory burden for various CMS programs, and included proposals that specifically target rural providers. For example, our current regulation at 42 CFR 485.635(a)(2) requires critical access hospitals (CAHs) to develop policies with the advice of at least one member who is not part of the CAH's staff. CMS proposed a policy to amend this regulation so the that CAHs will no longer be required to include a non-staff member because it has been a challenge for CAHs to comply with this requirement.

The Report to Congress supports increasing the Indian Health Service (IHS) budget. The President's FY 2011 Budget proposed a 9 percent increase for IHS in FY 2011. The President's FY 2012 Budget proposed a 14 percent increase for IHS, and a 5.8 percent increase was enacted. The President's FY 2013 Budget, proposed a 2.7 percent increase to the IHS budget. The final appropriation was at the FY 2012 level plus \$53 million for additional Staffing and Operations of New Facilities, less rescission and sequestration. As part of their outreach efforts, the Alaska Area IHS and the Department of Veterans Affairs (VA) in Alaska collaborated under a VA/IHS Memorandum of Understanding (MOU) to improve outreach to co-beneficiaries in Rural Alaska.

As a result of this interdepartmental collaboration, interaction with Tribes and Tribal Health Organizations has improved. Over 100 Tribal Veterans Representatives were trained to help facilitate VA benefits counseling and healthcare enrollment in Rural Alaska. Additionally, VA used contacts developed in part through its work with IHS and Tribal leaders, to conduct dozens of outreach visits throughout rural Alaska and to negotiate Sharing and Reimbursement agreements with Alaska Tribal Health Programs (ATHPs) for VA reimbursement of direct care services ATHPs provided to eligible Veterans in Alaska.

Question 6

I would like to ask you about the Health Profession Opportunity Programs Grants (HPOG). The Cook Inlet Tribal Council received one of these grants to train and educate over 200 participants in becoming nursing aides, licensed practical and licensed vocational nurses, as well as medical billing (The Cook Inlet Tribal Council contracted with the Alaska Institute of Technology to provide the training). How are the TANF programs and the HPOG grants working together to help TANF participants get trained? Tell me more about how this program is working to train healthcare professional in rural areas.

Answer: There are 32 HPOG operating in 23 states across the United States. To date, more than 23,800 individuals have enrolled in one of those programs. More than 9,100 have completed at least one training and 8,300 have either obtained employment or progressed to better employment in healthcare. The authorizing statute for the HPOG program specifies that grantees must serve Temporary Assistance for Needy Families (TANF) recipients and other low-income individuals. Of the total served, more than 3,700, or approximately 16 percent of those enrolled, are individuals who were receiving TANF cash assistance at the time of intake; the other participants are low-income. HPOG is encouraging the implementation of program practices that may increase the number of TANF recipients who participate. Sites have adopted a variety of different strategies to forge more effective partnerships to reach more TANF recipients. For example:

- Co-locating services;
- Curriculum developed so that by participating in HPOG training, individuals also fulfill work participation requirements;
- HPOG training programs monitor attendance and maintain records that help TANF case managers;
- HPOG programs leverage TANF resources to meet some participant needs like childcare, transportation, uniform allowance, gas cards and limited emergency expenses;
- Relationships are strengthened at multiple levels to include administrators, managers, and case managers. HPOG and TANF case managers meet to coordinate services that best meet client needs;
- TANF representatives serve on HPOG advisory councils;
- HPOG representatives are appointed to boards that oversee TANF; and
- State TANF offices send out guidance encouraging referrals to HPOG.

Cook Inlet Tribal Council is a good example of an HPOG program that is co-located with a TANF program. The case managers from each coordinate the services that best meet the needs of clients. HPOG provides training for healthcare occupations that are in high demand. For the Cook Inlet Tribal Council program, at least 24 percent of clients that enroll in HPOG also are receiving TANF cash assistance.

Seven of our 32 grantees are located in rural areas. As many as 10 other grantees are serving program participants from rural communities. Some of the strategies include placing HPOG staff at strategic locations across broad geographic regions, providing transportation assistance, and utilizing internet and telephone technology to reduce barriers to accessing training. For example, The Central Susquehanna Intermediate Unit serves a rural, ten-county region in Pennsylvania. A key to the program's success is the network of strategically placed Career Coordinators. Cross-trained for multiple roles, Coordinators serve as case managers, job developers, mentors, and all-purpose advocates. To effectively cover all communities, Coordinators are located in different types of organizations, including post-secondary institutions, Department of Public Welfare (*i.e.*, TANF) offices, libraries, and adult basic education providers, depending on what is the most accessible and practical location in a particular county.

In addition to gathering data from grantees, the Office of Family Assistance receives success stories to gain a glimpse of what lies behind the numbers of participants "enrolled," "completed," and "employed". One success story is Mackenzie Madison. Unemployed, fearing eviction and needing assistance with child care, she went to Cook Inlet Tribal Council and was surprised by how much help was available. Through TANF, she found help for her basic needs, including clothes for her and her daughter, gas for the car, and assistance with paying rent. Through HPOG, she was able to build on her experience as a Certified Nursing Assistant and complete the training to become a Registered Nurse. She is now gainfully employed and living independent of TANF.

Post-Hearing Questions for the Record
Submitted to Tom Morris
From Senator Heidi Heitkamp

“Improving Federal Health Care in Rural America: Developing the Workforce and Building Partnerships”
May 23, 2013

Question 1

In general, health workforce supply is a very serious issue facing the country. Certainly in rural areas, particularly the more remote and frontier areas like North Dakota, there is a gap between supply and demand. Nationally, only about 10 percent of physicians practice in rural America, but about 17 percent of the U.S. population is rural. Even in a rural state like North Dakota, about 25 percent of the practicing physicians are in rural areas but the rural population is about 52 percent of the state’s population so there is a significant maldistribution. About 65 percent of all Health Professional Shortage Areas are rural; in North Dakota 91 percent of the entire state is a Health Professional Shortage Area.

Question 1 Part A

- What are the agency’s projections about the future needs for physicians, mid-level practitioners and allied health professionals?

Answer: As part of its continuing work on the health care workforce, in April 2013, HRSA released a report on nursing workforce trends.¹ This report includes state level data on the supply of nurses. HRSA is continuing to work on several additional studies related to future supply and demand for health professionals with a particular focus on the primary care workforce.

In addition, HRSA has continued to grow the presence of primary care providers in the communities that need them most through the National Health Service Corps (NHSC). The combination of Recovery Act, Affordable Care Act, and appropriations has nearly tripled the number of primary care providers in the NHSC since 2008. Corps members provide care in the communities that need them most in return for scholarships and loan repayment incentives.

In May 2013, HRSA released the 2013 Area Health Resource File (previously known as the Area Resource File).² The AHRF is a database with extensive data at the county level from more than 50 sources, including data on health practitioners, health status, health resources, health care utilization and environment. It also includes a very helpful tool that lets the user compare data with counties with similar characteristics. We will be adding state-level data later in the year.

Question 1 Part B

- What proposals is the agency evaluating to meet those needs?

Answer: HRSA has a wide range of programs addressing access to health services and the supply and distribution of practitioners. These fall into six broad areas:

¹ <http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/index.html>.

² The AHRF can be accessed at <http://arf.hrsa.gov/download.htm>.

- Programs to increase the supply of health practitioners, especially primary care practitioners; this includes Title VII and VIII programs;
- Programs such as the NHSC and community health centers to address needs in underserved areas;
- Initiatives to encourage improved delivery of services particularly as it relates to the use of teams; these include support for the National Center for Interprofessional Practice and Education;
- A series of programs and initiatives to improve access in rural communities led by HRSA's Office of Rural Health Policy;
- Extensive collaboration with states through such programs as the State Primary Care Offices and state Offices for Rural Health; and
- Improved data collection and analysis on health workforce through the HRSA National Center for Health Workforce Analysis and technical assistance to states.

In FY 2014, HRSA will partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) to support an initiative to expand the behavioral health workforce, including \$35 million to expand the Mental and Behavioral Health Education and Training grant program by supporting training for masters level social workers, psychologists and marriage and family therapists as well as behavioral health paraprofessionals. Applicants will be asked to focus on vulnerable and underserved populations, such as rural populations, older adults, children and adolescents, victims of abuse, veterans, military personnel and their families.

Question 1 Part C

- **Are the current programs (including the National Health Service Corps, nurse loan repayment programs, nurse faculty training programs) capable of meeting the future needs?**

Answer: The NHSC and NURSE Corps programs address the recruitment and retention needs of communities in need through scholarship and loan repayment programs. NHSC providers include primary care medical, dental, and behavioral-mental health professionals, such as physicians, physician assistants, advanced practice nurses, dentists, dental hygienists, psychologists, licensed clinical social workers, marriage and family therapists, and licensed professional counselors. All NHSC providers must serve in Health Professional Shortage Areas. Since 2008, the number of providers in the Corps has nearly tripled. In FY 2012, approximately 45 percent of the nearly 10,000 Corps clinicians provided care in rural communities. The NURSE Corps providers include both registered- and advanced practice-nurses who work in rural health clinics, health centers, hospitals and other types of facilities in need. As a result of NURSE Corps loan repayment and scholarship programs, in FY 2012, approximately 3,000 registered nurses, including nurse practitioners, certified registered nurse anesthetists, certified nurse-midwives, nurse specialists and other advanced practice nurses were working in communities where they are needed most.

Question 2

Under the Affordable Care Act there is an understanding that in order to reform our health delivery system in a manner to better coordinate care, improve health care quality,

control costs, and to improve the efficacy of the system, there is a greater need for primary care providers. This includes primary care physicians like family medicine, but also nurse practitioners, physician assistants, advanced practice nurses, and others. However, at the same time, the President's FY 2014 budget proposal eliminates all federal funding for Area Health Education Centers.

- Can you please help me understand how to reconcile these two divergent policy streams -- recognition of a greater need for health workforce personnel under health reform and elimination of health workforce personnel programs?

Answer: The FY 2014 President's Budget prioritizes allocating federal resources to training programs that directly increase the number of primary care providers. The Area Health Education Center (AHEC) program focuses on exposing students to health profession careers to increase the pipeline into the health profession, providing current health profession students training opportunities in rural and underserved areas and providing continuing education to current providers. While HRSA has made longstanding investments in these activities to enhance health professions training, generally they do not directly increase the supply of providers. Given that most AHEC programs have been in place for many years and have state and local support, it is anticipated that the AHEC program grantees will continue much of their efforts relying on these other funding sources.

Question 3

Access to mental health services and providers is a pressing issue in rural areas. The prevalence of mental illness in rural areas is equal to or greater than in urban populations, with rural residents reporting greater rates of depression than those in metropolitan areas. The issues in rural mental health include disparities in access, availability of and culturally appropriate treatment, and quality of services. In North Dakota this is a serious issue for our Native American population as about 10 percent of suicides in my state are composed of Native Americans. In addition, 46 percent of our veterans in North Dakota are rural and face significant access issues. In North Dakota about 90 percent of our 53 counties are designated by the federal government to be mental health professional shortage area and all of our Native American reservations are part of a mental health shortage area.

Question 3 Part A

- How we can better meet our rural mental health needs?

Answer: HRSA is implementing a variety of projects to increase mental and behavioral health providers, place such providers in rural and underserved communities, and increase the primary health care workforce.

- HRSA is increasing the number of mental and behavioral health providers through the Graduate Psychology Education program and the Mental and Behavioral Health Education and Training program. The Graduate Psychology Education program supports doctoral-level psychology education. The Mental and Behavioral Health Education and Training program increases the number of behavioral health professionals at the masters and doctoral-level through support for clinical training (internships, field placements)

required for practice. Both programs include an emphasis on vulnerable and underserved populations. For the Mental and Behavioral Health Education and Training program, HRSA anticipates training more than 430 behavioral health providers during the three-year grant period.

- HRSA is also supporting the placement of mental and behavioral health providers through the NHSC. The NHSC has increased the number of mental and behavioral health providers that it supports over the past five years. In fact, 2,919 members of the NHSC (as of September 2012) are behavioral and mental health practitioners, including psychiatrists, clinical psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurse specialists. The distribution of all NHSC clinicians across the country is generally even between rural areas (45 percent) and urban areas (55 percent).
- HRSA is also increasing the ability of the primary health care workforce to address mental and behavioral health needs by partnering with SAMHSA on the Center for Integrated Health Solutions (CIHS). The CIHS is a national training and technical assistance resource center which promotes integrated primary and behavioral health services to address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS has formulated trainings for health center primary care providers, many of whom serve in rural areas, around the topic of providing mental health services.

In addition, SAMHSA's Block Grants provide flexible funds that States can use to provide access to necessary services, including services in rural areas. As a component of the application for Block Grant funds, States provide an assessment of their strengths and needs of the service system and identify unmet service needs and critical gaps.

SAMHSA's Grants to Expand Care Coordination through the Use of Health Information Technology in Targeted Areas of Need leverages technology to enhance and/or expand the capacity of substance abuse treatment providers to serve persons in treatment who have been underserved because of the lack of access to treatment in their immediate community. The use of health information technology, including web-based services, smart phones, and behavioral health electronic applications expand and/or enhance the ability of providers to effectively communicate with persons in treatment and to track and manage their health to ensure treatment and services are available where and when needed. Grantees use technology that will support recovery and resiliency efforts and promote wellness.

SAMHSA also held a webinar in May entitled, "Practical Strategies to Address the Needs of Children and Youth in Rural Communities: Coordination in Responding to Crisis in Rural Communities." This webinar focused on discussing the components necessary for the development of an effective crisis response plan within a rural community coordinating among all stakeholders.

In addition, SAMHSA is providing technical assistance to the National Association for Rural Mental Health to inform their planning for a 2014 national conference bringing together practice, research and policy leaders in rural mental health.

Finally, HHS has been a key participant in the White House Rural Council, which was created in June 2011 through an Executive Order. The Council is a combined effort of the White House Domestic Policy Council and the National Economic Council, with the Secretary of Agriculture serving as chair and Cabinet Agency heads serving as members. The Council works across executive departments, agencies, and offices to coordinate development of policy recommendations to promote economic prosperity and quality of life in rural America.

Question 3 Part B

- **I realize there are discussions that deal with ways to integrate different levels of care. I would like to hear your comments on the idea of linking primary care with behavioral and/or mental health. I realize current models like Federally Qualified Health Centers can do this, but how do we expand that thinking to include rural health clinics, critical access hospitals, and even nursing homes?**

Answer: We are taking steps to promote the integration of behavioral health and primary care. Through the expansion of the Community Health Center program, many health centers have been able to add mental health practitioners. Through the SAMHSA-HRSA Center for Integrated Health Solutions,³ we are working with providers to encourage the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. For example, the Center has adapted Mental Health First Aid to raise awareness and create a list of resources for mental health care services available in the community.

Question 4

One of the issues we discussed is how gaps in broadband access and other telecommunication services may prevent rural areas from taking full advantage of telemedicine to access health care services.

- **Can you please provide me a summary of the gaps in rural areas and what steps are being taken to bridge the divide?**

Answer: Data from the Federal Communications Commission (FCC) shows that some rural areas continue to lag behind urban population centers in access to affordable broadband, which can impede rural economic development and create challenges for rural communities seeking to leverage telehealth technology and implement electronic health records. According to FCC data, approximately 19 million Americans as of June 2012 had no access to robust broadband infrastructure. Rural residents compose a large majority of Americans without access to broadband. Broadband is defined as a connection capable of downstream speeds of at least three megabits per second and upstream speeds of at least 768 kilobits per second. As uses for and

³ <http://www.integration.samhsa.gov>.

capabilities of health information technology expand, rural health care providers without higher-speed broadband connections risk falling behind in terms of quality and coordination of care.

The upstream and downstream bandwidth needs of health care providers often exceed those of other businesses due to the demands of health information exchange and telemedicine. A map compiled by the FCC and current as of June 2011,⁴ shows which rural and non-rural areas have access to broadband. Rural areas west of the Mississippi River especially experience reduced access to broadband.

Both the FCC and the Rural Utilities Service (RUS) within the Department of Agriculture's Rural Development office offer several programs designed to increase access to broadband in rural areas. The FCC's newly-established Healthcare Connect Fund is specifically designed to increase access to broadband among rural health care providers as a means to increase efficiency of care and build regional and statewide networks of providers engaged in telemedicine and health information exchange.

FCC

- The Connect America Fund (CAF)⁵ was established in 2011 to help make broadband available to homes, businesses, and community anchor institutions in areas that do not or would not otherwise have access to broadband services. The first round of Phase I funding in 2012 provided \$115 million to price-cap carriers to deliver new broadband service to nearly 400,000 unserved Americans. The second round of Phase I funding will occur in 2013, and will disburse a maximum of \$300 million. All locations without a broadband connection are eligible to receive Phase I funding so long as they comply with certain FCC requirements. Phase II will use a combination of a forward-looking broadband cost model and competitive bidding to support efficient deployment of broadband networks for five years. The FCC expects that this funding model will significantly further expand broadband availability.
- The Healthcare Connect Fund (HCF),⁶ as a combination of the FCC's previous Rural Health Care Pilot Program and its Internet Access Program, seeks to expand access for rural health care providers to high-speed broadband services. Individual providers and consortia will be eligible to apply to for support for broadband infrastructure (purchased or independently constructed) as well as recurring costs. The HCF will cover 65 percent of eligible costs related to broadband services or facilities used for health care purposes. Participants in the previous Rural Health Care Pilot Program will be eligible to file for HCF support beginning July 1, 2013; all other applicants will be eligible January 1, 2014.

RUS

- The Rural Broadband Loan Program⁷ offers loans to fund the costs of construction, improvement, and acquisition of facilities and equipment to provide broadband service to

⁴ <http://www.fcc.gov/maps/section-706-fixed-broadband-deployment-map>.

⁵ <http://www.fcc.gov/encyclopedia/connecting-america>.

⁶ <http://www.fcc.gov/document/healthcare-connect-fund-fact-sheet>.

⁷ http://www.rurdev.usda.gov/utp_farmbill.html.

eligible rural areas on a technology-neutral basis. Loans are offered at either cost-of-money or four percent. Corporations, limited-liability companies, cooperative organizations, and Tribal and governmental entities are eligible to apply for the loans so long as the proposed service area meets certain requirements. Applications are accepted on a rolling basis.

- The Community Connect Grant Program⁸ funds the construction, acquisition, leasing, or improvement of facilities used to deploy broadband services to all customers within the proposed service area; it also covers the costs of providing necessary bandwidth for service to Critical Community Facilities. Corporations, limited-liability companies, cooperative organizations, and Tribal and governmental entities are eligible to apply for the loans so long as the proposed service area meets certain requirements. The application window for the current fiscal year closes on July 11, 2013, and \$21 million in grant funding is available.

⁸ http://www.rurdev.usda.gov/utp_commconnect.html.

**Post-Hearing Questions for the Record
Submitted to Matt Kuntz
From Senator Mark Begich**

**“Improving Federal Health Care in Rural America: Developing the Workforce and
Building Partnerships”
May 23, 2013**

1. I want to thank the National Alliance on Mental Illness (NAMI) for supporting my Mental Health First Aid bill, which trains people from all walks of life to know the signs of mental illness and get them help and support. How do you see the Mental Health First Aid legislation working for Veterans?

Thank you Senator for your efforts on that legislation. I believe that the Mental Health First Aid legislation will assist veterans with post traumatic stress injuries and other mental health issues by educating outside community members that can help the veteran get early and effective treatment. Post traumatic stress injuries and other brain conditions are very complex and they surface in a variety of ways, Mental Health First Aid and other education programs can provide a road map for compassionate members of the community to help guide people to the help they need to overcome their symptoms and begin to recover from their conditions.

I believe as you clearly do, that proper interventions by a trained community member can save lives. This legislation will help facilitate that process.

2. NAMI has always been in the forefront of peer support. Since rural states continue to struggle with finding health care professionals, how is NAMI working with federal agencies to train or promote more peer support teams/counselors?

Thank you for recognizing NAMI's role in developing peer support. It's an essential, but undeveloped part of our nation's mental illness treatment system. NAMI Montana is extremely excited about the VA's move towards utilizing peer specialists. NAMI affiliates, such as NAMI Montana, have promoted this this new resource throughout the country through our email and social media networks.

On a local level, I know that one of our NAMI Montana presentations helped key members of the Montana VA understand the role of peer support specialists in the treatment team. We have been active in this area of the treatment world for a long time, so we are able to act as an informal resource for any programs looking to get the most out of their peer support specialist positions.

Unfortunately, NAMI has had a very limited role in helping federal agencies train and promote peer support specialists. In 2013, the Veterans Administration (VA) awarded

DBSA (Depression and Bi-Polar Support Alliance) a contract to train and certify VA peer support staff across the country. Earlier this year the VA issued DBSA a second contract for additional services. NAMI would love to collaborate with the VA and DBSA to develop training programs, recruit peer specialist, or otherwise facilitate the development of this workforce if the opportunity became available.

NAMI has had a more active role in collaborating with the VA to train families caring for loved ones with mental illness. NAMI is continuing to successfully implement the non-VA funded, NAMI/VA MOU Project – now in its 6th year. Under the Extended Family-to-Family/Veterans Administration Project Memorandum of Understanding (MOU) NAMI is hosting education classes for families and veterans at 114 participating VA hospitals and medical centers in 46 states across the country.

NAMI is currently seeking VA funding for an extension of the NAMI Family-to-Family/VA partnership beyond the scheduled end date of December 2013 to reinforce the inclusion of peer-led family education service in the continuum of VA family services. An extended partnership – supported by VA funding - would allow for program roll-out and implementation in additional VA facilities, and targeted rural areas.

3. Coming from Montana, almost as rural as Alaska, you understand the access concern with getting mental health care close to home. Can you give me some examples of how rural veterans have accessed mental health care, when no CBOC is near?

Montana is very fortunate to have implemented a number of outside-of-the box solutions to address the challenges of mental health care access for rural veterans. We have ongoing fee-for-service contracts between VA and private regional mental health centers throughout Montana. The majority of these mental health centers have satellite offices that have the ability to reach veterans in many of Montana's most rural communities.

Montana has Mobile Vet Centers that allow rural veterans to access mental health services through both traditional counselors and the van's mobile telehealth network. For instance, a Mobile Vet Center pulls up in front of the Elks Lodge in Red Lodge, Montana twice a month. The Mobile Vet Center brings counseling for post traumatic stress injuries, grief, and military sexual trauma to this community of approximately 2,000 people nestled amidst the Beartooth Mountains.

Another way that veterans may access mental health care is to utilize a local primary care doctor to prescribe psychiatric medication. NAMI Montana stresses that this is not an effective way for anyone to access care for their mental illness. We recommend care by a psychiatric specialist combined with therapy from a licensed clinical counselor or licensed clinical social worker. However, some estimate that approximately 60% of the nation's psychiatric prescriptions are given by primary care providers. It is likely that veterans also seek that avenue of care, especially in rural areas with barriers to other types of service.

4. Along with the previous question, what is your opinion of fee-based mental health services to include the Guard and Reserve?

I am biased because I'm from a state that has pioneered fee-based mental health services for rural veterans. It is clear to me that fee-based services have a role to play in delivering mental health care to our nation's veterans. The VA is under very real monetary constraints in developing new facilities, especially in rural areas.

However, despite these fiscal constraints; rural veterans still require and deserve access to effective care. While technology may be able to help fill some need for providers in these communities, fee-based services are often essential for caring for veterans who are uncomfortable with tele-health services.

Additionally, it is imperative that these fee-for-service providers be available to serve members of the Guard and Reserve. The military's reliance on Guard and Reserve forces for multiple deployments in combat have led to post traumatic stress injuries in these service members and the need for treatment in these service members' home communities. Fee-for-service providers give these service members access to these essential services in communities where the VA may not have a brick-and-mortar location.

These fee-for-service providers may be especially important to helping these service members access care who may be afraid to access care through a more traditional service route due to fears of that their visits may be discovered by colleagues, friends and family. That fear may be irrational, but it still can be a barrier to care.