



THE AMERICAN LEGION
SYSTEM WORTH SAVING

"Ensuring Quality Health Care for Veterans."

2012 **System Worth Saving** Report on

RURAL HEALTHCARE

Fang A. Wong
National Commander



OFFICE OF NATIONAL COMMANDER

Dear Fellow Legionnaires:

The American Legion's National Executive Committee created the "System Worth Saving Task Force" in 2003 to continue conducting site visits of VA Medical Centers on behalf of The American Legion, National Commander.

Last year, the System Worth Saving program was enhanced, and rather than having one report drafted annually, there are now two reports completed per year; each report focuses on one quality-of-care issue affecting veterans.

From October 2011 to March 2012, the System Worth Saving Task Force conducted a series of visits to evaluate the challenges veterans living in rural areas face with their VA treatment. The task force visited 24 VA medical facilities, including Veteran Integrated Service Network (VISN), VISN Rural Health consultants, Rural Health Resource Centers, VA medical centers, Community-Based Outpatient Clinics and Project Access Received Closer to Home (ARCH) sites.

In our findings, we discovered that one out of three veterans enrolled in VA live in rural and highly rural areas. Of the 3.4 million rural veterans enrolled in VA, 2.2 million were treated in 2010. The number of rural and highly rural veterans is expected to increase. Additionally, veterans living in rural areas face many challenges, including the lack of primary/specialty treatment available, difficulty recruiting and retaining VA health-care providers in rural and highly rural areas, and the increased time and distance veterans experience in traveling to VA health-care facilities.

I encourage you to review our findings and recommendations from the 24 VA facilities we visited. The American Legion believes veterans should not be penalized or forced to travel long distances to access quality health care because of where they choose to live. VA has an obligation to provide access to quality care and treatment to our nation's veterans that serve our country and come home to rural communities.

We hope that our findings in this report will help Congress and VA understand what challenges our nation's returning servicemembers and veterans that live in rural communities face with accessing quality VA health care.

Respectfully,

Fang A. Wong
National Commander
The American Legion



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EXECUTIVE REPORT | A SYSTEM WORTH SAVING: 2012

By Michael D. Helm

Chairman

The American Legion Veterans Affairs & Rehabilitation Commission

Introduction and Background

The American Legion's National Executive Committee created the "System Worth Saving Task Force" in 2003 to continue conducting site visits of VA Medical Centers on behalf of The American Legion National Commander. The purpose of the site visits are to assess the quality and timeliness of VA health care and to provide feedback from veterans on their level of care. The findings and recommendations from site visits to VA medical facilities are compiled into this report and distributed to the President, members of Congress and senior VA officials to improve the delivery of health care to our nation's veterans.

From November 2011 to February 2012, the System Worth Saving Task Force focused on the challenges veterans in rural areas face in receiving VA health care. The task force examined rural health care for several reasons: the increasing number of veterans living in rural and highly rural areas across the United States, the lack of primary and specialty-care providers in rural and highly rural areas, and increased time and distance in traveling to health-care facilities.

The Office of Rural Health (ORH) estimates in 2011 that approximately 41 percent of all veterans (3.4 million) live in rural and highly rural areas, with the majority living in the Southern or Central portions of the country. Out of the 3.4 million rural and highly rural veterans enrolled in VA, 2.3 million were treated in 2010. These statistics indicate that one out of every three veterans treated by VA live in rural communities. According to demographic research by Katherine Curtis and Collin Payne, the rural proportion of the veteran population will increase and the number of veterans who will receive health care from the VA will increase.

Individuals living in rural areas have traditionally been underserved because of their lack of access to health care. This can be attributed to several factors, including: lack of health insurance, little awareness of VA benefits and services, and an inadequate number of primary and specialty health-care providers that work in rural communities. Previous research has found rural veterans to have lower Health-Related Quality of Life (HRQL) scores, measured by the Medical Outcomes Study Short Form 36-Item Health Survey for Veterans (SF-36V), Physical Component Summary (PCS) and Mental Component Summary (MCS) scores, and a higher prevalence of physical disease co-morbidities, but lower rates of mental health co-morbidities than urban-dwelling veterans (Proctor, 2011 p33).

Even if primary- or specialty-care services are available in rural and highly rural communities, veterans have unique and distinctive health complications associated with their military service that are difficult for civilian providers to treat. Some of these war-related injuries/illnesses are Traumatic Brain Injury (TBI), Post-Traumatic Stress Disorder (PTSD), depression and amputation – conditions that civilian providers are not suited to treat.

Dr. Kenneth Kizer, former Under Secretary for Health for VA, helped shift VA from a hospital-based system to a community-based outpatient clinic (CBOC) in order to move VA care closer to veterans' homes. In a recent article published in the Journal of American Medical Association in February 2012, Dr. Kizer stated, "Physicians in private practice may not be prepared to treat conditions prevalent among veterans – for example, the Reaching Rural Veterans Initiative in Pennsylvania found that primary care clinicians lacked knowledge of PTSD, and other mental health disorders prevalent among veterans, and were unfamiliar with VA treatment resources for such conditions."

The most noteworthy deterrents for veterans living in rural communities are the travel barriers. This includes greater distance to care and a lack of public transportation that contributes to limited access to health care as compared to urban veterans. According to the ORH, the current definition of rural and highly rural veterans is the same as the U.S. Census Bureau's definition. In order to define rural, the Census Bureau first defines urban as "all territory, population, and housing units within an urbanized area or an urban cluster. An urbanized cluster consists of a core census block or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. Urban clusters are found in small towns surrounded by a lower density population. Urbanized areas consist of contiguous densely settled block groups; along with adjacent densely settled census blocks together encompass a population of at least 50,000 people." VA defines urban enrollees as "any enrollees who are located within a Census-defined urbanized area. Rural enrollees are any enrollees not designated as urban (including those who live within urban clusters), while highly rural enrollees reside in counties with fewer than seven civilians per square mile." Based on this definition, the VA's estimates 60 percent of enrolled veterans reside in urban areas, while approximately 37 percent reside in rural areas. Fewer than two percent reside in highly rural areas.

According to the Veteran’s Health Administration (VHA) access standards, 70 percent of veterans should not travel more than 30 minutes to a VHA primary care facility, whether they reside in an urban area or rural, or more than one hour if they are highly rural. Sixty-five percent should travel no more than 90 minutes if rural and two hours if highly rural to access VHA acute care facilities. Although VA has established access standards, these standards – as well as the definition of rural and highly rural veterans – do not take into account the distance and driving time it takes for veterans to be provided with VA care. Establishing a VA definition based only on health-care needs may be a better representation of providing adequate care for veterans living in rural communities.

VA’s national travel time reports are presently being updated for fiscal 2011. The most recent national reports from FY 2010 are:

77 percent of all enrollees are within **30 minutes** travel time to Primary Care Services.

96.5 percent of all enrollees are within **60 minutes** to Primary Care Services.

79 percent of all enrollees are within **90 minutes** to Acute Care Services.

89.3 percent of all enrollees are within **120 minutes** to Acute Care Services.

92.4 percent of all enrollees are within **240 minutes** to Tertiary Care Services.

VA Office of Rural Health

In order to better serve rural veterans, VA created the Office of Rural Health (ORH) in 2007, funding more than 500 projects/programs across VA’s health-care system. In FY 2012, the ORH will be supporting more than 300 individual projects across the country, not including ORH-funded projects overseen by Veterans Rural Health Resource Centers (VRHRC). Many of these are in collaboration with other VA program offices, such as the VA Homeless Office, the Office of Geriatrics and Extended Care, and the Office of Telehealth Services. The ORH’s operating budget is \$274 million for FY 2010 and FY 2011, and is distributed directly to Veteran Integrated Service Networks (VISNs), VA medical centers and VRHRCs. Their mission is to improve access and quality of care for all veterans through a combination of CBOC expansion, increased partnerships with non-VA rural providers (Project Access Received Closer to Home), increased

use of telehealth and information technology, and a new effort to recruit and retain health-care providers in rural areas.

Telehealth has been one of the most dynamic rural health initiatives. According to VA’s Chief Consultant for Telehealth Services in 2011, telehealth programs are effective, cost-efficient, and have grown from 127,000 uses in FY 2008 to 256,000 uses in FY 2012. Although telehealth services have grown, rural communities need more space and infrastructure for telehealth services. Where possible, VA should consider expanding telehealth and collaborate with local post offices that can share space. Utilizing local post offices would be an appropriate alternative, given its existing infrastructure and government use. The ORH has also provided resources to support eight mobile clinics in FY 2012. The ORH uses the Rural Health Briefing Book to estimate enrollment, appointment, treatment received and non-VA treatment statistics. Most of the data recorded can be analyzed using geographic variables, such as rurality based on veteran’s address and location of their VA health-care provider.

The ORH publishes a quarterly newsletter, monthly fact sheets and a variety of peer-reviewed journal articles that highlight best practices. For example, the VRHRC in the Western Region created a toolkit and summary document that presents an overview, suggestions for setting up, operating and maintaining telemental health clinics for Native American veterans, as well as assistance with the creation of agreements and collaborations.

While the ORH has made many improvements since its inception, the Office of Inspector General conducted an audit of the ORH in 2011 to assess the effectiveness of planning and managing the FY 2009 and FY 2010 allocation of funds, and found four deficiencies. Improvements are needed in rural health fee usage, project selection process, fund monitoring and performance monitoring.

Currently, the ORH has made significant improvements in these areas by working more closely with the VRHCs, the VISNs and medical facilities to monitor daily the obligations of project funds. The budget analyst also shares budget information with the appropriate program analyst assigned to each VISN, as well as the ORH director and deputy director. The ORH uses a data management tool, O-MAT, to track performance measures of all funded projects. The VRHCs are required to report quarterly performance measures for their assigned projects. The information is reviewed by the assigned



program analyst for accuracy and to find any deficiencies. If deficiencies are found, the program analyst collaborates with the VRHC and project leaders to find solutions.

In an effort to understand the challenges/barriers veterans have in rural and highly rural areas, The American Legion's System Worth Saving Task Force conducted 12 site visits nationwide. In these visits the task force conducted meetings with VISN directors, VISN Rural Health Consultants (VRHCs), Rural Health Resource Centers (RHRC), Project ARCH sites, VA medical facilities and CBOCs. Additionally, the task force conducted five focus groups at American Legion posts to receive feedback from rural veterans on their level of care. There also was a site visit conducted to the Native American reservations in New Mexico and Arizona to understand what challenges those veterans face with access to VA and Indian Health Service (IHS) medical care.

Veteran Integrated Network Service (VISN)

The VISNs are responsible for all financial and operational activities for their medical centers. Each VISN is expected to track the number of veterans in the catchment area and their needs. The VISNs determine the type of programs needed by defining the demand and funds needed. With this objective in mind, current challenges are economic instability, enrollment, and expansion of CBOCs, and telehealth capabilities. The economy has a profound effect on VISNs budgets, and the VISNs are hesitating to start new programs for concerns that sufficient funds will not be continued. Also, Iraq and Afghanistan veterans are difficult to identify and track because they return to their rural communities without enrolling in any type of VA facility. The VISNs also need the most advanced telehealth technologies to capture the influx of veterans returning from Iraq and Afghanistan.

VISN Rural Health Consultant (VRHC)

Each VISN has a full- or part-time rural health consultant, whose primary function is to enhance the level of health care delivered to the veterans living in rural and highly rural areas. This is done by facilitating information across VISNs and supporting the ORH and each VISN. In addition, the VRHCs work closely with internal and external stakeholders in their VISNs to introduce, implement and evaluate ORH-funded projects, as well as monitor the budget and report on their effectiveness. Furthermore, VRHCs conduct outreach to develop strong relationships with the community, including state offices or rural health local health-care providers, advocacy groups, veterans groups and academic institutions. Each VRHC is responsible for the development of a rural strategic plan that must incorporate outcomes of periodic needs assessments for their respective VISN.

These needs assessments can be challenging because of surveying restrictions. Veterans cannot be surveyed unless one uses questions from a pre-approved database, which does not allow tailoring to specific issues or needs. An alternative is to create a survey instrument to submit to the Office of Management and Budget, which can be an exasperating process. It is important that these assessments reflect the veterans' needs with accuracy. The VRHC did not have sufficient time and access to rural health needs analysis to complete a comprehensive needs assessment. This creates some what of a barrier in understanding the needs of rural veterans.

In some cases, the VRHC reports to the VISN director and not to the ORH. The problems associated with VRHCs working directly for the VISN directors have been additional collateral duties, inconsistency with their schedules, and distracting the VRHC from needed outreach to facilities within their VISN. The ORH may serve as a better direct line of communication, as each VISN has its own budget-driven agenda, rather than focusing on veterans' rural health-care needs to the level of the ORH.

Rural Health Resource Center (RHRC)

The Rural Health Resource Center Consultant is advisory in nature. Half of the RHRCs are part time and represent VISNs 1-10. The RHRC assists the VISN Rural Consultants by performing research, and providing advice on implementing new favorable and measurable projects. The centers are divided into three regions of eastern, central and western locations, and function as field-based clinical laboratories for demonstration projects and pilot projects. These centers employ rural health experts (most have PhDs), act as educational and clinical repositories, and provide programmatic support to the ORH. The centers collaborate with VA and non-VA rural health-care providers and other experts to conduct studies, policy-relevant research and analyses, and clinical program development. Their goal is to identify and disseminate best practices to improve health care for rural veterans. They evaluate practices that impact rural veterans' health care, and recommend change or new initiatives. This is done by developing partnerships with non-VA federal, state and community agencies to coordinate efforts to improve rural veterans' health care, and develop and provide education activities of rural veteran issues for VA and non-VA audiences.

One concern is that they only conduct research, but the center is referred to as a resource center. Additionally, there does not seem to be well-developed telehealth infrastructure for outreach. Assuming a sufficient infrastructure was designed and used, many veterans do not have the appropriate technology to use telehealth programs in their homes. There have been constant concerns as to the proper technology, level of outreach, and staffing needed to meet rural and highly rural veteran's health-care needs.

Project Access Received Closer to Home (Project ARCH)

VA has implemented a pilot program to provide health-care service through contractual arrangements with non-VA care providers. The project is intended to improve access for eligible veterans by connecting them to health-care services closer to home. There are five pilot sites already established across the country: Northern Maine; Farmville, VA; Pratt, KS; Flagstaff, AZ; and Billings, MT.

VA will negotiate a contracted rate for services provided by non-VA providers. All veterans who participate in Project ARCH will still be responsible for co-payments. Each Project ARCH pilot site will contract with specific providers for each service covered under the pilot. Veterans must use those providers to participate in Project ARCH. However, participation does not affect eligibility for fee-basis services. The four main objectives of Project ARCH are patient satisfaction, access to care, benefits to veterans, and to conduct a thorough evaluation on the effectiveness of the program, including the program's cost, volume and quality of care. Identified by the program are strengths and challenges associated with implementation, which includes providing recommendations to continue the program's expansion to other VISNs, discontinuation of the program, or making the program permanent. Annual reports are submitted to Congress on the status of the program for each year it is conducted.

Some challenges have been in the level of outreach and a lack of significant participation in some locations. There is \$30 million budget for patient care, but a disproportionate amount of patients. It's unlikely all funds are being effectively utilized, partly due to the lack of awareness of the program. The outreach guidelines have not been clearly communicated to the facilitators, nor have not been a significant push to do so. This is only a three-year pilot program, so there are concerns about additional outreach. Funds are likely going unused and not cost effective. There have been no outreach services provided to the Pratt pilot site because guidelines are not clearly defined by the VA Central Office. And the structure and procedures are different in the VA system than non-VA systems. This can cause communication challenges and a different level of quality of care. Although some challenges exist, the success of the program is based on the location. Some sites have been better received than others and should be evaluated on case by case basis; in Arizona, Montana, and Northern Maine the program is highly successful.

VA Medical Centers (VAMCs)

The objective of the medical centers is similar to that of the VISNs but more focused in nature. The medical centers work more closely with the CBOC's, Rural Health Consultant and Rural Health Resource Centers, and Project Access Received

Closer to Home. The medical centers play a vital role in implementing these rural health programs and initiatives, and work more closely with the patients.

For VAMCs in rural America, recruitment and retention of primary- and specialty-care providers has been a continued challenge. Some clinicians prefer to practice in more urban settings with more research opportunities and quality-of-life that urban settings provide. Secondly, the level of bandwidth for telehealth programs has not proven to be sufficient as well as scheduling packages. The medical centers needs enhanced technology for better coordination between medical centers and CBOC's for telehealth appointments. Also, the veterans' transportation service has not been adequate to fulfill the needs for veterans in rural areas. The medical centers lack sufficient vans and staff to transport veterans from their homes to their medical appointments. Lastly, communication between the CBOCs, the rural health resources center and consultants needs substantial improvement.

Community Based Outpatient Clinics (CBOCs)

One of the most vital components in providing access to health care in rural communities is the utilization of CBOCs, which provide primary care but inadequate specialty care, which is critical to delivering quality health care to these unique veterans. VA is working to build more locations and increase staff nationwide, as well as to expand specialty services via telehealth. Telehealth optimizes care in their homes for patients with chronic conditions. Telehealth provides non-institutional care, chronic care management, acute care management and health promotion/disease prevention. It uses commercial off-the-shelf technologies in the home that link to enterprise-level VA IT support. These technologies are the future of delivering health care but must not replace quality access. VA is using many telehealth projects to increase access of care in CBOCs, VAMCs and non-VA facilities.

One of the challenges to telehealth is veterans not having cell phones or Internet connections. Many of the telehealth devices require Internet connections and/or cell phone reception. There also does not seem to be a standard manner in which enrollment is recorded and tracked. The managerial responsibilities do not seem to be clearly defined, but are instead spread throughout to the nurse managers and other clinicians. This may cause problems for the medical center to properly evaluate the need for additional resources. Lastly, there is a serious lack of space and staffing. Many of the CBOCs are overwhelmed; sometimes, closet space is used for office space.



VISN 1

VETERANS INTEGRATED SERVICE NETWORK

BEDFORD, MA

November 8, 2011

National Task Force Member: Todd E. White

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Steven J. Henry

VETERANS INTEGRATED SERVICE NETWORK RURAL HEALTH CONSULTANT

BEDFORD, MA

November 8, 2011

National Task Force Member: Todd E. White

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Steven J. Henry

RURAL HEALTH RESOURCE CENTER

WHITE RIVER JUNCTION, VT

January 9, 2011

National Task Force Member: Patrick R. Rourke

National Field Service Representative: Steven J. Henry

WHITE RIVER JUNCTION VA MEDICAL CENTER

WHITE RIVER JUNCTION, VT

December 12, 2011

National Task Force Member: Patrick R. Rourke

National Field Service Representative: Steven J. Henry

PROVIDENCE VA MEDICAL CENTER

PROVIDENCE, RI

November 8, 2011

National Task Force Member: Todd E. White

Deputy Director of Health Care: Jacob B. Gadd

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MANCHESTER VA MEDICAL CENTER

MANCHESTER, NH

January 10, 2012

National Task Force Member: Patrick R. Rourke

National Field Service Representative: Steven J. Henry

HYANNIS COMMUNITY BASED OUTPATIENT CLINIC

HYANNIS, MA

November 9, 2011

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TILTON COMMUNITY BASED OUTPATIENT CLINIC

TILTON, NH

January 9, 2011

National Task Force Member: Patrick R. Rourke

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CONWAY COMMUNITY BASED OUTPATIENT CLINIC

CONWAY, NH

January 10, 2012

National Task Force Member: Patrick R. Rourke

National Field Service Representative: Steven J. Henry

COLCHESTER COMMUNITY BASED OUTPATIENT CLINIC

COLCHESTER, VT

December 12, 2011

National Task Force Member: Patrick R. Rourke

National Field Service Representative: Steven J. Henry

AMERICAN LEGION POST FOCUS GROUP

MARTHA'S VINEYARD, MA

November 9, 2011

National Task Force Member: Todd E. White

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Steven J. Henry

RECOMMENDATIONS



VETERAN INTEGRATED SERVICE NETWORK 1 | BEDFORD, MA

Date: November 8, 2011

National Task Force Member: Todd E. White

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Steven J. Henry



Background

The Department of Veterans Affairs New England Healthcare System (NEHS) in VISN 1 consists of the six New England states: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut. VISN 1 has more than 35 CBOCs, six nursing homes and two domiciliaries. Comprehensive care offered by VA NEHS includes primary care, acute medical and surgical care, psychiatric care, long-term care, nursing home care and ambulatory surgery, and offer the full range of health-care services from basic outpatient care to open heart surgery, radiation therapy and kidney transplantation. The VA NEHS covers an area with a total veteran population of approximately 1.3 million. Current rural health projects and initiatives within VISN 1 include Project Access Received Closer to Home (ARCH). Future plans include opening more telehealth clinics since they require less formalities than CBOCs.

Challenges

Currently there are 980,000 veterans who reside in VISN 1, 339,645 of which are enrolled in VA, and 252,000 of which are active users. To address the transportation barrier, VISN 1 has

implemented the strategic initiative through a grant provided by VA's Central Office. VISN 1 purchased a bus and plans to use the grant to assist with opening more multi-specialty clinics, including Portland and Bangor, Maine. With such an aging population, there is speculation that the current veteran health-care system will be unsustainable.

Recommendations

Establish a clear and concise definition of "rural" and "highly rural" based on data specific to rural veterans who utilize the VA health-care system based on distance from the medical center and driving time. Communicate with VACO the difficulties veterans face with access to care and the necessity of establishing a transportation program to assist these veterans with the formidable task of transporting themselves to receive treatment.

VISN 1 RURAL HEALTH CONSULTANT | BEDFORD, MA

Date: November 8, 2011

National Task Force Member: Todd E. White

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Steven J. Henry

Background

The VISN 1 Rural Health Consultant (VRHC) transferred to his position in September 2010, and currently serves on a part-time basis. The budget for VISN 1 rural health projects is \$6.2 million. The VRHC position was originally funded by the Office of Rural Health (ORH) but is now fully funded by VISN 1. The VRHC receives initial training and continuous training through semi-annual VRC meetings.

The VRHC has implemented the following projects which have led to an improvement in VISN 1's delivery of health care to rural veterans:

- Project Access Received Closer to Home (ARCH). A pilot in northern Maine intended to assist veterans by making health care available in their local community by fee basis.
- Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) Rural Pilot. A program designed to provide OIF/OEF veterans with peer outreach and support. Veterans are provided with readjustment counseling and other mental health services. The program is a joint initiative of the Veterans Office of Rural Health and Veterans Mental Health Services.
- The New England Rural Health Needs Assessment. A resource tool for VISN and VAMC strategic planning, which includes maps developed by the VHA's geographic imaging center.

The VRHC serves as a liaison between the ORH and VISN 1, and advises VAMCs and CBOCs on current and future rural health programs and initiatives. The RHC also serves rural veterans by advocating for increased support for their needs and interests by serving on the board of directors on the New England Rural Health Roundtable.

Each individual facility located within VISN 1 developed rural health service plans based upon the needs of the veterans they serve. These plans were then combined to form the 2011 VISN 1 Rural Health Needs Assessment. This assessment was used to address barriers rural veterans face receiving care and services, including:

- Access to care. The VISN strategic planner and VRHC work together with the VAMCs using a variety of strategies to reduce access gaps, including tailoring and expanding services at some CBOCs, use of telehealth technology and fee care where appropriate

- Awareness. Working in coordination and support of VISN outreach initiatives to promote knowledge in rural veterans of the high quality VA health-care services and options they have earned

The VRHC attends two meetings per year held by the ORH, and conducts monthly conference calls where projects and best practices are shared with other VISNs.

Challenges

The biggest challenge facing veterans within VISN 1 is access to VA facilities for care, especially for those veterans residing in the far north area of the VISN. Another challenge is awareness of VA services that are available. The VRHC explained that many veterans who suffer from extreme cases of Post-Traumatic Stress Disorder (PTSD) will isolate themselves by moving to the most rural areas of the VISN, and reaching these veterans would require increased outreach initiatives such as town hall meetings and stand downs. The VRHC also noted that outreach provided during the Eastern States Exposition, "The Big E," was also very effective. However, the time needed to provide adequate outreach to isolated veterans is not sufficient, due to the VRHC position being a collateral duty. The VRHC is simply not able to dedicate the sufficient time needed to be successful in reaching these veterans.

Recommendations

The ORH should establish a specific job description for the VRHC position, along with a comprehensive training program that develops the candidate according to the responsibilities of the VRHC position. The VRHC should be a full-time position and not a collateral duty, to allow more time for outreach to rural veterans and other outreach and training initiatives, such as monthly meetings, conferences and town hall meetings. All VRHC positions should be fully funded and directed by the ORH.



RURAL HEALTH RESOURCE CENTER | WHITE RIVER JUNCTION, VT

Date: January 9, 2012

National Task Force Member: Patrick R. Rourk

National Field Service Representative: Steven J. Henry



Background

Currently, the White River Junction Rural Health Resource Center's FY 2011 budget was \$2.1 million and FY 2012 was \$2.2 million. Its project budget was \$1.6 million in FY 2011 and \$1.9 million in FY 2012. The VISN's Rural Health Resource Center works with the VISN Rural Health Consultants in VISNs 1-10 to identify how they may provide implementation support for current and new clinical demonstration, and quality improvement projects. The VRHRC offers expertise in Geographic Information System, developing and conducting evaluation and analyses, delivery of care via distance technology and health communications.

The purpose of the VHRC is to serve as field-based laboratories that conduct studies, and implement and evaluate innovative models of health-care delivery. The VHRC will continue to develop and implement projects that improve access and quality of care for rural veterans, support the Office of Rural Health's goals and initiatives, and support VA Secretary Shinseki's priorities.

The majority of projects in FY 2012 will continue into FY 2013 and a small number of new projects will be added. Current projects to be continued include:

- The delivery of primary care to veterans with spinal cord injury and disease (SCI/D) by clinical video telehealth to home or CBOC, and expanding telehealth services to SCI rural veterans
- Rehab for long-term stabilization/improvement in function for muscular sclerosis
- Clinical video telehealth neurology for follow-up care of veterans with progressive muscular sclerosis living in rural areas
- Telehealth program for pharmacy – brown-bag clinics for rural Maine CBOCs
- Rural health training program for medical, nursing and associated health professions students
- Public psychiatry fellowship program

New projects for the FY 2013 portfolio are currently under development but will address service gaps for rural veterans,

as well as expand the availability of telehealth services to rural veterans by partnering with other federal/state agencies and programs.

- **Rural Telehealth Veteran Independence Initiative (RVTRI):** This project delivers rehabilitation services to rural veterans in their homes using 21st century communications technology. Providers place Tandberg videophones in veterans’ homes and connect with veterans directly, providing rehabilitation services through high-quality, real-time video delivered over a unique, secure, encrypted Internet network. The RVTRI is a collaboration between the North Florida/South Georgia Veteran Health System’s Physical Medicine and Rehabilitation Service, local senior administration, VA’s Office of Rural Health, and VA’s local and national Office of Information Technology.
- **Houlton VA Outreach Clinic (HVOC) Evaluation:** The HVOC provides basic primary care, including medical evaluation, diagnosis, and medically necessary treatment of physiological and pathological conditions not requiring subspecialty or inpatient services. Evaluation of outcomes measured the resulting effects on access, quality of care, customer service and cost.
- **Rural Surgery Needs and Strategies/Collaborative Study – Maine:** The purpose of this project was to support an assessment of general surgery capacity and the sustainability of that capacity in rural Maine hospital service areas.

Challenges

There has not been a sufficient telehealth network in rural areas. This requires coordination within VA for telehealth video transmission, provider and presenter training, and capture of workload for accounting purposes. Another concern is privacy and security for telehealth in the veteran’s homes. Access to the Internet limits the use of home telehealth care delivery programs in some rural locations. Limited space is another concern in contract and VA-operated CBOCs located in rural areas.

Recommendations

The VRHC requested additional congressional funding because their work is focused specifically on rural veterans and on identifying and implementing best practices that will help improve the quality of VA health care they receive, as well as their ability to access this care. It is clear that rural veterans, which comprise almost

40 percent of the VA-enrolled veteran population, face different barriers in accessing health care than their urban counterparts.

The American Legion can assist the VRHC by supporting and sharing information about the good work of the VA Office of Rural Health, its three Veterans Rural Health Resource Centers, and 21 VISN Rural Consultants. With over 2.4 million members in 14,000 posts worldwide, The American Legion has an extensive communications network and the ability to reach veterans (particularly in rural areas) that VA may not. Many veterans don’t know they are eligible for VA services or how to complete the VA enrollment process, and that there are VA locations where they can receive care closer to home. By helping to inform veterans about what VA has to offer them, The American Legion is providing tremendous assistance.



WHITE RIVER JUNCTION, VA MEDICAL CENTER | WHITE RIVER JUNCTION, VT

Date: December 12, 2011

National Task Force Member: Patrick R. Rourk

National Field Service Representative: Steven J. Henry

Background

The White River Junction (WRJ) VAMC is responsible for delivery of health care to eligible veterans in Vermont and four neighboring counties in New Hampshire. Those services are delivered at the main campus at WRJ and in the four CBOCs in Bennington, Rutland, Colchester, VT and Littleton, N.H. There are approximately 75,670 veterans who fall in the catchment area for the White River Junction VAMC. Of those veterans, approximately 29,067 are enrolled in the VA health-care system; 53,148 are considered to be rural.

Budget

WRJ VAMC's budget for FY 2011 was \$162 million and \$136 million in FY 2012. In FY 2011, \$13.8 million of the WRJ VAMC budget went to fee basis care. The medical center utilizes fee basis care for dental, physical therapy, some chiropractic and acupuncture. The expected fee basis amount for FY 2012 is currently unknown. In FY 2011, \$2.8 million was dedicated to rural health programs and \$604,738 in FY 2012. In FY 2011, the majority of funds dedicated to rural health went to salaries, supplies and rent for the Battleboro and Keene CBOCs, and to extend telehealth mental health services to rural Vermont. It's not expected to affect their rural health program, but the WRJ VAMC is facing roughly a \$5 million projected budget deficit at the beginning of FY 2012. The medical center has encountered projected budget deficits in both FY 2010 and FY 2011 and was able to close these deficits throughout the fiscal year through budget-reduction strategies. If the medical center is unable to close the deficit in FY 2012, there is a process to ask the VISN for additional funding to do so.

In response to the deficit, the executive team formed a committee to focus on being more efficient to reduce the expected deficit, using such strategies as: taking advantage of specific purpose funds to cover operating expenses, reducing overtime without impacting patient care, restricting fee usage to eligible veterans only, reducing planned station projects, limiting employee travel to VA-sponsored programs only, reducing planned equipment purchases under \$100,000, reducing all other spending to only medical necessity or emergent and working to develop a strategy to maximize WRJ VAMC resources and evaluating (not limited to) current programs and workload, right-sizing staffing, cost avoidance, revenue generation, and Full Time Equivalent Employee reduction strategies.

Recently, the administration of beneficiary travel was shifted to the business office where discrepancies were discovered that included veterans giving a false address and veterans taking shuttle service and still claiming beneficiary travel. There are currently nine open cases within the Office of The Inspector General, which is investigating fraudulent beneficiary travel payments. To assist in reducing the possibility of abuse, WRJ no longer makes beneficiary travel payments to veterans who are traveling longer distances on purpose to receive a greater amount. It was also mandated that veterans who were traveling to WRJ for business other than a scheduled appointment only received mileage for one way. After these stipulations went into effect, business office personnel were approached by veterans who notified them that they were taking away half their income. Group providers at WRJ soon noticed group numbers decline after the mandated travel stipulations, making the groups more manageable and effective. WRJ is also implementing a new program that requires a veteran who is submitting a request for travel pay to also present his driver's license at check in.

Staffing

Currently the WRJ health-care system is actively recruiting for mental health providers to include psychologists and psychiatrists. To help fill the void, there are floaters that travel between clinics to provide mental health care. The WRJ medical center actively recruits through Dartmouth University for medical providers; however, compensation is not competitive with the private sector, making it difficult to recruit and retain qualified applicants even with retention incentives.

Telehealth

Currently, the VAMC offers several different telehealth programs and clinical video telehealth. Some examples of telehealth programs include: retinal imaging, rehabilitation and mental health. White River Junction is currently developing the following telehealth programs for podiatry, pathology, geriatrics, rehabilitation, dermatology, mental health for veterans in their homes. Group telehealth projects include MOVE and diabetes education. Equipment for the telehealth programs that are currently offered was purchased through the T-21 funding program. Training is offered either over the phone or in person, but in-person training proves to be difficult for the veterans who reside in more rural areas and may have to travel farther distances

to the VAMC for training. Once the training is received, the veterans quickly install their own equipment, and no high-speed connection is required since the telehealth equipment runs over a normal landline. Out of all the veterans who have received the in-home equipment, approximately 75 percent are active participants in their respective program. The WRJ staff noted that telehealth could expand to be used for Compensation and Pension exams. Telehealth is starting to be implemented into all CBOCs, though some CBOCs – including Rutland and Colchester – do not have the space to accommodate the program.

Specialty Care

The VAMC provides a full range of primary, secondary and specialty care, with clinical services focusing on a comprehensive, compassionate continuity of care. Mammograms and pre-natal services are fee-based into the community.

The medical center does not have the numbers needed to support hiring a full-time mammogram technician; though implementing the use of a mobile mammogram clinic was discussed. The WRJ Women Veterans’ Coordinator was hired in 2002 and performed the function part time until 2008, when she assumed the role full-time. Soon after, a committee consisting of women veterans was formed to advise the coordinator on women veterans’ issues within the WRJ VAMC. Out of the 1,380 women veterans enrolled in the WRJ, 1,151 actively use the system, with 119 being Operation Iraqi Freedom/Operation Enduring Freedom veterans. White River Junction currently is constructing a new 4,000 square-foot Women’s Comprehensive Care Center scheduled to open in April 2012. The center will offer a private outside entrance, but also an indoor entrance in case of inclement weather. The receptionist will have a visual of both entrances to help decrease unwanted guests from entering the center.

The women veterans’ coordinator stressed that women veterans still face many challenges, including not recognizing themselves as veterans and not realizing they have access to veterans benefits. It was agreed that VA has done an excellent job in providing outreach to women veterans. However, even as far as VA has come, there are still strides to make when it comes to offering services to women veterans.

WRJ is anticipating an addition to the Specialty Care unit of Building 39 that will include audiology, neurology and several

components of the Department of Surgery. The new specialty care floor will have its own reception desk and waiting areas.

Challenges

Many veterans must travel long distances to receive care at the WRJ medical center. The WRJ medical center has difficulties in recruiting and retaining qualified applicants due to the lack of competitive compensation. The staff at WRJ is greatly anticipating the implementation of the telehealth program. If implemented correctly, it could have a significant impact on beneficiary travel. However, before the program may be fully implemented, an assessment should be completed at all anticipated sites to determine if the current infrastructure can support the program.

Recommendations

Before the telehealth program may be fully implemented, an assessment should be completed at all anticipated sites to determine if the current infrastructure can support the program. Many of the mental health providers use one monitor while providing care to veterans. It was noted that it would be more efficient if each provider were supplied with two monitors, making it possible to view the veteran’s treatment record while treating the veteran. This would keep the provider from having to switch back and forth between screens, saving precious treatment time for the veteran.



PROVIDENCE VA MEDICAL CENTER | PROVIDENCE, RI

Date: November 8, 2011

National Task Force Member: Todd E. White

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Steven J. Henry

Background

The Providence VAMC is dedicated to providing high-quality comprehensive outpatient and inpatient health care to veterans residing in Rhode Island and southeastern Massachusetts. Veterans also can receive primary care and some specialty services at the CBOC in New Bedford, MA, Hyannis, MA and in Middletown, R.I. There are 71,211 veterans in the catchment area of Providence VAMC, 26,953 of which currently are enrolled in VA. Of the veterans enrolled, 3,000 are considered to be “rural”. Currently there are no veterans enrolled who would be classified as being “highly rural”.

Budget

Total budget for FY 2011 is \$179 million. Fee basis/purchased care expenditures FY 2011 are \$13.7 million and \$12.2 million in FY 2012. Beneficiary travel budget for FY 2011 are \$1.5 million and \$1.7 Million for FY 2012.

Staffing

The medical center and CBOC currently are adequately staffed, with open psychiatry positions in Hyannis and Bedford CBOCs. There is a low vacancy rate for nurses; recruiting for all open positions is ongoing, with an emphasis placed on recruiting veterans. The medical center offers hiring incentives, including retention bonuses for positions open in rural areas.

Telehealth

The medical center’s telehealth program currently serves 307 patients, with 80 utilizing mental health services. The medical center has expanded its telehealth program to include dermatology. The telehealth program provides care/case management to veterans in their homes, utilizing nothing more than a landline phone line; the program is being expanded for veterans to use their cell phones if they do not have a land line. Veterans are given initial training in the medical center and then provided with the necessary equipment that requires a five-minute setup period. Veterans utilizing mental health are required to be assessed at least three times a week by responding to questions regarding their current mental status.

Specialty Care

The medical center provides a full range of patient care services, providing specialty care in most instances at the Providence

VAMC, Veterans Affairs Connecticut Health Care System or Boston Health Care System. Comprehensive health care is provided through primary and specialty care in the areas of medicine, surgery and psychiatry. The medical center offers primary care, mental health, smoking cessation and neurology.

Providence VAMC also takes part in important areas of research, including rehabilitation medicine, cardiology, mental health, dermatology, neuroscience, substance abuse, health services and pulmonary disease. The medical center is involved in a multi-center robotic arm project and an initiative to investigate ways to improve access to care for homeless veterans. For female veterans seeking OB care and mammograms, these services are fee-based to other facilities. The Providence VAMC purchased a trailer with 2,200 square feet of space for less than \$500,000 that will be utilized as the new women veterans center. There will be a private entrance, four exam rooms, and a room for labs, meeting room and a play room for children accompanying veterans on appointments. Currently, there is no playroom for children, so clinic staff must watch the veterans’ children during appointments.

Challenges

Veterans who reside on Martha’s Vineyard must travel off the island through the use of a ferry, and then take a cab to the Hyannis CBOC. Many veterans are owed but not reimbursed for beneficiary travel through the Providence VAMC. The staff of the Providence VAMC should maintain clear communication with the veterans who reside on Martha’s Vineyard in regards to the contract negotiation process with Martha’s Vineyard Hospital.

Recommendations

The Providence VAMC should provide more outreach and communication with the veterans on Martha’s Vineyard concerning the contract negotiation process between the VAMC and the private hospital on Martha’s Vineyard. A training program for the beneficiary travel program should be established to ensure they are properly adjudicating claims. Transportation difficulties for veterans living in rural areas should be addressed.

MANCHESTER, NEW HAMPSHIRE VA MEDICAL CENTER | MANCHESTER, NH

Date: January 10, 2012

National Task Force Member: Patrick R. Rourke

National Field Service Representative: Steven J. Henry

Background

The medical center is a level III facility located in Manchester, N.H., that provides a broad range of outpatient health-care services and inpatient CLC services. Outpatient care also is provided at four CBOCs in Conway, Portsmouth, Somersworth, and Tilton, N.H. The medical center is part of VISN 1 and serves a veteran population of about 127,960 in the New Hampshire counties of Belknap, Carroll, Hillsborough, Merrimack, Rockingham and Strafford. Of those veterans, 41,699 are currently enrolled in VA, 49 percent are considered rural and 27,139 are active users.

Budget

Manchester VAMC's budget for FY 2012 is \$123 Million. In FY 2011 Manchester's beneficiary travel budget was \$1.8 million, more than half of which was Special Mode travel. All Special Mode travel requests are ordered through a clinical consult and are reviewed for administrative eligibility and medical necessity. Manchester currently is working with contracting to develop a multi-county Special Mode contract to satisfy the needs of veterans who reside in rural areas. Manchester has also submitted a proposal to be part of Phase IV for Veterans Transportation System (VTS) pilot.

Manchester's fee FY 2011 fee-basis expenditures were \$28.9 million for FY 2010 and \$18.6 million in FY 2011. In the first quarter of FY 2012, fee basis expenditures were \$4.9 million. A large portion of fee-basis expenditures in FY 2010 and FY 2011 represented dialysis treatment. In FY 2011 the cost for dialysis treatment for one veteran decreased to \$19,000, as opposed to \$450,000 per veteran in the preceding year. Although there was no specific amount mentioned for rural health programs in FY 2011, it was noted that funds would be appropriated from both general and specific allocation models from the overall medical center budget.

Specialty Care

Manchester VAMC provides most of the outpatient care services the Boston Healthcare System (BHS) does, but not at the same level of complexity. For example, Manchester VAMC provides and performs many ophthalmology procedures (cataracts, glaucoma, etc); however neurological, plastic and certain retina cases are referred to BHS because of their complexity. In FY 2011 the top 10 consults to BHS were orthopedic, electromy-

ography, ophthalmology, pain management, vascular surgery, general surgery, general cardiology, ear nose and throat, gastroenterology, audiology and plastic surgery. With the exception of electromyography and vascular surgery, all of these services are provided at VAMC Manchester, just at a lesser level of complexity. It was also noted that VAMC Manchester offers a daily shuttle service to BHS, and veterans who utilize this service would not be entitled to beneficiary travel reimbursement. BHS is responsible for beneficiary travel reimbursement for those veterans who choose to travel to BHS on their own.

To minimize the transportation cost of assisting veterans who receive care at the Boston VAMC, Manchester VAMC has established an acute inpatient care contract with a local community hospital to provide medical and surgical inpatient care. Additionally, Manchester continues to add new services, such as sleep studies, MRIs and palliative care, and has expanded the complexity level of the existing services. Manchester currently is collaborating with VISN leadership and its stakeholders to develop a plan to expand services to reduce the need for veterans to travel out of state to receive care.

The women veterans' clinic is located on the sixth floor of the Manchester VAMC. Within the clinic are three exam rooms, and waiting and check-in rooms. Currently, there is no space for a play room for children; it was discussed that the clinic could move into a larger space that could accommodate a play room. Of the 2,333 women veterans enrolled at Manchester, roughly 1,000 are active users and currently receive treatment at the women's clinic. The providers at the women's clinic offer primary care, gynecological care, mammograms, osteoporosis screenings, birth control, maternity care, wellness and healthy living.

Telehealth

Manchester VAMC has a fully implemented telehealth program that includes three home telehealth registered nurses and one MOVE registered nurse. There is an ongoing recruiting effort for the two remaining telehealth clinical technical positions that are currently open.

Manchester VAMC currently uses the Health Buddy, Viterion, ATI and Interactive Voice Response machines for the telehealth programs. The Health Buddy and Viterion both require the use of a landline. Each machine is easy to use and set up.



Based on which program the veteran is using, he/she will be asked questions to evaluate their current status. The veteran simply presses a button that corresponds with his answer. The only difference between the Viterion and Health Buddy is that the Viterion is more difficult and expensive to purchase, due to it being manufactured in the area affected by the earthquake that hit Japan in 2011.

The ATI is similar to the Health Buddy and Viterion, except that larger letters are used for veterans who may not be able to see the letters on the Health Buddy or Viterion.

The Interactive Voice Response may be used for hypertension, diabetes and depression, and does not require a land line. Similar to the Health Buddy, Viterion and ATI, the veteran simply answers questions updating their current condition. The answers are given over the veteran's cell phone. This gives the veteran flexibility to travel and have the ability to take part in the telehealth programs. The program is most effective with patients who travel to Florida for the winter.

Telehealth is a popular program with veterans and currently has more than 300 participants. The staff noted that biggest challenge with establishing the telehealth program is developing the infrastructure needed for the program to be effective.

Specialty Care

The Manchester Primary Mental Health Clinic (MPMHC) provides seamless and immediate integration of mental health and primary care to veterans through immediate treatment by providing a screening process for additional needs. Veterans may be seen by appointment or as a walk in.

The Homeless Veterans (HV) program falls under the auspices of the MPMHC and includes a homeless coordinator. The HV program provides services in the community in coordination with VA and non-VA organizations such as Harbor Homes, New Horizons Shelter and the New England Center for Homeless Veterans. The HV coordinator provides outreach, clinical assessment, education about VA programs, referrals and case management.

The HV also offers a transition program for homeless veterans through a partnership with Harbor Homes. The transition program is a two-year program for homeless veterans that have

little or no income. For up to two years, veterans have the ability to access housing, with the stipulation that they have to work and maintain constant sobriety.

Challenges

Rural veterans must travel long distances to receive care at the Manchester VAMC. If Manchester does not provide the necessary treatment, the veterans must travel to Manchester, then travel to Boston or Providence for their care.

Recommendations

The Department of Veterans Affairs Central Office (VACO) must realize the importance of establishing a transportation system to assist veterans who are unable to travel to appointments on their own.

HYANNIS COMMUNITY BASED OUTPATIENT CLINIC | HYANNIS, MA

Date: November 9, 2011

National Task Force Member: Todd E. White

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Steven J. Henry

Background

The newly renovated Hyannis (CBOC) provides comprehensive primary health care to veterans residing on Cape Cod and the surrounding islands. The Hyannis clinic has been at its current location for 12 years and was remodeled three years ago to accommodate the growing and currently full panel of patients. Every patient has a primary care provider who coordinates their health-care needs. The provider ensures the veteran receives appropriate care by providing easy access to any of the Providence VAMC's 32 subspecialty clinics.

Laboratory services are contracted through Quest Laboratories and are located nearby in Hyannis. Pharmacy services are also offered to the veteran. If emergency prescriptions are needed, a local pharmacy is able to fill the prescription. All other prescriptions for medications are sent to the Providence VAMC daily and then mailed directly to the veteran's home. Refills are obtained either by sending a signed refills slip to the Providence VAMC or by using the convenient phone system. For radiology, Hyannis has contracted with a local radiology facility to provide easy access to X-ray services. Test results are typically faxed to the veteran's provider within 24 hours. Abnormal results are called in immediately to expedite the treatment process. There are three Patient Aligned Care Teams (PACT) made up of two licensed practical nurses, two registered nurses and three patient care assistants. Also on staff is a full-time psychiatrist.

The Hyannis CBOC currently offers the following therapy groups: The anxiety/depression psychotherapy group, the WWII/Korean War veterans psychotherapy group, complex post-traumatic stress psychotherapy group, later-life issues psychotherapy group, Vietnam combat veterans psychotherapy group, mental health psychotherapy group, the stress management program and the popular “MOVE” weight-loss program.

Challenges

The greatest challenge veterans face with accessing care is distance. Many veterans who reside on Martha's Vineyard and travel to Hyannis for treatment must do so after a 45-minute ferry ride and 25-mile drive. In some instances the Martha's Vineyard veterans must travel to Providence VAMC, which is 77 miles away. Even newly renovated, the Hyannis CBOC is outgrowing its current space. All panels are full, so no new patients are

accepted and forced to travel 48 miles to the closest CBOC or the Providence VAMC. There are mental health groups that are facilitated by a social worker, but the clinic is limited as to how often the groups meet since the clinic does not have the staff to support it.

Recommendations

Assistance must be provided to veterans who have difficulty traveling to the CBOC for treatment. Hire or redirect a current employee to assist veterans who are currently living on Martha's Vineyard and need to contact the Hyannis CBOC for fee-basis pre approval



TILTON COMMUNITY BASED OUTPATIENT CLINIC | TILTON, NH

Date: January 9, 2012

National Task Force Member: Patrick R. Rourk

National Field Service Representative: Steven J. Henry

Background

The Tilton CBOC resides within the jurisdiction of the Manchester VAMC. The clinic was previously located in the Old Soldiers home before moving to its current location. The clinic maintains a panel of 1,590 veterans through one full-time physician, one part-time nurse practitioner, two registered nurses, one licensed practical nurse and one health-care technician.

Laboratory services are provided using a courier. Lab work is done in-house and then sent to the Manchester VAMC. Normally, results are ready to be reviewed by the veteran's provider the same day. Mental health services are provided on Tuesday, Friday and every other Wednesday. It was reported that veterans normally receive their initial mental health appointment within the mandated 14 days. The clinical pharmacist offers care for diabetes, including hypertension.

The Tilton CBOC offers telehealth programs that include MOVE and Retinal services. Tilton currently employs a part-time telehealth technician who utilizes two rooms designated for telehealth treatment. It was noted that veteran participation would be hard to gauge based on limited access to high-speed Internet or a landline, since some veterans live in areas where neither are available.

The Tilton CBOC is located in VISN 1, which is one of the first VISNs to participate in the "Secure Messaging" program through MyHealtheVet. Through this program, veterans are able to send email messages to their respective providers and receive feedback from their providers and VA such as dates and times of appointments, medications and treatment. This gives the veteran the ability to communicate with their provider without having to travel to the facility.

Challenges

The staff of the Tilton CBOC expressed concern over the lack of signage displayed for the clinic. Without knowledge of the clinic's location, it is difficult to locate due to the lack of advertisement. It is unknown how many veterans will have the ability to participate in the telehealth program due to a lack of accessibility and available infrastructure. Many veterans live in areas where landlines and/or high speed Internet is not available. Tilton actively recruits for open positions in other areas surrounding Tilton due to the lack of local quali-

fied candidates. Currently, there is not enough outreach provided to reach those veterans that isolate themselves due to the effects of severe PTSD. To assist future veterans utilizing the Telehealth programs, funds should be made available to hire a full time telehealth technician.

Recommendations

It is recommended that VA leadership promptly address and correct the lack of signage at the clinic. Also, the CBOCs require additional funds for telehealth programs. An assessment of rural areas needs to be completed to ascertain which areas have the available infrastructure for telehealth programs. There should be funds allocated to assist medical centers with recruiting incentives to make employment opportunities in rural areas more attractive to qualified candidates.

CONWAY COMMUNITY BASED OUTPATIENT CLINIC | CONWAY, NH

Date: January 10, 2012

National Task Force Member: Patrick R. Rourk

National Field Service Representative: Steven J. Henry

Background

The Conway CBOC is a local clinic that resides within the jurisdiction of the Manchester (VAMC). The clinic was previously a contract clinic that was located in a nearby hospital but then relocated to a separate location. The clinic soon switched over to being a VA clinic. On September 29, 2010, the director of the Manchester VAMC conducted a ribbon-cutting ceremony for the new clinic. The clinic currently resides on the third floor of their building, for which they hold a five-year lease with the option to renew. Clinic management is looking to possibly moving to the first floor of the building to avoid veterans having to use the stairs or the elevator to access the clinic.

The clinic currently employs one full time physician, one nurse practitioner, one mental health nurse practitioner, two registered nurses, two licensed practical nurses and one telehealth technician. The clinical pharmacist offers care for diabetes, including hypertension. A social worker visits the clinic once a month to assist veterans with any questions or issues they may have, such as eligibility, enrollment and insurance. Labs are sent to Manchester VAMC through the use of a courier that normally produces same-day results.

The Home Based Primary Care (HBPC) team consists of a registered nurse who provides primary care to veterans in their homes who may not be able to travel to the clinic. The HBPC nurse was hired in September, and in four months her panel is nearly 19 patients; the panel will be full with 20 patients.

The Conway CBOC currently treats 910 veterans; though one out of three patients seen on a daily basis is considered a "new" patient. The amount of veterans the clinic treats has doubled since it switched over to being a full VA clinic. Until June 2012, the clinic's panel size will be 1,575 veterans since it is a "new" clinic and will have only been open for nine months. After June the panel will be increased to 1,900.

The Conway CBOC currently offers the following services on a fee-basis nature:

- Urology, offered locally
- Radiology – basic X-rays are offered locally, but Cat Scan or Magnetic Resonance Imaging must be performed in Manchester
- Mammograms, offered locally

- Colonoscopy exams, offered locally
- Occupation Therapy for evaluation and training for use in adaptive equipment, offered locally
- Podiatry, offered locally

Since becoming a VA clinic, the panel for Conway is quickly growing. Its building has a working elevator but still presents problems for older veterans who require assistance through the use of a walker or wheelchair. Clinic staff expressed interest in moving to the first floor and even needing more space, but also admitted that they are very happy with their current location. Veterans that were interviewed expressed how pleased they were with the VA-staffed clinic. Two veterans spoke of poor service received through the older, non-VA clinic. One veteran even stated he refused to use the clinic for his health care, choosing instead to travel to White River Junction 94 miles away. After the clinic changed to being VA-staffed, the same veteran now receives all of his care from the Conway clinic.

The Manchester VAMC staff played an important role in having the clinic changed to a VA-staffed clinic. The VAMC director personally traveled to Conway and conducted four separate town hall meetings to hear veterans' concerns about the health care they were receiving at the contract clinic. Soon after hearing the veterans concerns, the director expressed an immediate interest in solving the care issues veterans faced.

Challenges

Veterans who utilize the Conway CBOC stressed they are happy with the care they are receiving; they did note that it would be helpful to have an audiologist to visit the clinic a few times a month to check and repair hearing aids.

Recommendations

The Manchester VAMC should develop a program to have an audiologist visit the Conway CBOC at least twice a month. The space issue should also be addressed, since the clinic's panel is growing very quickly. More staff should be added to the HBPC team to address the growing number of patients.



COLCHESTER COMMUNITY BASED OUTPATIENT CLINIC | COLCHESTER, VT

Date: December 12, 2011

National Task Force Member: Patrick R. Rourk

National Field Service Representative: Steven J. Henry

Background

The Colchester CBOC, affiliated with the White River Junction (WRJ) VAMC, is located in Burlington, VT. The CBOC at Fort Ethan Allen in Colchester, VT serves the primary health-care needs of eligible veterans in the greater Colchester/Burlington area. Opened in September 2000, the VA-staffed clinic employs five full-time physicians that service 4,126 patients, eight percent of which are female veterans.

The Colchester CBOC has a contract with a local pharmacy that will fill prescriptions for veterans. Any labs taken at the CBOC are sent to the WRJ VAMC via courier, results normally come the next day.

The mental health team at Colchester includes 12 providers. Colchester also offers counseling outside of the CBOC by its Mental Health Intensive Care Team (MHICT) that includes four providers who travel into the community to counsel in public places veterans who may not be able to receive treatment inside a government clinic due to trust issues. The MHICT covers a radius of approximately 50 miles. The Colchester home-based primary care team includes 16 providers who travel to veterans homes to offer care to veterans who are not able to travel to the CBOC. That team covers a radius of approximately 50 miles.

Challenges

The Colchester CBOC currently is located in a 10,000 square-foot facility in Burlington, VT. With close to 50 employees and 4,200 patients, the facility has over-grown its current space. There is an ongoing search for a 20,000 square-foot facility that is no more than two stories and in close proximity to the hospital to replace the current location. CBOC management is anticipating moving into a new larger space in February 2013. After arriving at the CBOC and speaking with veterans in the waiting room, we were informed that the average wait time for appointments was at least 30 minutes. During the site visit it was discussed that the White River Junction Medical Center had hired a telehealth technician to be employed at the Colchester CBOC to assist veterans who are using the in-home telehealth equipment; however, the Colchester CBOC is unable to offer the in-home telehealth service since there is no available storage space in the current building to store the

equipment. All available storage space has been converted into office space for new employees as more services were added. There currently is no open office space for the newly hired telehealth technician. Even with the lack of space, the Colchester CBOC manages quite well by maximizing the space they do have, converting many of the storage closets into offices and with all employees sharing office space. In many cases employees share a space so small it would be difficult for all employees to sit at their desk at the same time.

Recommendations

The clinic has more than exceeded its current space and needs to relocate to a new facility that gives them the ability to accommodate its current panel of patients. Without additional space, the clinic is unable to move forward with a telehealth program. It is recommended that VA leadership reviewing the existing space in the clinic to determine if the clinic can be expanded or should move to another location.

MARTHA’S VINEYARD AMERICAN LEGION FOCUS GROUP | MARTHA’S VINEYARD, MA

Date: January 10, 2012

National Task Force Member: Todd E. White

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Steven J. Henry

The focus group was held at the local American Legion Post 257 on Martha’s Vineyard. During the discussion, issues concerning the contract in negotiations between the Providence VAMC and the Martha’s Vineyard hospital were raised. In 2008, the contract lapsed between Providence VAMC and the Martha’s Vineyard Hospital (MVH) that allowed veterans who resided on Martha’s Vineyard to receive care at the hospital. Veterans were not informed by VA that the contract had lapsed and received bills in the mail from collection agencies for services received at the Martha’s Vineyard hospital. Since then it has been an ongoing struggle for veterans who reside on Martha’s Vineyard to receive care.

One of the biggest obstacles is the travel involved to a VA CBOC or the Providence VAMC. Veterans must take a ferry off of the island and then drive an hour to the Hyannis CBOC. If the weather is not cooperating the ferry will not sail. If veterans make the trip off the island and the weather decreases, they are forced to stay on the island for the evening. Veterans also stated they must receive all their care in the winter months, since

tourism during the summer makes it next to impossible to get a spot on the ferry. If the veterans are in need of specialty care not available at the CBOC, they must drive approximately two hours to reach the Providence VAMC.

Veterans who are service connected at 50 percent or greater may receive a fee-basis card to receive care for their service connected disabilities at the Martha’s Vineyard Hospital. However, these veterans must call the Hyannis CBOC for preapproval before seeking care at the MVH. This has caused some problems when the CBOC representative goes on vacation. A veteran explained that the surgery he received on his wrist in November was going to require a removal of the cast and physical therapy that he had scheduled at the MVH in late December. Unfortunately, when the veteran called the Hyannis CBOC to receive approval for the care, he was notified the representative was on vacation and that he would be unable to receive approval until she returned, which happened to be a week after his cast was scheduled to be removed.

RECOMMENDATIONS

VISN 1 Director

- Establish a clear and concise definition of “rural” and “highly rural”
- Conduct assessments of current infrastructure to determine if it is able to accommodate the telehealth program.

VISN Rural Health Consultant

- Establish a specific job description for the VRHC position
- Establish a comprehensive training program
- Should be a full-time position and not a collateral
- All VRHC positions should be fully funded and directed by the ORH.

VAMC

- An assessment should be completed at all anticipated sites to determine if the current infrastructure can support the program
- It was noted that it would be more efficient if each provider were supplied with two monitors to be able to view the veteran’s records while treating the veteran

CBOCs

- Should address the lack of space to add new patients, since presently all panels are full.
- Increased space could be used for telehealth capabilities.
- Complete the contract on Martha’s Vineyard in order to provide care to those veterans
- Hyannis CBOC should consider hiring a new employee to assist with the approval process for Martha’s Vineyard veterans or designate another employee to do so.
- Conway CBOC should have an audiologist visit twice a month.
- The clinic should have vans equipped with special mode transportation.
- Place signage on building and roads leading to the CBOC
- Insufficient transportation throughout VISN 1



VISN 15

VETERANS INTEGRATED SERVICE NETWORK

KANSAS CITY, MO

November 29, 2011

National Task Force Member: Past National Commander Jimmie L. Foster

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

VETERANS INTEGRATED SERVICE NETWORK RURAL HEALTH CONSULTANT

POPLAR BLUFF, MO

January 3, 2012

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

PROJECT ACCESS RECEIVED CLOSER TO HOME

ARCH - WICHITA, KS

November 30, 2011

National Task Force Member: Past National Commander Jimmie L. Foster

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

KANSAS CITY VA MEDICAL CENTER

KANSAS CITY, MO

November 29, 2011

National Task Force Member: Past National Commander Jimmie L. Foster

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

JOHN J. PERSHING VA MEDICAL CENTER

POPLAR BLUFF, MO

January 3, 2012

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

MARION VA MEDICAL CENTER

MARION, IL

February 7, 2012

National Task Force Member: William R. (Bob) Wallace

National Field Service Representative: Kevin H. Blanchard

HUTCHINSON COMMUNITY BASED OUTPATIENT CLINIC

HUTCHINSON, KS

December 1, 2011

National Task Force Member: Past National Commander Jimmie L. Foster

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

SIKESTON COMMUNITY BASED OUTPATIENT CLINIC

SIKESTON, MO

January 4, 2011

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

MT. VERNON COMMUNITY BASED OUTPATIENT CLINIC

MT. VERNON, IL

February 8, 2012

National Task Force Member: William R. (Bob) Wallace

National Field Service Representative: Kevin H. Blanchard

EFFINGHAM COMMUNITY BASED OUTPATIENT CLINIC

EFFINGHAM, IL

February 8, 2012

National Task Force Member: William R. (Bob) Wallace

National Field Service Representative: Kevin H. Blanchard

AMERICAN LEGION POST FOCUS GROUP

INDEPENDENCE, MO

November 30, 2011

National Task Force Member: Past National Commander Jimmie L. Foster

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

AMERICAN LEGION POST FOCUS GROUP

SIKESTON, MO

Date: January 3, 2012

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

RECOMMENDATIONS



VETERAN INTEGRATED SERVICE NETWORK 15 | KANSAS CITY, MO

Date: November 29, 2011

National Task Force Member: Past National Commander, Jimmie L. Foster

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

Background

VA's Heartland Network is one of 21 VISNs. The VA Heartland Network is headquartered in Kansas and Missouri, as well as parts of Illinois, Indiana, Kentucky and Arkansas. The region has eight VAMCs, 32 CBOCs and multiple affiliations, such as the University of Kansas School Of Medicine and the University of Missouri at Kansas City. There are 339,334 veterans residing in the catchment area.

Budget

The total budget in FY 2011 was \$1.9 billion and slightly increased to \$2 billion in FY 2012. The total fee-basis/purchased care expenditure in FY 2011 was \$282 million and was \$300 million in FY 2012. Total VISN rural health fee-basis/purchased care expenditure for FY 2011 was \$61,000 and increased to \$1.5 million in FY 2012. The large disparity is that "Rural Health/Fee Basis" and Project Access Received Closer to Home (ARCH) didn't start until August of FY 2011. So with only two months in the fiscal year there was only \$61,000 in expenditures versus the estimated FY 2012 total of \$1.5 million. The VISN beneficiary travel budget in FY 2011 was \$38 million and \$40 million in 2012. Of the 2011 budget, \$19 million was dedicated to rural health programs and initiatives; that number was decreased to \$14 million in 2012. This decrease was due to uncertainty in new project effectiveness and veteran participation.

Current rural health-care projects:

- St. Louis VAMC FY 2012 home-based primary care (HBPC) sustainment and expansion: Marion VAMC HBPC
- Care coordination home telehealth sustainment
- Marion VAMC telehealth program for pharmacy
- V15 rural veteran transportation project
- Collaborative discharge planning for veterans returning to rural areas

Challenges

The current economy is still a considerable challenge for the VISN. The appropriation of funds is not sufficient to pay for certain costs, such as transportation and medications for veterans living in rural communities. New programs need to be

fully developed and planned based on evidence supporting its legitimacy. Funds are scarcer, and the VISN must prioritize and measure program performance to evaluate whether to extend the program or direct resources elsewhere. Furthermore, programs and initiatives need a proper management team to ensure its success and measure its performance financially and in quality of care. Rural health care delivered via CBOCs and telehealth programs need to have equivalent care or care superior to current care. More access to care must not replace quality of care.

A constant barrier for the VISN has been enrollment. From the 339,334 veterans residing in the catchment area only 234,000 are enrolled in VA. It has been difficult reaching these veterans, especially in highly rural areas where there is limited technology. Many veterans are not aware of the health-care benefits offered and have no reason to seek care. Struggling to educate older generations on health-care benefits and gaining confidence in the VA health-care system has always been a struggle. This same paradigm is true for the current generation of veterans but is slowly improving as the quality of care and outreach increases.

Recommendations

Tracking veteran's eligibility for health-care benefits will be more important in the coming years with returning combat veterans. The VISN needs to prepare now for this influx and test tracking and finding technologies to reach each veteran, ensuring they understand the health-care benefits granted to them. Telehealth will be a crucial component in making the delivery of health care cost-effective. The VISNs should invest funds into these types of programs and technologies now before it's too late. Before granting the VISN funds for any rural health program or technology, it should be tested managerially and functionally beforehand.

VISN 15 RURAL HEALTH CONSULTANT | POPLAR BLUFF, MO

Date: January 3, 2012

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

Background

Given that 75 percent of VISN 15 is designated rural, providing a VISN Rural Health Consultant (VRHC) to the area is evident. The full-time position went into effect on May 22, 2011, at the Poplar Bluff VAMC. The VRHC's primary role is to provide leadership and consultation to identify, develop and/or support initiatives that will enhance services delivered to veterans residing in rural and highly rural areas. The RHC is expected to interact with all VAMCs in the VISN, giving them guidance and support as needed to achieve results and improve rural health access and patient outcomes. The VRHC reports 75 percent of their time to the VISN and 25 percent of their time to the Office of Rural Health (ORH). The ORH's overall focus is community collaborations such as partnering with the Department of Health, reaching out to the veteran's homes via telehealth, and accepting locations called “end point” to receive health care.

The Veterans Affairs Central Office (VACO) and ORH provide specific funds for the VRHC position. Initially, training was done on the job by the ORH's liaison guidance. The VRHC is a registered nurse by trade, completed an orientation in November and continued training via bi-annual meetings, monthly conference calls and ad hoc contact with the ORH liaison and other full-time VRHCs in other networks. There are monthly conference calls within the VISN and ORH, and monthly calls with the VISN rural health staff. The VRHC is not responsible for developing rural health service plans based on VISN-wide needs assessments. However, one was done during the consultant's transition into the position. The VRHC, ORH and the VISN complete needs assessments and then send to the ORH to identify common needs across the board. The ORH provides a template based on demographics.

The VACO also works to educate the ORH, fulfilling obligations of needs assessments, performance reviews and programs, and sends project proposals to the ORH. Information is shared through email, telephone and, most importantly, the VISN Rural Health SharePoint page. The SharePoint page is designed as an open intranet portal to store information, allowing it to be viewed by many and to share their thoughts without requesting it from any one individual. There is a concentration on sharing “best practices” or challenges unique to the VISN with other VISNs through this portal.

In conjunction with communication capabilities, the VRHC works to improve outreach of its programs to their rural veteran population. This is done by developing collaborative relationships with the state Department of Health Services. In particular, the VRHC has been meeting with the Missouri Department of Health and Rural Service Coordinator to work on sharing information on projects and programs such as VA's Health Exchange Pilot and Missouri's Healthcare Workforce Registration Exchange. Contact has been made with Kansas and Illinois, but no meetings have been conducted.

Challenges

There has not been sufficient time and direction on how to complete a comprehensive needs assessment. Federal regulations have become increasingly strict and are creating somewhat of a barrier for surveying veterans. Also, there is an information overload in using SharePoint.

Recommendations

Needs assessments should be done in a more comprehensive manner. More veterans should be personally asked what type of services they need and what improvements should be made, but some types of methods, such as surveys, are against federal regulation. Also, Operation Enduring Freedom and Operation Iraqi Freedom veterans are very difficult to record, as these veterans are hard to identify and track. The VRHC should communicate with the VAMC and other VISNs to identify methods of collecting this data. The SharePoint portal is available to a wide range of internal employees, but the information is not always relevant. This is an easy place to put information, but the result is overload and confusion on how to use it. Transportation is always an issue; VA tries to partner with veterans service organizations, but there is not enough participation. This may be a combination of a lack of incentive or outreach.



PROJECT ACCESS RECEIVED CLOSER TO HOME (ARCH) | WICHITA, KS

Date: November 30, 2011

National Task Force Member: Past National Commander, Jimmie L. Foster

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

Background

Project Access Received Closer to Home (ARCH) pilot program provides health-care services through contractual arrangements with non-VA care providers. The site is located in Pratt, Kansas, and operated at the Wichita, Kansas VAMC. It was launched both nationally and locally on August 29, 2011. The ARCH site coordinator for Pratt is located at the Wichita VAMC and is a full-time position. The age range of veterans participating in Project ARCH is between 55-91 years and 96 percent male. The total budget in FY 2012 is \$1.4 million for patient care and \$100,000 for employee salaries. There are weekly calls with the Office of Rural Health that involve participating VISNs and monthly calls for VISN 15. There are only 23 veterans currently enrolled in the program.

To be eligible for the program,

- Veterans must be enrolled in VA prior to August 29, 2011, reside in one of Project ARCH's five pilot site areas; and
- Live more than 60 minutes driving time from the nearest VA health-care facility providing primary care services; or
- Live more than 120 minutes by car from the nearest VA health-care facility providing acute hospital care; or
- Live more than 240 minutes by car from the nearest VA health-care facility providing tertiary.

Challenges

This is a minimally advertised program without a great deal of participation. There is \$1.4 million budgeted for patient care for only 23 patients. It's unlikely all funds are being effectively utilized, partly due to the lack of awareness of the program. The outreach guidelines have not been clearly communicated to the facilitators, and there has not been a significant push to do so. This is only a three-year pilot program, so there is apprehension for additional outreach, although funds are likely going unused. There have been no outreach services provided to the Pratt, Kansas ARCH pilot site, because guidelines are not clearly defined from the Veterans Affairs Central Office. Lastly, the structure and procedures are different in the VA system than non-VA systems. This can cause a communication and work flow problem.

Recommendations

The current numbers indicate the program is not effectively using its resources. There seems to be opportunities for veterans to utilize health care from this program. This can be done by better advertising or loosening the eligibility requirements. A clear communication path needs to be defined with the contracting facility, VAMCs and VACO.

KANSAS CITY, VA MEDICAL CENTER | KANSAS CITY, MO

Date: November 29, 2011

National Task Force Member: Past National Commander, Jimmie L. Foster

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard



Background

The Kansas City VAMC (KC VAMC), located in Kansas City, Missouri provides a broad range of patient care, including seven CBOCs. It also has affiliations at the University of Kansas and University of Missouri at Kansas City. There are 150,079 veterans residing in the KC VAMC catchment area. The center has master agreements with the University of Kansas Medical School and University of Missouri-Kansas City Medical School, and currently uses their telehealth capabilities for addressing access to health care to rural veterans. There are 13,313 rural veteran users in the KC VAMC.

The current rural health-care initiatives are to optimize the use of available and emerging technologies such as telemedicine, Web-based networking tools, and the use of mobile devices to deliver care to rural and highly rural veterans. There are six current rural veteran initiatives: Veterans Affairs Central Office Rural Health Grant, Mobile Medical Clinic, telemedicine, satellite capabilities, wheelchair accessibility, transportation pilot and treating enrolled veterans.

Budget

The budget was \$248 million in FY 2011 and projected at \$240 million for FY 2012. There was \$1.6 million dedicated to rural health programs and initiatives in FY 2011, but FY 2012 amounts are unknown. In FY 2011 there was \$38.7 million of fee-basis/purchased care disbursed among 1,665,574 veterans. In FY 2011 the beneficiary travel amount reached \$7.3 million, divided between special mode and mileage reimbursements.

Staffing

There is a low vacancy rate for nurses; recruiting for all open positions is ongoing, with an emphasis placed on recruiting veterans. The medical center offers hiring incentives such as retention bonuses for positions open in rural areas. The total staff in FY 2011 was 1,470, along with 356 volunteers. The medical center provides competitive market salaries that can be adjusted depending on the level of skills needed. Currently, positions are needed for providers via telemedicine, registered nurses, health technicians and support services at the main hospital.



Telehealth

The Telemedicine Task Force of KC VAMC is responsible for coordination of telemedicine initiatives throughout the KC VAMC and the CBOCs. Interactive-video mediated education sessions are being conducted via telehealth. The Home Tele-care Coordination Project started in October 2004. This project is VISN- wide and nationwide, extending care to the home for veterans with hypertension, diabetes mellitus, and chronic obstructive pulmonary disease. Psychiatry via telehealth will soon be available as well.

Specialty Care

KC VAMC continues to expand women's clinic panels with two new full-time providers. Women veterans generally request the same care males do, with the addition of female specialists such as gynecologists. There are two full-time providers: a gynecologist and pharmacist who both have experience with women veterans needs. Currently, there is a community-based single vendor for mammography to facilitate scheduling and records management, and improve patient access. Mental health programs for rural veterans include extending services to CBOCs via telemedicine.

Outreach

The outreach program extends to the community by way of events to educate the health-care communities and collegiate communities on VA's services for male and female veterans, and by networking with other federal agencies that also promote health and wellness programs. Also, a provider conducts full-day clinics once a week from the CBOC sites in Carrolton, Trenton and Bolivar.

Challenges

One of the most notable challenges has been the fundamental difference in how health care is delivered, requiring a unique paradigm shift in veterans and providers. Many previous generations prefer health care to be delivered the traditional way, such as in-person consultation and not using a video feed or other devices for diagnosis. This method of health care lacks some "patient to provider" interactions and emotions associated with it, but due to the influx of veterans into the VA health-care sys-

tem, this approach offers care to many more veterans and easier accessibility. Although these health-care methods are unique, VA must maintain the same level of care as conventional care. The technology and method of delivery is relatively new in the VA health-care system, and further research and techniques of evaluating rural veteran's are needed. Outreach has been another challenge due to marketing restrictions from the Veterans Affairs Central Office. KC VAMC noted it having an aggressive outreach team that works closely with veterans' service organizations to assist reaching veterans. But the marketing restrictions are getting tighter and creating somewhat of a barrier.

Recommendations

The VAMC has complained of marketing restrictions from the VACO, making it difficult to reach out to veterans in rural communities; furthermore, marketing guidelines have not been clearly defined from any office. The VAMC should work to define a clear communication path in which these questions and related ones can be answered.

JOHN J. PERSHING, VA MEDICAL CENTER | POPLAR BLUFF, MO

Date: January 3, 2012

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

Background

The VAMC – located in Poplar Bluff, Missouri, 150 miles from St Louis – provides care to veterans throughout 29 counties of South-east Missouri and Northeast Arkansas. Approximately 58,000 veterans live in the catchment area, and about 40 percent of them receive care at the medical center annually. The entire VAMC is considered a rural health-care facility; its programs and services are designed to serve these unique veterans. There are 23,460 rural male veterans and 888 rural female veterans using the VAMC.

Budget

It is difficult to accurately depict how much was dedicated to rural health programs and initiatives because the facility considers most of its budget geared to rural health care. The total budget for FY 2011 was \$113.4 million and \$100 million for FY 2012. Fee-basis/purchased care for FY 2011 was \$9.1 million and \$2.3 million for FY 2012. Beneficiary Travel for FY 2011 was \$2.2 million and \$4.6 million for FY 2012.

Staffing

Recruitment and retention have been difficult in this area. There is a number of positions open, but much of the facility cannot afford top medical talent. Furthermore, many newly trained medical professionals go to larger cities where the salaries are higher and lifestyles are more suited to their desires. Newly trained doctors prefer an urban setting over an environment such as Poplar Bluff. VA has incentives in place, such as medical school debt assistance, but not enough to attract top talent.

Telehealth

Poplar Bluff VA has one of the largest and most developed telehealth labs in the country, but it's not without challenges. The newest generation adapts well to this technology, which is used for mental health, demonology, amputee evaluation and maintenance, and recording vital signs and blood sugar levels from home. These technologies have worked well and continue to improve. The generation gap in the patients, as well as the health-care provider, has been a challenge; however, there has been positive feedback from both ends. More specifically, capabilities and educating staff have been suppressing barriers. Educating staff of the new technology is a profound paradigm shift in the way health care is delivered. Some staff feels it's necessary for every appointment to be conducted in-

person and accepts no alternative. Lastly, increased bandwidth is needed to serve the increasing number of veterans using telehealth.

Specialty Care

The VA noted female veterans have relatively the same medical needs as male veterans, with the exception of female-specific medical issues and Military Sexual Trauma. The Poplar Bluff area has more female veterans than many other parts of the country because there are less post-high school opportunities. These females are sometimes left with joining the military as the best option. Female specialists are placed in various CBOCs throughout the area, and there are female sexual trauma specialists conducting focus groups at the VAMC. Telehealth is also available for the female population. Most recently, the medical center constructed a children's care center in the lobby that was scheduled for completion in March 2012.

Outreach

Outreach is conducted using VSOs meeting periodically with the medical center's leadership. Community events are also a large part of outreach, including fairs, radio advertisements and parades. However, there was not any comprehensive outreach program shown during the visit.

Challenges

Recruitment and retention have been challenging because the medical center has yet to properly identify the correct clinicians. The medical center may need to change its focus of recruitment, unless it can offer a better incentive program to attract top clinical talent. Many highly trained clinicians want to live in urban areas.

Recommendations

Poplar Bluff, Missouri is exceptionally rural, which results in recruitment and retention difficulties. The VAMC must recruit in one of two ways: by increasing employee incentive packages of better compensation and student loan assistances, or target top clinicians in the area. More paid positions should be available for the Veterans Transportation System. Currently, there are only volunteers driving veterans to and from their appointments. These volunteers are important, but not consistently available. Paid drivers will be more consistent and reliable and create jobs for other veterans. There should be a fully functional transportation department in the VAMCs that measures transportation demand and meets the needs of the veterans.



MARION, ILLINOIS VA MEDICAL CENTER | MARION, MO

Date: February 7, 2012

National Task Force Member: William R. (Bob) Wallace

National Field Service Representative: Kevin H. Blanchard



Background

The Marion, Illinois VAMC has a catchment area of 125,000 veterans and provides care to 43,700 veterans annually in 27 counties in southern Illinois, eight counties in southwestern Indiana and 17 counties in northwest Kentucky. There is an estimated 85,000 rural and highly rural veterans in the catchment area; of those, only 2,000 male veteran and 43 females use VA. Opportunities exist for increasing veteran enrollment in southwestern Indiana (Evansville) and western Kentucky (Owensboro). The facility planned monthly open houses, and health fair events beginning in March 2012 at each satellite clinic throughout the catchment area.

Budget

The VAMC budget for FY 2011 was \$275.4 million but fell to \$265.1 million in FY 2012. There was \$6.6 million in 2011 and \$5.2 million in 2012 dedicated to rural health programs and initiatives. The fee-basis/purchased care expenditures in FY 2011 were \$36.7 million and \$15.8 million in 2012. The beneficiary travel budget in FY 2011 and FY 2012 was \$8.4 million.

Potentially all specialty services could be fee-based. Services that are fee-based are dependent upon availability of the service within the VA, as well as the level of care required for the veteran. Per National Fee Guidelines, VA services must be considered first; this is accomplished by determining service availability at Marion VAMC, Evansville Health Care Center, John Cochran VAMC and other VAMCs within the VISN. The number of veterans using fee-based care depends on the veteran's need for services, ability to travel and service availability at the VA facilities.

In the instances of contracted care, the consult unit tracks veterans who are referred for fee-basis, and follows up with the non-VA provider and/or facility to request records after the appointment. A report that indicates consults that are scheduled and needing results is generated weekly by the program manager. The VAMC obtains feedback from the veterans by contacting them either by phone for follow-up appointment information or by them contacting the consult unit to provide the VAMC with an update on their visit.

Staffing

The VAMC is currently recruiting for one psychiatrist, one gastroenterologist, one orthopedic surgeon, two general surgeons, chief of extended care (physician) and chief of imaging service. There are a few incentives the VAMC considers during recruitment: relocation expenses, Education Debt Reduction Program and Student Loan Repayment Program.

Telehealth

The VAMC has a range of telehealth programs for the following conditions: substance abuse disorder, smoking cessation, diabetes education, individual mental health appointments, spinal cord injury, telehealth services (i.e. retinal screening, pharmacy). The training required for these programs is short (completed during a normal appointment), and includes primary care provider education and digital boards. Veterans often travel to CBOCs for these programs, and the information collected is sent to their respective VAMC. In some cases, veterans can be set up and trained on telehealth equipment at home on the same day.

Specialty Care

There is a full range of mental health care available at the CBOCs and VAMC. All CBOCs have full-time mental health providers and social workers. There are two CBOCs with full-time psychologists, five CBOCs with a full-time psychiatrist or a psychiatric nurse practitioner on site, two CBOCs with part-time psychiatrists and six CBOCs with mental health nurses. There are eight CBOCs assigned to Marion VAMC, which also has a therapist and a mental health social worker who has been trained in multiple evidence-based therapies for PTSD and is available to provide those therapies via telehealth to all sites of Marion’s catchment area.

In addition to the specialty services available to their male counterparts, women veterans have access to a gynecologist on site who is able to treat cervical dysplasia (Pre-cancerous cervical changes), perform biopsies for further diagnosis of abnormal pap smears, and other more specialized gynecological concerns such as post-menopausal bleeding, pelvic pain and infertility evaluation. In September 2011, Marion VAMC opened its first Women’s Health Clinic (WHC), located at the primary care annex across from the medical center. If veterans are enrolled at this clinic as their primary care clinic, they receive their care in the comprehensive care model, so that gender specific needs (pap smears and breast exams) are done at the same visit with their regular checkup for other health concerns. This eliminates the need for multiple appointments. Within the WHC, veterans can also have blood drawn for any same-day labs that need to be done without going to the annex lab or the hospital lab for this service.

All CBOCs provide primary care to women veterans and currently have identified designated women’s health primary care providers who are preferentially assigned women veterans to their panels. These are providers who have been identified as interested, trained and engaged in providing care to women veterans. As all of the providers receive additional training, comprehensive women’s health care will be provided at all CBOCs. This is already being accomplished at some sites and will be at all sites by year’s end.

Services that are fee-based for women veterans in all cases include mammograms and obstetrics care, including all prenatal care, hospital delivery care and hospital care for the newborn related to the delivery. Other fee-based services are

based on the individual veteran, including service connection and extenuating circumstances.

Outreach

Beginning in March, the medical center began hosting open-house events at each CBOC in 2012. Each event will include advertising and public-service announcements in local newspapers and on local TV and radio. Targeted public-service announcements and advertisements are planned to reach veterans in these areas.

Challenges

Challenges include access due to distance to care, including fuel costs, child care concerns, conflicting responsibilities (aging parents, work responsibilities, school responsibilities), and lack of transportation or reliable transportation. There are two major initiatives currently underway that help address these concerns. The first is expanding the range of women’s health specialty services that will be available at the Evansville Clinic, which will significantly decrease the distance that many patients have to travel to receive the services from the gynecologist. Space has been identified and will be ready in the spring for these services. Planning is in process for this implementation. Secondly, funds have been requested to initiate tele-gynecology between the Marion campus and two strategically selected CBOCs. Some gynecology visits do not require physical exams in which the patient and the physician are in the same room. Current technology will allow for a certain number and type of visits to be completed virtually.

Recommendations

More paid positions should be available for the Veterans Transportation System. Currently, there are only volunteers driving these veterans to and from their appointments. These volunteers are not available consistently. Paid drivers will be more consistent and reliable and also create jobs for other veterans. There should be a fully functional transportation department in the medical center that measures transportation demand and meets the needs of the veterans and needs of the program.



HUTCHINSON COMMUNITY BASED OUTPATIENT CLINIC | HUTCHINSON, MO

Date: December 1, 2011

National Task Force Member: Past National Commander, Jimmie L. Foster

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

Background

The CBOC in Hutchinson, Kansas opened on May 12, 2008, and is staffed by VA employees, with the exception of one contract with a non-veteran service organization. The clinic provides primary care services in addition to individual behavioral health counseling, specialty care referrals to the Wichita VAMC, blood drawing services and prescription processing, including mail-out service through My HealthVet, and fee-basis for mammograms, infectious disease, cardiology and dialysis. Oncology is not available for fee-base.

The clinic has done outreach events at health fairs with the Yellow Ribbon fund and community agencies, but no specific events and its effect have been recorded. Furthermore, during our visit, there did not appear to be comprehensive information of current benefits for veterans like travel benefits.

Challenges

Most of the concerns are with the amount of staff the CBOC has; the current ratio of staff to patients is 11 to 957. This panel size is not significantly balanced and capable of treating these patients at the standard of care needed. The clinic has been recruiting for one physician since July 16, 2011. Everyday this position is not filled is a day a veteran could have received care. Also, the clinic does not have proper managerial capabilities. Many of the clinicians are tasked with treating patients and managerial responsibilities for which they have not been properly trained.

Recommendations

The daily managerial and operational tasks should be assigned to a business-minded employee and not left in the hands of clinicians. This not only is an ineffective way to manage, but takes away from the superior health care veterans need. If resources do not lend itself to hiring a full-time business manager, then those tasked with the responsibilities should receive the proper training.

SIKESTON COMMUNITY BASED OUTPATIENT CLINIC | SIKESTON, MO

Date: January 4, 2012

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

Background

The Sikeston CBOC opened on 21, 2009, and is in Poplar Bluff VAMC jurisdiction. The clinic is staffed with predominately full-time VA employees, and one part-time psychologist. All positions have been filled. Acute care and visits to the emergency room are fee-based out. Specialty services include psychology, female-adapted rooms and several vaccinations. The CBOC offers X-rays and labs, but no pharmacy service other than a pyxis machine with limited medications; veterans need to go to Poplar Bluff for other medications. Panel sizes are at a comfortable level at around 1,000 patients. Telehealth also is offered to veterans with diabetes and mental health issues. The veterans primarily use the “Heath Buddy System” in their homes to monitor their vital signs and blood sugar levels. Telehealth devices are very easy to setup for the veteran.

Challenges

The largest challenge is the telephone response time. Many veterans complain of no answer or being redirected to Poplar Bluff VAMC. The time in which they called, and context, is unclear, but was a reoccurring comment from veterans. Challenges in telehealth include veterans not having cell phones or Internet connection. Many of the telehealth devices require Internet connections and/or cell phone reception. Lastly, the CBOC did not seem to have one person assigned to take travel questions; a travel clerk would be beneficial. Also, there were no postings in the lobby about travel benefits.

Recommendations

Veterans should be asked to take a survey on their telephone response time and if there is a desire for benefits education. Although there have been complaints of the telephone system, this should be measured quantitatively and in the proper context.



MT. VERNON COMMUNITY BASED OUTPATIENT CLINIC | MT. VERNON, IL

Date: February 7, 2012

National Task Force Member: William R. (Bob) Wallace

National Field Service Representative: Kevin H. Blanchard

Background

The Mt. Vernon CBOC is in the jurisdiction of the Marion VAMC and received its first patient on May 18, 2009. The CBOC is staffed with full-time VA employees and has one primary care position opening. The clinic offers telehealth services via “Health buddy,” but no video feed. There is no X-ray service available.

Challenges

There is a 200-person waiting list for patients who want to receive care and are forced to go to other locations for their health-care needs. No solution to this problem has been developed. There also is little to no outreach. This may be because the CBOC is already overwhelmed treating patients and cannot handle any more. There also did not seem to be a standard manner in which enrollment was recorded and tracked. This may cause problems for the medical center to properly evaluate the need for additional resources.

Recommendations

The clinic needs to ensure the VAMC is aware of the current demand of the waiting list. If the clinic can effectively bring this to the VAMC’s attention, these veterans stand a better chance of having the clinic expand to allow for more patients. Depending on regulations, the clinic could petition the community of its desire and need to expand.

EFFINGHAM COMMUNITY BASED OUTPATIENT CLINIC | EFFINGHAM, IL

Date: February 8, 2012

National Task Force Member: William R. (Bob) Wallace

National Field Service Representative: Kevin H. Blanchard

Background

The Effingham CBOC is fully staffed with VA full-time employees. There are 3,000 total patients for one clerk, one registered nurse, and one Licensed Practical Nurse.

Challenges

Similar to other CBOCs, Effingham needs more space and staff. There did not seem to be a complete training transition program for the management. Management was unable to answer many of the daily operational questions. There should be a comprehensive training program for all the CBOC's management.

Recommendations

Every new staff member should be trained on all aspects of their position and on who their point of contact is at the VAMC. Periodic meetings with the clinic's leadership and relevant VAMC staff would more clearly define channels of communication.



AMERICAN LEGION POST FOCUS GROUP | INDEPENDENCE, MO

Date: November 30, 2011

National Task Force Member: Past National Commander, Jimmie L. Foster

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Kevin H. Blanchard

The task force conducted a focus group on November 30, 2011, at Tirey J. Ford Post 21 in Independence, Missouri. Approximately 10 veterans participated. There was a guided discussion on the accessibility, timeliness and quality of health care. The majority of the veterans had no problem with the VA's timeliness and quality of care. The only issue was with the Veterans Transportation System.

AMERICAN LEGION POST FOCUS GROUP | SIKESTON, MO

Date: January 3, 2012

National Task Force Member: Phillip L. Driskill

National Field Service Representative: Kevin H. Blanchard

The task force conducted a focus group of approximately 30 veterans on January 3, 2012, at Post 114 in Sikeston, Missouri. There was a guided discussion on the accessibility, timeliness and quality of health care. The majority of the veterans had no problem with VA timeliness and quality of care.

RECOMMENDATIONS

VISN 15

- Increase telehealth for the entire VISN using a needs assessment from the ORH.
- Partner with existing telehealth capacities, such as the University of Kansas, and staff them with VA employees.
- Invest in rural health programs and technologies
- Collaborate with other VISNs to ensure there is a standard way of reaching out to rural veterans.

VISN Rural Health Consultant

- More time is needed to complete a comprehensive needs assessment and more specialized job training.
- Train staff members using the SharePoint to ensure its maximum benefit.
- Diversify methods of assessing veterans’ needs to adhere to federal regulations.

VAMC

- Implement a better incentive program to capture the most talented clinicians in the country.
- Increase bandwidth for telehealth programs.
- Update training programs to make it easier for clinicians and the older generation of veterans to use telehealth methods.
- Increase telehealth services to CBOCs by requesting an up-to-date needs assessment.
- Develop advanced communication and partnerships between VA and VSOs in the area.
- Increase transportation using VA paid staff or contracting out, rather than relying only on volunteers.
- Increase targeted outreach.
- Provide better communication and training sessions with each CBOC.

Project ARCH

- Identify the appropriate person at the VACO for clear guidelines and procedures on the program.
- Increase outreach and measure the “patient return on investment.”
- Expand to more rural and highly rural areas, such as western Kansas.
- Utilize all available telehealth capabilities and measure for financial effectiveness and quality performance.
- Use methods such as surveys to determine best practices for rural veterans.

CBOC

- Don’t place the CBOCs managerial responsibilities in the hands of the clinical providers.
- Increase space and staff.
- Provide more equipment.
- Increase outreach through local reserve units, VSOs and community events.
- Provide a comprehensive communication training program between medical centers and the CBOCs.



VISN 18

VETERANS INTEGRATED SERVICE NETWORK MESA, AZ

December 14, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

VETERANS INTEGRATED SERVICE NETWORK RURAL HEALTH CONSULTANT MESA, AZ

December 14, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

PROJECT ACCESS RECEIVED CLOSER TO HOME ARCH - FLAGSTAFF, AZ

February 8, 2012

National Task Force Member: Chairman, Michael D. Helm

National Field Service Representative: Warren J. Goldstein

PHOENIX VA HEALTH CARE SYSTEM PHOENIX, AZ

December 15, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

NEW MEXICO VA HEALTH CARE SYSTEM ALBUQUERQUE, NM

January 17, 2012

National Task Force Member: Ralph P. Bozella

National Field Service Representative: Warren J. Goldstein

NORTHERN ARIZONA VA HEALTH CARE SYSTEM PRESCOTT, AZ

February 7-8, 2012

National Task Force Member: Chairman, Michael D. Helm

National Field Service Representative: Warren J. Goldstein

GLOBE-MIAMI COMMUNITY BASED OUTPATIENT CLINIC GLOBE, AZ

December 15, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

FARMINGTON COMMUNITY BASED OUTPATIENT CLINIC FARMINGTON, NM

January 18, 2012

National Task Force Member: Ralph P. Bozella

National Field Service Representative: Warren J. Goldstein

FLAGSTAFF COMMUNITY BASED OUTPATIENT CLINIC FLAGSTAFF, AZ

February 8, 2012

National Task Force Member: Chairman, Michael D. Helm

National Field Service Representative: Warren J. Goldstein

AMERICAN LEGION POST FOCUS GROUP GLOBE, AZ

December 14, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

RECOMMENDATIONS



VETERAN INTEGRATED SERVICE NETWORK 18 | MESA, AZ

Date: December 14, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

Background

The VA Southwest Health Care Network Headquarters is located in Mesa, Arizona. VISN 18 employs approximately 10,000 full-time equivalent employees (FTEES) and has a total annual budget of \$2 billion to provide health care to 240,000 veterans residing in its catchment area. VISN 18 provides medical coverage for 352,000 square miles of highly diverse geography across Arizona, New Mexico and western Texas, as well as bordering counties in Colorado and Kansas. VISN 18 has seven health-care systems that include six medical centers, one independent outpatient clinic, six VA nursing home care units, three domiciliaries, and 41 CBOCs that provide a comprehensive continuum of health care. The medical facilities treat 24,000 inpatients and support 3 million outpatient visits per year. These services include inpatient acute care, outpatient and primary care, mental health services, psychosocial rehabilitation, geriatric care, long-term care, diagnostic services, and specialized care such as blind rehabilitation, spinal cord injury care, and traumatic brain injury care.

In FY 2011, approximately \$12 million of VISN 18's annual budget was dedicated to rural health initiatives. In FY 2012, VISN 18's annual budget was increased by \$18 million for rural health care.

In FY 2012, VISN 18 will be incorporating the following programs and initiatives from the Office of Rural Health (ORH):

- Rural health outreach to homeless veterans.
- Expansion of telemedicine.
- Rural Veterans Transportation Services.
- Pharmacy disease management.
- Enhanced mental health services for rural veterans at the CBOCs and for Native American veterans who reside in the Hopi and Navajo nations
- Project Access Received Closer to Home (ARCH)

Challenges

A significant challenge the network has is access and trying to accommodate veterans who have to travel long distances to medical facilities for treatment. Due to those distances, the VISN's total expenditures for beneficiary travel in FY 2011 was \$35 million; in FY 2012, the estimated projections are \$37 million. Also, as a result of having a significant amount of rural and highly rural veterans in their catchment area, there has been a significant increase of

fee basis for veteran health care within the VA Southwest Health Care Network. The VISN is projecting \$313 million in FY 2012, an increase of \$16 million from FY 2011 for fee-basis health care. The network headquarters and its medical facilities cover a large, highly rural and mountainous geographic territory comprised of three different time zones (Pacific, Mountain, and Central), 17 congressional districts, and three states that require long distance drives and/or air travel. Another major challenge at the VISN level is the ability to build more capacity at tertiary care facilities.

The Southwest Network has another financial challenge that involves non-reimbursement for Native American Indian healing ceremonies. The VISN currently has 1,641 enrolled Native American veterans, a number that has tripled in the past three years. These ceremonies are not included in the medical center's annual budget and can be extremely costly to the medical center, depending on the veterans' length of stay and what specific kind of healing ceremony is requested. For example, in FY 2011 the Phoenix VA Medical System expensed an amount of \$38,000 for Native American healing.

The provision of VA services on Native American land is governed through three memorandums of understanding involving VA, the tribal group, and Indian Health Services (IHS) when its space or services are used by VA. VA has a general MOU recently signed by IHS, but individual MOUs are necessary for specific agreements and include the tribal group as a stakeholder in the agreement. One deterrent for Native American veterans to use VA services – either at VA facilities or IHS facilities utilized by VA – is Native American veterans may be required to pay co-payments to VA, according to their eligibility status. However, IHS requires no co-payments for delivery of health care to their eligible beneficiaries, including Native American veterans. Using VA services instead of IHS services may cause a financial/economic burden to the Native American veteran.

Recommendations

Since many veterans in VISN 18 live in rural and/or highly areas, access to a VAMC and/or CBOC is critical to obtaining health care. There needs to be continued funding to support projects for rural veterans, such as the T-21 Veterans Transportation Service initiative, tele-medicine technology in the CBOCs, and mobile health vans expanded throughout all the medical facilities to support the needs of rural veterans and improve overall access to services.

VISN 18 RURAL HEALTH CONSULTANT | MESA, AZ

Date: December 14, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

Background

VA's VISN 18 has a full-time VISN Rural Health Consultant (VRHC) who is dedicated and committed to meeting the health-care needs of rural veterans residing in large geographic areas within the VISN. The VRHC has a collateral duty of being the Native American representative and consultant for the VISN. The VA Southwest Healthcare Network has more than 50 sites of care covering urban, rural, highly rural, remote desert and mountain locations. Of those 338,237 enrolled veterans within the network, 18,696 (six percent) are highly rural, 132,958 (37 percent) are rural, and 206,159 (57 percent) are considered urban. Of those enrolled, 190,650 are urban males, and 141,820 are rural and or highly rural males. There are 15,509 female urban enrolled veterans and 9,834 female rural and or highly rural enrolled veterans. In FY 2012, VISN 18 has 19 projects specifically dealing with veteran rural health care access and telemedicine expansion in the CBOCs. The VISN also has five Veterans Transportation Service funded projects scheduled in regards to providing vehicles for veteran transportation to and from the medical facility for health-care treatment.

Challenges

The significant challenges that VISN 18's VRHC faces are distance and funding for travel. In regards to travel, VISN 18 covers 349,615 square miles, which is significantly larger than VISN's 1, 2, 3, 4 and 5 combined. In order for the VRHC to cover the large geographic territory and more than 50 health-care sites, several days of driving and/or flying is involved.

Recommendations

To improve communication between the VRHC and the medical center's rural health program coordinators, VA needs to make the medical center's VRHC and/or Native American Indian Coordinator a full-time position, rather than have them as a combined position. Continued communication between the medical center's VRHC and the VRHC will create more continuity with the VISN and medical centers.



PROJECT ACCESS RECEIVED CLOSER TO HOME (ARCH) | FLAGSTAFF, AZ

Date: February 8, 2012

National Task Force Member: Chairman, Michael D. Helm

National Field Service Representative: Warren J. Goldstein

Background

Project Access Received Closer to Home (ARCH) is a congressionally mandated pilot program designed to improve rural health-care access for eligible veterans by connecting them to health-care services and providers closer to their home. Project ARCH's pilot selection site, contracted through Humana Veterans Healthcare Services, is located in Flagstaff, Arizona and is one of five VISNs selected for a three-year pilot project that launched both nationally and locally on August 29, 2011. As of January 4, the program has 485 consented patients, 304 veterans that have completed authorizations and 282 veterans that have been assigned a health-care provider. The Project ARCH Care Coordinator for Flagstaff is a full-time position that is funded from the Office of Rural Health (ORH) and is employed by the Northern Arizona VAMC in Prescott, Arizona.

The Project ARCH Care Coordinator's responsibilities are to answer any questions veterans may have regarding Project ARCH, help veterans access non-VA health-care providers, work closely with non-VA health-care providers to ensure that they have all of the veterans health-care information, and to ensure that the VA receives all the necessary information from the non-VA provider to keep the veterans medical records up-to date. The VA Southwest Healthcare Network's Project ARCH services are offered through the program's affiliated hospitals – Verde Valley Regional Medical Center, Flagstaff Medical Center and Humana Veterans care network in the Flagstaff area. The services offered are acute inpatient and outpatient medical and surgical care, including related consultations and ancillaries, and outpatient specialty consultation that include related diagnostic imaging and laboratory services.

Eligibility for the Project ARCH program is:

- Be enrolled in VA health care prior to August 29, 2011, reside in one of Project ARCH's five pilot site areas, live more than 60 minutes driving time from the nearest VA health-care facility that provides primary care services; and
- Live more than 120 minutes by car from the nearest VA health-care facility providing acute hospital care; and
- Live more than 240 minutes by car from the nearest VA health-care facility providing tertiary health care.

Challenges

Some of the challenges that the Northern Arizona VA Health Care System (NAVAHCS) is experiencing with the Project ARCH pilot program are coordination of durable medical equipment, prosthetics, and therapy services upon a veterans discharge; filling veterans prescriptions upon discharge; receiving veterans claims in a timely manner for services rendered; veterans receiving invoices for Project ARCH services; and Humana Veterans Network providers sending claims directly to VA, instead of Humana processing the claims.

Recommendations

The NAVAHCS needs to improve the way it coordinates non-VA health-care services for veterans. The medical system needs to improve communication between VA, Humana and their providers in order to improve the effectiveness and efficiency of Project ARCH.

PHOENIX VA HEALTH CARE SYSTEM | PHOENIX, AZ

Date: December 15, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

Background

The Phoenix VA Health Care System (PVAHCS) is a clinical referral level 1b tertiary care medical center located in Phoenix and has been serving veterans in the area for more than 50 years. PVAHCS consists of the Carl T. Hayden VAMC and seven CBOCs across four counties: Buckeye, Globe-Miami, Sun City, Payson, Show Low, Mesa and Thunderbird. In FY 2011, 23,321 rural and 1,397 highly rural veterans were enrolled in the Phoenix VA Health Care System.

The Phoenix VAMC is part of VISN 18, which includes VA medical facilities in Prescott and Tucson, Arizona; Albuquerque, New Mexico; and Amarillo, Big Spring and El Paso, Texas.

Budget

The budget for the Carl T. Hayden VAMC for FY 2011 was \$453.5 million. The budget for FY 2012 is \$454.8 million, an increase of \$1.3 million from FY 2011. In FY 2011, \$1.5 million of the Phoenix VAMC budget was dedicated to rural health-care programs and initiatives. In FY 2012, the PVAHCS has committed the same \$1.5 million for their veteran rural health-care programs.

In FY 2011, \$75 million of the PVAHCS budget went to fee-basis services. It is projected that the amount will remain the same in FY 2012. The medical center utilizes fee-basis/contract physicians for specialty surgical and/or medical services for cardiovascular, ophthalmology, orthopedics, obstetrics/gynecology, trauma care, radiology, neurology and dental.

Staffing

According to management there are approximately 2,200 employees throughout the PVAHCS. The PVAHCS currently has an interim director, interim associate director and interim chief of staff. The medical center is actively recruiting for a new director and chief of staff. There are currently eight open primary care positions for licensed vocational nurses and medical support assistants. There are 146 employees at the PVAHCS CBOCs, providing primary care, mental health, women's health care, audiology, speech pathology, telehealth and select medical specialties. The PVAHCS utilizes the telehealth nurse manager as the expert and representative for rural health issues. In conjunction, the associate chief of staff for ambulatory care manages the two contracts for primary care for the Buckeye and Payson contract clinics.

Telehealth

The PVAHCS has a telehealth program with two home telehealth registered nurses and one clinical video telehealth provider dedicated to meeting the medical needs of veterans without having them travel long distances through difficult geography to the medical center. The PVAHCS offers home telehealth, clinical video telehealth, and store and forward telehealth medical services. The three telehealth services that the medical center offers are related to the veterans Primary Aligned Care Team (PACT). The PVAHCS and their CBOCs have several current and planned home, clinical video, and store and forward telehealth programs, including Care Coordination Home Telehealth (CCHT), Health Hero/Health Buddy, cardio-com, and other telehealth services (i.e. mental health, pulmonology, diabetic education, spinal cord injury, vascular, orthopedic and mental health for compensation and pension VA exams). All medical centers within VISN 18 will have retinal imaging services via telehealth. In FY 2012 the PVAHCS will be exploring the possible implementation of Tele-Movi, VA's version of Skype.

Specialty Care

The Phoenix VAMC womens clinic has eight staff members who provide comprehensive health-care services to the approximately 26,313 women within their catchment area. The PVAHCS currently has 7,033 enrollees and 5,101 users – including 2,235 under age 40 and 1,708 Operation Enduring Freedom and Operation Iraqi Freedom women veterans within their medical system. In order to provide privacy for women's health care, the women's health clinic will be moving in January 2012 into a brand new clinic that will be separated from the rest of the hospitals inpatient units. The main challenge for the PVAHCS women's health clinic in the near future is to meet the medical needs of the projected increase of women veteran enrollees. Major challenges that the womens clinic is facing is the increased need for gender-specific care, including reproductive care, and a place for female veterans to live for 30 days prior to delivery.

The mental health services at the PVAHCS and affiliated CBOCs have approximately 16,000 patients receiving treatment and services. The mental health treatments and programs that are offered for the veteran include Cognitive Pro-



cessing Therapy (CPT), Prolonged Exposure Therapy (PET), psychotherapy to treat substance abuse, and cognitive-behavioral therapy for depression

Outreach

As a result of having 16,837 Operation Enduring Freedom and Operation Iraqi Freedom veterans in the PVAHCS catchment area the OEF/OIF program staff partnered with the women veterans health-care program to attend or sponsor 13 outreach events in which they enrolled 282 veterans into their medical system. In addition, other outreach events included 30 Post-Deployment Health Reassessments, six demobilization events, six Yellow Ribbon Reintegration Programs, one Marine Inactive Ready Reserve event and six community events. PVAHCS works with local VSO offices and periodically conducts town hall meetings or similar events to make veterans aware of its presence in area communities.

Community-Based Outpatient Clinics

The PVAHCS has seven primary care CBOCs – two of which are (2 contracted in Payson and Buckeye, Ariz. – that have medical, mental health, nursing, dietetics, pharmacy and telehealth services in order to medically treat highly rural and rural veterans. In FY 2011, those CBOCs had 35,204 unique and 122,981 total patient visits. In the near future, the PVAHCS is planning to add more outpatient clinics to serve the increasing numbers of veterans that reside in the PVAHCS catchment area.

Challenges

The Phoenix VAMC's main challenge to providing health care is high fee-basis medical costs due to providing specialty health-care services not offered at the medical center to those highly rural and rural veterans that are enrolled in the system. The typical challenge for providing health care in a rural setting also applies to the provision of women's health care. The PVAHCS developed processes to address these challenges. These systems and processes include training of providers in comprehensive primary care services for women veterans, point of care testing, and referral avenues both within the VA and through fee-basis in the community to meet additional needs. The challenges associated with providing mental health services in a rural setting include availability of mental health providers in the local community, coordination of specialty services and lack of

inpatient treatment facilities in the community. To assist with meeting these challenges, the PVAHCS plans to extend its Evidence Based Psychotherapy Program via telehealth to each of its CBOCs. Veterans often face transportation challenges to and from clinic sites, and access to specialty care and acute care in the local community.

Recommendations

VA needs to continue investing money in telehealth programs in order to meet the medical needs of highly rural, rural and urban veterans. Veterans should be able to receive proper medical care through modern technology that VA offers, no matter where a veteran chooses to reside

NEW MEXICO VA HEALTH CARE SYSTEM | ALBUQUERQUE, NM

Date: January 17, 2012

National Task Force Member: Ralph P. Bozella

National Field Service Representative: Warren J. Goldstein



Background

The New Mexico VA Healthcare System (NMVAHCS) is a level Ia tertiary care facility located in Albuquerque, New Mexico that services veterans in the New Mexico, southern Colorado and western Texas. The NMVAHCS has 12 CBOCs (five contracted) located in Alamogordo, Artesia, Espanola, Farmington, Gallup, Las Vegas, Raton, Rio Rancho, Santé Fe, Silver City and Durango.

As of FY 2011, there are 162,390 veterans residing in the New Mexico VAMC catchment area. There are 57,374 veterans currently enrolled at the NMVAHCS. In FY 2011, the NMVAHCS veterans population was 5,016 highly rural, 12,752 rural, 27,150 urban and 64 unknown.

The NMVAHCS is part of VISN 18's VA Southwest Healthcare Network, which includes VA medical facilities in Phoenix, Prescott and Tucson, Arizona, and Amarillo, Big Spring, and El Paso, Texas.

Budget

The budget for the Raymond G. Murphy VAMC for FY 2011 was \$411.1 million. The budget for FY 2012 is \$403.5 million, which was a decrease of approximately \$7.6 million from FY 2011. The medical center collects approximately \$6 million per year from Kirkland Air Force Base in Albuquerque for medical services rendered and on-site clinical space, helping offset the \$7.6 million deficit.

In FY 2011, \$2.1 million of the NMVAHCS's budget was dedicated to rural health programs and initiatives. In FY 2012, the NMVAHCS has committed \$1.9 million for their veteran rural health-care programs. The funds that the medical center has dedicated toward rural health programs and initiatives represent rural health grants awarded to the medical center from the VA Office of Rural Health.

In FY 2011, \$21.8 million of the NMVAHCS budget went to fee-basis services, including contract hospital care, outpatient care, radiation therapy, millennium-bill (emergency room care at non-VA facilities) and dental care. The medical center's fee-basis expenditures currently are not available for FY 2012.

In FY 2011, the NMVAHCS's beneficiary travel budget was \$12.5 million; \$11.3 million has been allocated for 2012. In order to reduce fraudulent beneficiary travel claims, the NMVAHCS has taken strong initiatives, such as implementing an audit program and invoice/reimbursement system in order to prevent fraudu-



lent claims. The medical center recently prosecuted 30 veterans for trying to process fraudulent beneficiary travel claims. NMVAHCS's beneficiary travel budget is significantly higher than other facilities in VISN 18 because it is the only VA facility in the state and receives referrals from distant facilities such as El Paso, Big Spring, and Amarillo, Texas. This creates a disproportionate effect on the NMVAHCS's budget when contrasted to other VISN 18 facilities.

Staffing

According to management, there are approximately 2,100 dedicated employees serving the health care needs of veterans in the NMVAHCS. Of the 2,100 employees, 785 (37.4 percent) are veterans. The NMVAHCS currently has open specialty positions in primary care, orthopedics, oncology, geriatrics, ophthalmology and psychiatry.

Telehealth

The NMVAHCS has 816 veterans that are enrolled in home-based telehealth. The NMVAHCS goal is to expand the services that are available through telemedicine to support specialty care that can be provided at the CBOCs in order to reduce veteran travel. It takes 15-30 days for a veteran to receive and set-up a home-based telehealth appointment. The NMVAHCS offers a wide variety of home tele-health services, including clinical video tele-health, and store-and-forward telehealth medical services at their affiliated CBOCs, retinal imagining (offered at 10 of the 12 rural clinics across New Mexico) and dermatology (offered at six of the 13 rural clinics across New Mexico). Other telehealth services offered are vascular, neurology, MOVE, nutrition, mental health, co-occurring pain clinic, anesthesia pain clinic, coordination in home, chaplain, social work, spinal cord injury and discharge planning. In the near future, the NMVAHCS will be adding pulmonary/sleep, polytrauma, neuro psych, general urology, orthopedics, neuro surgery, pharmacy, ethics, wound and anesthesia pre-operation. The three telehealth services that the medical center offers are in conjunction with the veterans Primary Aligned Care Team (PACT).

Specialty Care

The NMVAHCS women's health clinic has its own PACT comprised of four female staff members who provide comprehensive, gender-specific, and behavioral women's health-care

services to approximately 17,000 women veterans that reside within their catchment area. There are 10,038 women veterans that reside in highly rural and/or rural areas of New Mexico.

The NMVAHCS currently has 3,906 enrollees, 3,736 unique users and 900 Operation Enduring Freedom and Operation Iraqi Freedom women veterans enrolled within the medical system and their affiliated CBOCs. In order to provide privacy for women veterans health care, the women's health clinic is a "one-stop shop" with a separate entrance and a private waiting room.

The NMVAHCS women's health program offers special programs at the medical center and affiliated CBOCs, including vocational rehabilitation and services for homeless women veterans, and coordinates outreach with the Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn program manager.

The challenges for women veterans who live in rural areas are consistent with servicing the overall medical needs of women veterans. The NMVAHCS offers women veterans comprehensive gender-specific medical health care treatment at the CBOCs.

The mental health services at the NMVAHCS and its affiliated CBOCs offer a large behavioral health-care line with several treatment teams and programs that specifically addresses all aspects of the veterans' mental health and hygiene. There are 265 mental health providers that provide evidence-based psychotherapy, holistic treatment, pharmacology, family therapy and group therapies to 8,000 unique veterans who are in need of mental health care, either as an inpatient or as an outpatient. The NMVAHCS is one of few VAMCs across the country that has a Psychiatry Primary Care Clinic that uses the PACT model. This specific clinic provides primary care and mental health case management care for veterans with chronic serious mental illness.

Outreach

As a result of having 12,500 OEF/OIF/OND veterans in the NMVAHCS catchment area, the OEF/OIF/OND program staff partnered with the Women Veterans Health Care Program staff and the Native American Veteran Coordinator, and have attended and/or sponsored 22 outreach events to enroll veterans. Outreach efforts at the NMVAHCS are designed to educate veterans and community members about VA health-care ser-

vices and benefits. OEF/OIF/OND focus groups are conducted each year to get feedback from the most recent combat veterans on their experiences transitioning from active duty to veteran status to assist in improving collaboration between the VA and Department of Defense.

Community Based Outpatient Clinics

The NMVAHCS has 11 Primary Care CBOCs – six contracted – located in smaller-populated areas of New Mexico and southern Colorado. The NMVAHCS CBOCs are staffed with two primary care providers and a registered nurse at each clinic. The CBOCs are multidisciplinary, with medical, nursing, dietetics, pharmacy and telehealth services. In FY 2011, the NMVAHCS had 73,800 patient visits at their affiliated CBOCs. In the near future, the NMVAHCS is planning to add more outpatient clinics to serve the increasing numbers of veterans that reside in rural areas of New Mexico.

Challenges

The main rural health-care challenge for the NMVAMC is retaining/recruitment of doctors and professional/specialty staff to live in rural areas. This is true throughout the country, not unique to VA. Due to the rural nature, physicians do not want their medical practices to be located far away from major medical centers. Overall, there are fewer providers in rural sites because of family and differences in rural lifestyles, compared to urban lifestyles. There is a need to speed up the contract leasing process to move into much needed additional space, and a need for creative recruitment methods of professional staff, to include recruiting services and advertisements. There also is a need for improved infrastructure for phones, computers (T-1 lines); continued support for the expansion of telehealth; updated scheduling system to support veteran scheduling needs for telehealth appointments; and optimizing the transportation system to support veteran travel to the medical center for coordinated specialty and primary provider care. All veteran beneficiary travel funding comes from the facility operating budget and the facility has much greater expenditures in this area than other many other facilities because veterans travel from all over the state and West Texas to obtain specialty and inpatient care. NMVAHCS needs to operate within their allocated budget, so they have to reallocate resources from other operational areas such as staff and equipment.

Recommendations

The main rural health-care recommendations for the NMVAMC are: the NMVAHCS needs veteran(s) to become part of the PACT steering committee for their input and perspective on improving veteran health care; giving VA the same ability as other governmental agencies/programs to invoice Medicare for services rendered at the medical center; increase the availability of veterans service organizations (VSOs) sponsored travel services; advertise VA programs and initiatives, such as “my healthy Vet, in VSO newsletters and mailings so veterans are made aware of the services and programs that are available; and make VSO newsletters available in medical centers and CBOCs to advertise to veterans what VSOs are doing on behalf of veterans and their families.



NORTHERN ARIZONA VA HEALTH CARE SYSTEM | PRESCOTT, AZ

Date: February 7-8, 2012

National Task Force Member: Chairman, Michael D. Helm

National Field Service Representative: Warren J. Goldstein



Background

The Northern Arizona Department of Veterans Affairs Health-care System (NAVAHCS), also known as the Bob Stump VAMC, is located in Prescott, Arizona and services veterans that reside in Northern Arizona and its surroundings areas. The Bob Stump VAMC, located in the mountains of north central Arizona, is the largest veteran health-care facility within a 60,000 square-mile area. The medical facility is 96 miles northwest of Phoenix and is in a tri-city community of approximately 100,000 people. The Northern Arizona VA Health Care System has five CBOCs and two VA-staffed telehealth outpatient clinics located in smaller populated areas of central and northern Arizona. The CBOCs and one VA-staffed primary care telehealth outpatient clinic are located in Anthem, Cottonwood, Flagstaff, Kingman, Lake Havasu, Holbrook, and Chinle (Navajo Nation).

There are two NAVAHCS-affiliated PTSD clinics located in Chinle on the Navajo Nation Reservation and Second Mesa on the Hopi Reservation in Arizona to treat Native American veterans.

As of FY 2011, 19,565 veterans reside in the NAVAHCS catchment area. There are 31,667 veterans currently enrolled at the Bob Stump VAMC. In FY 2011, the NAVAHCS rural veteran enrollment was as follows: highly rural 979, rural 21,499, urban-9,058 and unknown 131.

The NAVAHCS is part of VISN 18 VA Southwest Health Care Network, which includes VA medical facilities in Phoenix and Tucson, Arizona; Albuquerque, N.M.; and Amarillo, Big Spring and El Paso, Texas.

Budget

The budget for the NAVAHCS for FY 2011 was \$160.2 million, which includes special-purpose funding. The budget for FY 2012 is \$152.3 million includes special-purpose funding at a decrease of approximately \$7.9 million. Some programs supported by special-purpose funding money are Rural Health, Project Access Received Closer to Home (ARCH), and outreach programs and initiatives.

In FY 2011, \$3.2 million, or two percent, of the NAVAHCS annual budget was dedicated to rural health programs and initiatives. In FY 2012, the NAVAHCS committed \$14.1 million, or 9.28 percent, of its annual budget to veteran rural health-care programs. The reason for the approximate \$11 million increase in FY 2012 was the award of \$10.8 million from the Office of Rural Health for serving as the Veterans Healthcare Administration (VHA) ARCH program pilot site located in Flagstaff, Arizona.

In FY 2011, \$35.9 million of the NAVAHCS budget went to fee-basis services that included outpatient services such as dialysis, radiation, chemotherapy, emergency room, home visits, adult day health care and air transports. The inpatient fee-basis services included orthopedics, cardiology, pulmonary, gastroenterology, infectious disease and vascular health-care services. In FY 2011, most of the medical system's fee-basis costs went towards inpatient care, oncology care, dialysis care, chemotherapy treatment and care, and orthopedic care. In order to reduce fee-basis medical care for veterans, the medical system currently is putting in place several initiatives to reduce their overall fee-basis costs for high-priced specialty services. For example, the medical center will save over \$1 million per year of fee-basis costs

as a result of hiring a radiation oncologist to provide in-house oncology services. As of January 2012, the medical system currently has spent nearly \$2.5 million on fee-basis expenditures.

In FY 2011, the NAVAHCS beneficiary travel budget was \$3.1 million, with \$1.3 million being spent on mileage. For FY 2012, the medical center has requested \$3 million, approximately \$100,000 less than FY 2011, which is due to the implementation of the VA Veteran Transportation Service program at the Northern Arizona Health System and its CBOC affiliates. In order to reduce fraudulent beneficiary travel claims, the NAVAHCS has taken strong initiatives to prevent such actions and have reported those behaviors up their chain of command.

Staffing

According to management, there are 959 full-time, part-time and intermittent dedicated employees serving the health-care needs of veterans. Of those 959 employees, 37 percent are veterans. The NAVAHCS currently has 50-75 open positions due to the location of the facility; Prescott and its surrounding areas have a high cost of living, making it difficult to recruit healthcare providers. Due to NAVAHCS not being a tertiary care facility, the main staffing challenge for the health-care system is recruiting specialty health-care positions such as gastroenterologists, neurologists, physician assistants, etc. In order to fill the current staffing openings at the medical center, the human resources department has several plans of action, including outreach, and is actively recruiting primary care and specialty care positions from local health-care facilities within the Prescott area.

Telehealth

The NAVAHCS has 250 veterans that are enrolled in home-based telehealth. Telehealth patients had a 76 percent decrease in bed days of care, decreased emergency room visits and lower laboratory tests, in part to the availability of home telehealth and Primary Care Aligned Team (PACT) programs. The NAVAHCS goal is to expand telehealth services to support specialty care that can be provided at the CBOC in order to reduce several hours of veteran travel and increase access to medical care. The NAVAHCS has several telehealth and video telemedicine programs, and an initiative at all of their affiliated CBOCs to improve veteran access. In FY 2011, the medical system has implemented a pulmonary clinic for telehealth in conjunction with the Phoenix VAMC, implemented a

spinal cord telemedicine clinic with the San Diego and Long Beach VAMCs, hosted the VISN 18 telehealth mini-residency program, and activated the PCTOC in Holbrook, Arizona. As part of a multi-facility initiative, the NAVAHCS is establishing primary care telemedicine clinics in rural areas in Arizona. For example, NAVAHCS received funding from the VA Office of Rural Health to establish primary care telemedicine in the Navajo Nation and Hopi Reservation; the program is being implemented in Chinle, Arizona (Navajo Nation), and Polacca, Arizona (Hopi Nation). The NAVAHCS also has procured a mobile van with video telehealth capabilities to reach rural veterans who live in remote areas of Arizona.

Some of the home telehealth, clinical video telehealth, and store-and-forward telehealth services that the NAVAHCS offers at its affiliated CBOCs are: retinal imaging, dermatology, vascular, mental health, home monitoring of vital signs, weight management, diabetes, PTSD monitoring and depression. The NAVAHCS made an agreement with Indian Health Services to see Native American veterans who reside in Navajo Nation in Chinle via clinical video telehealth technology is inside NAVAHCS's mobile clinic stationed at the Chinle Comprehensive Health Care Facility.

Specialty Care

The NAVAHCS's womens health care is integrated within the PACT and provides comprehensive, gender-specific care. Behavioral womens health-care service, through the mental health department, is provided to 1,769 enrolled and 1,299 unique women veterans who reside within the NAVAHCS catchment area. Of the 1,006 enrolled veterans in FY 2011, 2 percent are highly rural, 63 percent are rural, 34 percent are urban and one percent was unknown. In December, women veterans comprised five percent of the enrolled veterans at the NAVAHCS, and additionally make up 10 percent of the enrolled Operation Iraqi Freedom(OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND) veterans. The gender-specific women health-care services offered through fee basis or other VA referrals are mammograms, breast biopsy/surgeries, colonoscopies, intrauterine device implantation, maternity care and gynecological consultation for abnormal findings.

The NAVAHCS womens health program offers such special programs and services as domiciliary services, monthly educational campaigns, and health education and clinics, and sponsors women health fairs in the community. The women veteran's



program manager collaborates with the Medical System's OEF and OIF, and OND Program Manager and the Rural Health Program Coordinator to develop and launch outreach events.

The NAVAHCS has a large mental and behavioral health-care line with several treatment teams and programs that specifically address all aspects of the veterans mental health and hygiene.

The Mental Health and Behavioral Sciences Services (MHBS) line at NAVAHCS and its affiliated CBOCs has 109 mental and behavioral health providers who provide evidence-based psychotherapy, holistic treatment, pharmacology, family therapy and group therapies to 24,763 unique veterans that are in need of mental health care, either as an inpatient or as an outpatient. In FY 2011, the NAVAHCS MHBS had 443,473 veteran encounters and 295,248 veteran visits. The NAVAHCS has a mental health and behavioral service outpatient clinic located in Chinle to help in the mental health treatment for Native American veterans who reside in Navajo Nation.

Outreach

As a result of having a large population of veterans living in the rural areas within the NAVAHCS catchment area, the system has a full-time Rural Health Program Coordinator who is dedicated and responsible to meeting the health-care needs and providing outreach to highly rural and rural veterans. The Rural Health Program Coordinator coordinates all the rural health-care projects and services for veterans and Native American veterans who reside throughout north central Arizona, including the Navajo and Hopi nations. Some of the NAVAHCS rural health outreach projects in FY 2012 include rural outreach to homeless veterans, providing Compensation and Pension examinations at CBOCs, telemedicine expansion, VA-staffed mobile health clinic, VA/Indian Health Service partnerships, mental health services at CBOCs, and PTSD services at the Hopi and Navajo reservations. The NAVAHCS is planning for the future, in terms of meeting the health-care needs of rural veterans, by expanding the following services for rural veterans: home-based primary care in Kingman and Flagstaff, Arizona, tele-mental health services at its affiliated CBOCs, tele-health clinic sites to increase rural veteran coverage, veterans transportation services including more runs between its CBOCs and the two Native American Indian reservations, and creating a one-call center for transportation scheduling in order to reduce beneficiary travel.

Community Based Outpatient Clinics

The NAVAHCS CBOCs are staffed with two primary care providers and a registered nurse (PACT) at each clinic. The CBOCs are multidisciplinary, with primary care, health promotion and disease prevention, Compensation and Pension examinations, pharmacy disease management services, tele-medicine services, homeless veteran services, OEF/OIF/OND support services, Project ARCH (Flagstaff), limited laboratory services and VTS. In FY 2011, the NAVAHCS had 52,214 patient visits and 11,476 unique patients served in their affiliated CBOCs.

In the near future, the NAVAHCS is planning to add more outpatient health-care services to its clinics in order to better serve the increasing numbers of veterans that reside in rural areas of North Central Arizona.

Challenges

One of the rural health-care challenges for the NAVAHCS is having a large amount of "snowbird veterans" – veterans who are considered snowbirds cannot be assigned to two primary care panels, so they are not identified in the system as belonging to a NAVAHCS primary care provider. Other challenges are recruitment/retention of specialty health-care positions in the rural areas, getting enough resources for rural health programs and initiatives for veteran health care, and CBOC space for continued veteran growth within the medical system's catchment area.

Recommendations

One rural health-care recommendations for the NAVAHCS is that the system needs to improve the way it coordinates non-VA health-care services for veterans. The medical system needs to improve communication between VA, Humana and their providers; provide video/telehealth capabilities so the provider can medically treat veterans in their house so they do not have to travel to CBOCs or medical centers for medical treatment; VA needs to allocate the Veterans Equitable Resource Allocation dollars in six-month intervals, rather than two- year intervals, so the medical center can change the veterans price group categories; the ORH needs to increase funding for the sustainment and/or expansion of rural health programs and initiatives; the ORH needs to continue to provide funding for telehealth projects between VA and Indian Health Service; and Congress needs to allocate more money in the medical centers general purpose funding.

GLOBE-MIAMI COMMUNITY BASED OUTPATIENT CLINIC | GLOBE, AZ

Date: December 15, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

Background

This facility located in Globe, Arizona is approximately one and a half hours from the Phoenix metro area. The Globe-Miami CBOC (GMCBOC), opened in FY 2000, is located on the campus of the Cobra Valley Regional Medical Center. This CBOC, which is affiliated with the PVAHCS, provides primary care services, laboratory testing, psychiatry tele-health, nutrition, tele-dermatology, veteran eligibility services and some urgent care. The GMCBOC has a staff of four – one nurse practitioner, two registered nurses and one nursing assistant—to treat a panel size of 624 out of the 2,000 veterans that reside in the Globe-Miami catchment area.

The GMCBOC also has contracted a pharmacist that is attached to the veterans Primary Aligned Care Team (PACT). The CBOC also has contracted pharmacists in the surrounding areas for providing emergency prescriptions when written by a VA primary care provider. The PVAHCS also has contracted with the Cobra Valley Regional Medical Center for emergency evaluations and radiology services in order to provide easy access to X-ray services. Some of the other medical services that the PVAHCS contracts and or obtains through fee-basis include orthopedics, neurology, cardiology, physical therapy, radiology, and womens health. The CBOC also participates in the Veterans Transportation System that the PVAHCS implemented to assist in the transportation of veterans to the medical center in Phoenix.

As previously noted, outreach activities are included for all the returning warriors through Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn staff, including those who reside in the Globe/Miami area. Public-service announcements have been placed in the local media in an effort to let all veterans in the Globe/Miami area know of the services available at this clinic. Other outreach activities, such as town halls and meetings with the local veterans’ service organization representatives, are being explored.

Challenges

The GMCBOC would like to enroll more patients. Its daily visits are eight veterans per day. Due to the approximate distance, the veterans who reside in the Globe-Miami area of Arizona can chose between the Phoenix VAMC and the VAMC in Tucson to receive their medical care.

Recommendations

Veterans can achieve this by VA allowing veterans to be enrolled in multiple medical facilities. This would allow the residents of this region able to be treated at their nearest CBOC even though they are not enrolled in the affiliated VAMC.



FARMINGTON COMMUNITY BASED OUTPATIENT CLINIC | FARMINGTON, NM

Date: January 18, 2012

National Task Force Member: Ralph P. Bozella

National Field Service Representative: Warren J. Goldstein

Background

This CBOC opening in 1987 and is located in Farmington, N.M., which is considered the four corners (Colorado, Utah, Arizona and New Mexico) area of the United States. The Farmington outpatient clinic is three hours from the Albuquerque metro area.

This CBOC, affiliated with the New Mexico Department of Veterans Affairs Healthcare System (NMVAHCS), provides primary care services, laboratory testing, electrocardiograms (EKGs), immunizations, nurse clinics, seven tele-health services, veteran eligibility services, mental health services, social work services, pharmacy services, and Operation Iraqi Freedom, Operation Enduring Freedom and Operation New Dawn case management through the medical center in Albuquerque. The Farmington CBOC staff consists of 13 employees treating a panel size of 2,000 veterans residing in the Farmington area. The Farmington CBOC has fee-basis/contracted hospital emergency and pharmacy services, radiology and mammography services with the San Juan Regional Medical Center in Farmington.

Due to space constraints and a growing veteran population, the Farmington CBOC is moving to a 6,000 square-foot clinic in the Farmington community at the end of FY 2012.

Challenges

As a result of veterans residing in highly and or rural locations of New Mexico, a significant challenge to veterans is the distances they have to travel from their home to the medical center and/or CBOCs to receive primary and/or specialty health care. The NMVAHCS and its CBOCs have difficulty in recruiting and retaining professional staff to work in rural areas of New Mexico (which has been exacerbated by recent limitation on recruitment and retention incentives), and getting enough resources to treat highly rural and rural veterans.

Recommendations

The NMVAHCS needs veteran(s) to become part of the Primary Aligned Care Team (PACT) steering committee for their input and perspective on improving veteran health care. VA needs the same ability as other governmental agencies/programs to invoice Medicare for services rendered at the medical center. The CBOC should increase the availability of veterans' service organization-sponsored travel services, and

also increase advertising VA programs and initiatives (ex. "my healthy Vet) in VSO newsletters and mailings so veterans are made aware of the services and programs available. The VSO newsletters need to be made available in medical centers and CBOCs to advertise to veterans what VSOs are doing on behalf of veterans and their families.

FLAGSTAFF COMMUNITY BASED OUTPATIENT CLINIC | FLAGSTAFF, AZ

Date: February 8, 2012

National Task Force Member: Chairman, Michael D. Helm

National Field Service Representative: Warren J. Goldstein

Background

This 11,000 square-foot, 12-treatment room CBOC, opened in November 2011, is located at the foot of the mountains in Flagstaff, Arizona. The Flagstaff CBOC is two hours from the Northern Arizona Department of Veterans Affairs Healthcare System (NAVAHCS) in Prescott, Arizona. The clinic is staffed with one physician, registered nurse, medical support assistant, licensed practical nurse, Compensation and Pension (C&P) provider, tele-health coordinator, social worker, Housing Urban Development and Veterans Affairs Supportive Housing (HUD/VASH) coordinator, and a pharmacist to provide services to approximately 5,000 veterans that reside north of Flagstaff and surrounding areas. This CBOC, which is affiliated with the NAVAHCS, provides primary care mental health, womens health, disease prevention, chronic disease management, pharmacy, tele-medicine/tele-health, and C&P examinations.

The Flagstaff CBOC has fee-basis/contracted health-care services via Project Access Received Closer to Home (ARCH) and oncology services. The Flagstaff CBOC, through fee-basis and/or contracts, provides any necessary health-care services that are not available through the NAVAHCS and/or other VAMCs within VISN 18.

Challenges

Some of the challenges that the Flagstaff CBOC face are similar to the challenges faced by the VAMC, such as limited access to other facilities' specialty clinics due to the high veteran demand and lack of specialty providers at the tertiary medical care facilities.



AMERICAN LEGION POST FOCUS GROUP | GLOBE, AZ

Date: December 14, 2011

National Task Force Member: Vickie D. Smith-Dikes

National Field Service Representative: Warren J. Goldstein

Background

A rural health veteran focus group was conducted at the Herry Berry American Legion Post 4 in Globe, Arizona on December 14, 2011. Some of the issues and or concerns that came out of the focus group were:

- A veterans home is needed in the Globe-Miami area because there are approximately 3,500 veterans who reside in the surrounding areas.
- The priority groups need to be changed because all veterans deserve medical care, despite their financial income.
- The cooperation and/or affiliation between medical facilities within the state and the services they provide needs to improve in order to meet the medical needs of the veteran.
- More specialty services are needed at all CBOCs, which will help alleviate traveling long distances to the nearest VAMC.

RECOMMENDATIONS

VISN 18

- Congressional funding needs to be expanded in order to support projects for rural veterans such as the T-21 (Veterans Transportation Service) initiative so that it can be expanded throughout VA
- Medical facilities to support the needs of rural veterans and to overall improve access to services.

VISN Rural Health Consultant

- Improve communication (meetings, information sharing, conference calls, etc) between the Veterans Integrated Service Network, Rural Health Consultant (VRHC) and the medical center’s rural health program coordinators for updates regarding veteran rural health care.
- The VRHC should have administrative responsibility for the entire VISN to improve and maintain rural health programs.
- Improving communication between the rural health coordinator and the VRHC will create more continuity with the VISN and medical centers.

Project ARCH

- The NAVAHCS needs to improve the way they coordinate non-VA health-care services for veterans. The medical system needs to improve communication between VA, Humana and their providers.

VAMC

- VA needs to continue to invest money in tele-health programs in order to meet the medical needs of highly rural, rural and urban veterans. Veterans should be able to receive proper medical care through modern technology that VA offers, no matter where a veteran chooses to reside.
- The Office of Rural Health needs to increase funding for the sustainment and/or expansion of rural health programs and initiatives
- VA needs to allocate the Veterans Equitable Resource Allocation dollars in six-month intervals, rather than in two year intervals, so the medical center can change the veterans price group categories

- VA also needs to make the Rural Health Native American Indian coordinator/planner at the medical centers a full-time position, rather than have it as a collateral duty as assigned.
- The New Mexico VA Health Care System needs veteran(s) to become part of the Primary Aligned Care Team (PACT) steering committee for their input and perspective on improving veteran health care.
- VA needs the same ability as other governmental agencies/programs to invoice Medicare for services rendered at the medical center.
- Increase the availability of veterans’ service organizations-sponsored travel services
- Advertise VA programs and initiatives (ex. “my healthy Vet) in VSO newsletters and mailings so veterans are made aware of the services and programs that are available
- VSO newsletters need to be made available in medical centers and CBOCs, advertising to veterans what VSOs are doing on behalf of veterans and their families.

CBOCs

- Allow veterans in the Globe-Miami and the surroundings area to be able to dual enroll in two medical centers. This would allow the residents of this region to receive treatment at their nearest CBOC even though they are not enrolled in the affiliated medical center.
- Enhance video/tele-health capabilities so the provider can medically treat veterans in their house, so they do not have to travel to CBOCs or medical centers for treatment
- Since many of the veterans in Arizona live in a rural and/or highly rural areas, access to a VAMC and/or CBOC is critical to obtaining health care.
- Veterans access could be enhanced if VA permitted veterans to be enrolled in multiple medical facilities



VISN 19

VETERANS INTEGRATED SERVICE NETWORK DENVER, CO

December 13, 2011

National Task Force Member: Thomas P. Mullon

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

VETERANS INTEGRATED SERVICE NETWORK RURAL HEALTH CONSULTANT GLENDALE, CO

December 13, 2011

National Task Force Member: Thomas P. Mullon

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

RURAL HEALTH RESOURCE CENTER SALT LAKE CITY, UT

January 10, 2012

National Task Force Member: Past National Commander Paul A. Morin

National Field Service Representative: Jonathan M. Naraine

PROJECT ACCESS RECEIVED CLOSER TO HOME ARCH - BILLINGS, MT

February 8, 2012

National Task Force Member: Past National Commander Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine

CHEYENNE VA MEDICAL CENTER CHEYENNE, WY

December 14, 2011

National Task Force Member: Thomas P. Mullon

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

VA EASTERN COLORADO HEALTH CARE SYSTEM DENVER, CO

December 15, 2011

National Task Force Member: Thomas P. Mullon

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

VA SALT LAKE CITY HEALTH CARE SYSTEM SALT LAKE CITY, UT

January 10, 2012

National Task Force Member: Past National Commander Paul A. Morin

National Field Service Representative: Jonathan M. Naraine

VA MONTANA HEALTH CARE SYSTEM FORT HARRISON, MT

February 7, 2012

National Task Force Member: Past National Commander Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine

POCATELLO COMMUNITY BASED OUTPATIENT CLINIC POCATELLO, ID

January 11, 2012

National Task Force Member: Past National Commander Paul A. Morin

National Field Service Representative: Jonathan M. Naraine

NEPHI COMMUNITY BASED OUTPATIENT CLINIC NEPHI, UT

January 12, 2012

National Task Force Member: Past National Commander Paul A. Morin

National Field Service Representative: Jonathan M. Naraine

ANACONDA COMMUNITY BASED OUTPATIENT CLINIC ANACONDA, MT

February 7, 2012

National Task Force Member: Past National Commander Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine

BILLINGS COMMUNITY BASED OUTPATIENT CLINIC BILLINGS, MT

February 8, 2012

National Task Force Member: Past National Commander Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine

AMERICAN LEGION POST FOCUS GROUP TORRINGTON, WY

December 14, 2011

National Task Force Member: Thomas P. Mullon

Deputy Director of Health Care: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

RECOMMENDATIONS



VETERAN INTEGRATED SERVICE NETWORK 19 | DENVER, CO

Date: December 13, 2011

National Task Force Member: Thomas P. Mullan

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine



Background

The Rocky Mountain Network is one of VA's 21 VISNs. Services are provided through primary care and supported by six Joint Commission-accredited medical centers. VISN 19 consists of nine Rocky Mountain states: Colorado, Wyoming, Montana, Utah, Idaho, Kansas, Nebraska, Nevada and North Dakota. VISN 19 has Community Based Outpatient Clinics (CBOCs), five of which are contracted and 31 VA-staffed; five outreach clinics; one mobile van; nine sites that provide VA mental health services via telehealth to 13 Native American tribes, and 10 rural health Primary Care Telehealth Outreach Clinics (PCTOCs). As of 2011, there are 754,661 veterans residing in the catchment area of VISN 19, 267,045 of which are enrolled in VA. Rural and highly rural veterans represent 45 percent of the VISN's veteran user population.

VISN 19's rural health program progress involved implementing 10 new PCTOCs. All VISN 19 facilities offer telehealth staffing and technologies to support telehealth with primary care and tertiary care. Patient and provider education is supported by telehealth staffing and technologies at all VISN 19 facilities.

Budget

VISN 19's rural health-care budget for FY 2011 was \$19.4 million, and the FY 2012 estimated budget is projected to be \$21.7 million. Its fee-based/purchased care expenditure

in FY 2011 was \$174 million, and the projected FY 2012 expenditure is \$181 million. VISN 19's beneficiary travel budget for FY 2011 was \$30 million, and the FY 2012 projected budget is \$35 million.

Challenges

Since 45 percent of the 754,661 veterans within VISN 19 are considered rural and highly rural, there are several challenges the VISN encounters. First, there has been a lack of transportation available for veterans. Second, there has been a lack of high-level specialty care for veterans living in rural areas. Finally, a complicated issue remains with scheduling between multiple health-care providers. Providers are using different scheduling programs, which complicates appointment status.

Recommendations

The VISN should continue to move forward on the plans of creating 10 new (PCTOC clinics. They will be located in Hamilton and Plentywood, and Montana; Idaho Falls, Idaho; Worland, Rawlins and Evanston, Wyoming; Price and Moab, Utah; and Salida and Glenwood Springs, Colorado. Also, VISN 19 has to incorporate the rural mobile telehealth clinic, which services remote communities around Cheyenne, Wyoming.

VISN RURAL HEALTH CONSULTANT | GLENDALE, CO

Date: December 13, 2011

National Task Force Member: Thomas P. Mullan

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

Background

The VISN Rural Health Consultant (VRHC) position is a full-time position located in the Fort Collins Vet Center, Colorado. There are 40,000 veterans in Larimer and Weld County around Fort Collins. VRHC receives no official training, but receives yearly telehealth training and conducts monthly video conference calls with VA's Office of Rural Health (ORH). The VRHC defines rural health care by the time and miles traveled to a medical facility.

Challenges

A consistent challenge in VISN 19 is scheduling and providers' ability to access patient schedules. Since the introduction of telehealth, there has been a need for a scheduling program for telehealth. In addition, contracted civilian facilities lack staff and resources required to treat veteran issues. Civilian facilities are not equipped to address issues such as Post-Traumatic Stress Disorder and Traumatic Brain Injury. Another issue facing the VA system involves recruiting enough staff to address a variety of patient care.

To provide the highest quality of health care for veterans, cooperation between contract and VA facilities should be strengthened. Veterans should be educated about services that VA provides. Despite cooperation with local community clinics, veterans should still be able to access VAMCs. To ensure veterans receive quality care at local community clinics, VA should maintain quality contracts with local clinics. If contracts are not monitored, then veteran's health care may be overlooked and civilian patients may be taken as priority.

Recommendations

To improve metrics, data in determining outcomes, travel cost fee and contract services should be organized by patient identifier. Also, Veterans Health Administration and Patient Alignment Care Team should be integrated together.



RURAL HEALTH RESOURCE CENTER | SALT LAKE CITY, UT

Date: January 10, 2011

National Task Force Member: Past National Commander, Paul A. Morin

National Field Service Representative: Jonathan M. Naraine

Background

The Rural Health Resource Center (RHRC) is located on the Salt Lake City VAMC. The VAMC budget for FY 2011 was \$2.1 million. The center does not provide direct care, nor does it staff clinics, but it does help with funding. The CBOCs receive support and ideas from the RHRC. The center connects with all veterans' service organizations willing to help veterans.

The center serves as a field-based clinical research center for pilot programs. The center also provides educational, academic and clinical information to provide new outreach and care models. They have a crucial function in enhancing academic affiliation with nursing and medical schools, which helps direct outreach to veterans. The center works closely with the Office of Rural Health (ORH) to disseminate information to veterans in the VISN's catchment area.

Specifically, the center provides ORH support to veterans residing in areas such as the Great Plains, American Samoa and the Philippines. They have recently launched the Rural Native American Veterans Promising Program initiative; this program develops models of care for the Native American veteran population in rural areas. The center provides outreach to build partnerships with community agencies and organizations that serve rural communities.

In 2011, the health resource team set out to the rural area of Kodiak, Alaska, to help educate the residents on VA health care. The center's main goal is to find areas where veterans need help the most and to administer VA information.

Current projects include funding for medical services to keep physicians qualified on parasynthesis and lumbar puncture. Currently, there is a program being developed to control pain medicine use, and to improve the use of other pain management, including yoga.

Challenges

The RHRC had difficulties finding areas where veterans need medical assistance. There are many veterans who are not afforded proper medical attention or not educated about the VA system.

Recommendations

The American Legion has offered its collaboration efforts with the RHRC. The American Legion has available questionnaires

involving veteran issues. The questionnaires could provide important information for the HRC. Also, it may be beneficial for HRC to contact other VSOs for help within veteran communities. In addition, there should be assigned Veterans Affairs Special Services numbers for CBOCs to assist in tracking patients. To ensure proper health care for returning National Guardsmen, surveys should be provided.

PROJECT ACCESS RECEIVED CLOSER TO HOME (ARCH) | BILLINGS, MT

Date: February 8, 2012

National Task Force Member: Past National Commander, Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine

Background

Billings CBOC offers Project Access Received Closer to Home (ARCH), a VA pilot program designed. Billings is one of five sites authorized to use Project ARCH. It is designed to improve access for eligible veterans by connecting them to health-care services closer to home. The health services are provided through contractual arrangements with non-VA health-care providers.

The total Project ARCH budget for 2012 will be \$10.3 million. There are currently 400 veterans participating in the pilot programs. Every veteran in Montana is eligible to participate in this program, except veterans living in Lincoln County. The veterans participating are between the ages of 20- 90. Veterans enrolled in VA health care prior to August 29, 2011 are eligible.

They must meet the following criteria:

- Veteran must live more than 60 miles drive time from the nearest VA facility providing primary care services, or
- Live more than 120 miles drive time from the nearest VA health-care facility providing acute care, or
- Live more than 240 miles drive from the nearest VA health-care facility providing tertiary care.

Project ARCH started on August 29, 2011, both nationally and within Montana. Employees coordinating ARCH include the program support assistant and care coordinator. The program support assistant has been with the program since July 5, 2011, and the care coordinator since September 12, 2011. Both are full-time positions. The positions are funded by the Office of Rural Health (ORH) and specific purpose funds are authorized for three years. Both the ORH and Veterans Affairs Central Office provide the necessary training for Project ARCH.

The care coordinator and program support assistant have bi-weekly conference calls with the other four VISN Project ARCH sites. There is also a weekly call to the health insurance company Humana Veterans Healthcare Services. Humana is a third party that contracts with outside health-care providers in partnership with the VA.

Billings provides outreach by administering conference calls, in-person meetings, teleconferences, information packets, and letters. Currently all Project ARCH sites are working on an educational video for veterans, providers and the VA. To ensure

the program's effectiveness, Project ARCH staff created a financial spreadsheet. In 2012, a contract company, Altarum, will be working on a report for Congress to notify them of the program's effectiveness. Altarum is also working on a patient satisfaction survey and a report of the benefits within the program.

Project ARCH staff has not worked with Project Healthcare Effectiveness through Resource Optimization and is not offered through VA Montana. Project ARCH staff has received complaints regarding non-VA providers on topics such as curtness, rudeness and poor communication. In addition, some veterans complained about travel to ARCH-contracted providers, instead of receiving care within their town.

Challenges

ARCH staff has encountered communication issues between Humana Veterans Healthcare Services, the contracted providers and VA Montana. There is pressure to support the staff, yet the manager is not involved in the budget process. Travel is an issue for ARCH. There needs to be more specialty care and access to that care. VA has problems receiving veteran's records outside of the VA. If a contract doctor under ARCH wants to order tests for the veteran, that doctor needs to go back to the VA for approval.

Recommendations

Project ARCH has been a valuable tool for Montana VA system. The facility would like to see an expansion of the project. Some believe Project ARCH may eventually replace the VA health-care system and proposed to limit its use. It was advised to use the Project ARCH funds for facilities and personnel expansion.



CHEYENNE VA MEDICAL CENTER | CHEYENNE, WY

Date: December 14, 2011

National Task Force Member: Thomas P. Mullan

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

Background

The Cheyenne VAMC opened on May 4, 1934, and began with seven buildings. Cheyenne VAMC provided services to 19,000 veterans and had 206,000 outpatient visits in 2011. Of those veterans, 11,000 live in rural and highly rural areas. In the past three years, there has been an increase in outpatient visits of 27 percent.

There are approximately 68,800 veterans residing in the catchment area. As of 2011, there are approximately 600 employees working at the Cheyenne VAMC. The Cheyenne VAMC provides outpatient care to eight sites: Fort Collins, Greeley and Sterling, CO; Laramie, Rawlins, Torrington and Wheatland and Sidney, NE. In addition to outpatient clinics, the telehealth mobile clinic is stationed at the Cheyenne VAMC. It conducts site visits to Sterling, CO Wheatland, Torrington, and Laramie, WY. The mobile health clinic serves more than 600 veterans and utilizes the Primary Care Telehealth Outpatient Clinic (PCTOC) model.

In 2011, the Cheyenne VAMC Opening of a PCTOC in Rawlins, WY on July 2011. Additionally, In June 2011, the VAMC opened the Greeley Home Based Primary Care program was awarded a \$300,000 grant from the ORH.

Budget

Cheyenne VAMC's overall budget in FY 2011 was \$76 million; the FY 2012 proposed budget was \$94 million. Rural health funds in FY 2011 were \$5 million. Fee-based care is carefully monitored through measures set in place by the Cheyenne VAMC. The measure is a simple procedure where fee-based care is not paid until the contracted facility provides the information obtained through services performed. The facility resorts to fee based if the service provided cannot be afforded by Cheyenne VAMC.

Staffing

The medical center currently has vacancies in the areas of mental health; psychiatrists, orthopedic surgeons, cardiologists and chief radiologist.

Telehealth

Current telehealth programs include move, pain, chaplaincy, primary care, mental health, dermatology, retinal, surgery and wheelchair. Services provided through PCTOC and mobile

sites involve immunizations, health screenings, referrals to specialty care, mental health exams, counseling, electrocardiography and lab testing.

The mobile clinic has been scheduled for replacement in 2012, with \$2.6 million awarded from the ORH. Rawlins PCTOC enrollment exceeded the 2011 goal with 227 enrollees. There has been an increase with telehealth performance measures in 2011, with improvements specifically in enrollment.

Specialty Care

The Cheyenne VAMC mental health service team manages the CBOCs in Greeley and Fort Collins, Colorado. The medical team works within the community to address issues involving substance use disorders, homelessness, life management, career development and mental illness. Specialized care is delivered through cognitive behavioral therapy, cognitive processing therapy, solution focused treatment, psychiatric rehabilitation, pharmacological interventions, dialectical behavioral therapy and prolonged exposure therapy.

The mental health service team provides specialized programs to address veterans with shared challenges. The programs offered include suicide prevention, military sexual trauma, mental health intensive care, homeless veteran care, Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn programs, and Post-Traumatic Stress Disorder treatment. In 2011, the mental health services team served more than 4,200 veterans, and the number has increased in recent years due to returning troops.

In the near future, the Cheyenne VAMC will have completed a reorganization of the mental health services line. The restructuring will reduce the amount of supervisors, increase ability to create strategies, improve productivity, increase communications and create better support for staff. In addition, the mental health service team will be developing new services in the future, including medical foster homes, the Veterans Individual Training Assistance Link program, reaching out to two college campuses in the area, psychiatric services with emergency observation and evaluation elements, and veterans justice outreach.

The Cheyenne VAMC provides professional services with a personal touch for care involving women veterans. The women veterans program provides services through comprehensive

primary care, mental health, specialty care, mobile health services, telehealth services and outreach events. In 2010, Cheyenne VAMC was awarded T-21 funds to purchase gynecologic operative equipment. The equipment has given the facility surgical capabilities and offer minimally invasive gynecology (GYN) surgical cases.

In 2011, Cheyenne VAMC had 1,173 women veterans enrolled, and in a four-year span there has been an average increase of 100 female veterans per year. Cheyenne VAMC uses targeted outreach events to educate and recruit female veterans. In 2011, the women veterans department collaborated with community partners to coordinate the first annual women veterans baby shower. The event highlighted services ranging from preconception, maternity care, and education on transitioning veterans between VA and non-VA care. Recently, VISN 19 submitted a proposal regarding a rural health grant to provide GYN telehealth services for rural women veterans. The services requesting involve the first obstetrics and GYN consults that do not require an exam.

Challenges

Cheyenne VAMC has had problems in employee recruitment and retention in specific areas of psychiatry, orthopedic surgeons, cardiologists and radiologists.

Recommendations

A successful completion of a new Cheyenne CBOC would improve rural health care. Also, employment retention could improve if incentives and salaries were raise



VA EASTERN COLORADO HEALTH CARE SYSTEM | DENVER, CO

Date: December 15, 2011

National Task Force Member: Thomas P. Mullan

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

Background

Denver VAMC currently has 129,000 veterans residing in its catchment area. Of the 129,000, 103,156 are enrolled in VA health care – 93,814 male and 9,342 female. There are 30,412 veterans enrolled in the Denver VAMC who are considered rural and highly rural. There are nine CBOCs located in Pueblo, Aurora, Alamosa, LaJunta, Lakewood, Lamar, Fontanero, Spruce Street and Burlington. All CBOCs provide primary and mental health services. Denver VAMC has proposed to provide telehealth services such as audiology and pulmonary in its CBOCs.

Budget

The total medical center budget for FY 2011 was \$475 million, and the projected budget for FY 2012 is \$517 million. Its rural health program budget consists of \$3 million for FY 2011 and \$2 million for FY 2012. The medical center's fee based/purchased care expenditures for FY 2011 was \$68 million and a proposed \$72 million in FY 2012. The travel beneficiary VISN budget was \$3 million in FY 2011 and \$4 million is proposed in FY 2012. Some medical services may need to be fee-based, such as optometry and physical therapy services. Dialysis services may also need to be fee-based out if the veteran resides 30 or more miles away. A portion of the \$200 million dollar grant from the Office of Rural Health (ORH) was used for orthopedic services in 2009 and 2010.

Staff

The Denver VAMC has approximately 2,000 employees, with vacancies for mental health personnel. There is a special need for mental health personnel in Colorado Springs. Specialty staffing is limited; the medical center uses administrative staffing to fulfill the positions. Recruitment incentives are provided and based on staffing positions. The medical center uses voluntary services to supplement the full time staff. The approximately 800 volunteers average four hours a week.

Telehealth

Denver VAMC telehealth programs include clinical video, store-and-forward and E-console. Other telehealth services include dermatology, retinal, mental health, psychiatrist, wheelchair seating, education and virtual intensive care unit. Denver

VAMC offers surgery for pre- and post-surgical assistance via telehealth. To implement these programs, directors for each department come together to teach other hospitals and Intensive Care Unit staff. Veterans are not able to access telehealth in their homes, but Denver VAMC has received adequate funds to make telehealth a reality in veteran homes. Currently, there are no plans to add Primary Telehealth Outpatient Clinics (PTOCs) or CBOCs, but VISN 19 is proposing to refit facilities in 2012.

Specialty Care

Women veterans are afforded the same primary care services as male veterans. CBOCs in Denver VAMC's jurisdiction have the necessary information regarding women veterans programs, including pamphlets and brochures. Denver VAMC ensures that every room has privacy for women veterans, ensuring a comfortable and safe experience. Within Denver VAMC's jurisdiction there are vacancies in mental health at Colorado Springs, Fontanero and Spruce Street CBOCs. Denver VAMC suggests hiring personnel in Denver and piloting them out to Colorado Springs. Currently, Denver VAMC has had to accommodate the massive demand for special staff by supplementing with administrative staff.

Outreach

The medical center conducts outreach events such as the Yellow Ribbon event. This event allows the medical center to contact as many Operation Enduring Freedom and Operation Iraqi Freedom veterans as possible. The facility also attends Individual Ready Reserve musters. Their goal is to help facilitate a smooth transition from active duty and reserve military to VA status.

Challenges

Denver VAMC has been contemplating building new CBOCs or upgrading existing CBOCs.

Recommendations

The medical center should equip all CBOCs with the necessary upgrades, such as audiology and pulmonary via telehealth. An important accomplishment for the VISN will be the construction of the new Denver VAMC, to be completed in January 2014.

VA SALT LAKE CITY HEALTH CARE SYSTEM | SALT LAKE CITY, UT

Date: January 10, 2012

National Task Force Member: Past National Commander, Paul A. Morin

National Field Service Representative: Jonathan M. Naraine



Background

Salt Lake City VAMC has eight CBOCs and three Primary Telehealth Care Outreach Clinics (PCTOCs). The clinics are located in Elko and Ely, Nevada; Price, Nephi, Orem, Ogden, Roosevelt, West Valley City and St. George, Utah; and Idaho Falls and Pocatello, Idaho. The CBOCs offer mental health and primary care, but no specialty care. The clinics also offer pharmacy and lab work, but contracts out X-ray services with the local community. If there is a need for emergency medication, the CBOC contracts out medication through the local community. Comprehensive health care is provided through areas of medicine, surgery, psychiatry, physical medicine, rehabilitation, neurology, oncology, dentistry, geriatrics and extended care.

There are 182,000 veterans currently residing in the catchment area of the Salt Lake City VAMC. Of the total veterans, only 47,327 of them are actually enrolled in the system. There are 4,081 veterans living in rural areas, and 870 veterans are consid-

ered highly rural. There are 4,475 rural male veterans and 476 rural female veterans. There are several challenges experienced with enrollment and coordination between quality of care with other VAMCs in the network and out of network. Challenges include geographic distance and lack of public transportation, including flight schedules challenging the coordination of care for veterans within VISN 19.

The VAMC provides shuttle service for transportation of rural veterans. There are two systems being used, Disabled American Veterans (DAV) and the VA shuttle service. The VAMC shuttle service out-performs the DAV van in several areas. The service is able to carry more oxygen and animals, such as service and companion dogs. Emergency care is available during the drive, because drivers have cell phones and can contact the Ranger System. The Ranger System is similar to a global positioning system. It tracks the vehicle and its speed, and maintains the shuttle schedule. All of this information is available to the Salt Lake City VAMC.



Budget

Salt Lake City VAMC total budget for FY 2011 was \$360 million, and the proposed FY 2012 budget was \$368 million. The medical center had a FY 2011 budget of \$9 million and a projected \$7 million for rural health programs. The medical centers fee-basis and purchased care expenditures in FY 2011 was \$31 million and a projected \$30 million in FY 2012. The medical centers beneficiary travel budget was \$7 million in FY 2011 and \$7 million in FY 2012.

Staffing

Salt Lake VAMC finds it hard to retain primary care physician positions. There has been a lack of space within the CBOC to harbor them. The medical center has shown recruitment incentives by using a program called Recruitment, Retention, and Relocation. This program is advertised through local newspapers and television. Currently the state of Utah does not offer License Practical Nurse educational programs; however, there have been 463 nurse positions filled. The University of Utah specialty doctors are on a dual appointment with the VAMC and the university.

Telehealth

The Salt Lake City VAMC provides social work programs in tele-combat, tele-homeless, Tele-Housing and Urban Development, and tele-mental health. The medical center provides the following telehealth services – audiology, primary care, women health care, nutrition, MOVE, cardiology and pharmacology, palliative, pain, hypnosis, diabetes, heart and many more.

In 2011, there were 4,000 unique patients in telehealth usage. Tele-health is still used in a clinic-based environment. Veterans travel to their local clinics to receive training for tele-health equipment. Currently, veterans do not have the option to access the tele-health program in their homes. There are three tele-health clinics: Price and Idaho Falls PCTOC, and the newly constructed Elko location. Homeless coordination can be done in person and through telehealth clinics.

Specialty Care

There are 18,000 women veterans, and only 6,000 are enrolled in the Salt Lake City VAMC. The University of Utah offers pregnancy services and other major services. The VAMC cared for

13 pregnant females in 2011. The CBOC provides trained providers and nurses. The VAMC provides several outreach events every month, such as Operation Baby Shower, holiday parties, heart health awareness and support groups.

The VAMC has raised women veteran awareness by creating a public service announcement. The video is 30 seconds long and is aired on the local television CBS affiliate. The medical center plans on making a similar video for mental and rural health.

In 2011, there were 100,000 outpatient visits for mental health-related issues. Also there was a new 3,000 square foot mental health building constructed on the campus of Salt Lake City VAMC, which includes 68 total beds. The facility provides a full-time mental health provider. The medical center has also created an initiative that offers a mental health pub pilot program. The program has mental health professionals at Salt Lake City who supplement work by giving hours of support to their sister facilities. Denver VAMC receives 60 hours, Grand Junction, Helena and Cheyenne receive 10 hours, and Salt Lake City receives 30 hours of support.

Challenges

Salt Lake City and VA nationwide have been dealing with the mass recall of returning troops from Operation Enduring Freedom and Operation Iraqi Freedom. Salt Lake City has also been observing how Post-Traumatic Stress Disorder can affect a veteran's family. The medical facility has encountered several challenges. There has been a need for more funding to build and expand CBOCs. The Pocatello CBOC needs to be expanded, and the CBOC's current lease status is expiring. The problem involves congressional guidelines, which restrict CBOCs to a maximum of 10,000 square feet and a \$300,000 annual lease cost. In 2011, Salt Lake City VAMC received \$4 million in special funding for mental health. The 2011 figure was \$3 million below 2010's rural health funding. Beneficiary travel has also been a problem, with patients abusing the system. For example, some veterans use a different address, along with their current address, to acquire two checks.

Recommendations

To combat the massive troop recall, Vet Centers should help contribute medical aid. The medical facility should have counseling for veteran families to prepare them for possible challenges.

VA MONTANA HEALTH CARE SYSTEM | FORT HARRISON, MT

Date: February 7, 2012

National Task Force Member: Past National Commander, Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine



Background

Fort Harrison VAMC in Helena, Montana is a medical surgical facility that offers chronic, acute and specialized services. It provides inpatient and outpatient services for male and female veterans. The facility provides specialty care in the form of internal medicine, gerontology, neurology, dermatology, cardiology, rheumatology, palliative care, pain management, medical oncology, surgery, urology, orthopedics, plastic, ophthalmology, podiatry, gynecology, chiropractic care, psychiatry, ambulatory care and military sexual trauma care.

VA Montana Healthcare System oversees 12 CBOCs, which includes Bozeman, Miles City, Billings, Glendive, Glasgow, Cut Bank, Kalispell, Anaconda, Great Falls, Lewistown, Missoula and Havre. There are Primary Care Telehealth Outpatient Clinics (PCTOCs) in Plentywood and Hamilton. Missoula and Billings CBOCs provide endoscopic exams; Billings CBOC has the only in-house pharmacy. The other CBOCs receive emergency medication from local pharmacies.

The medical center typically processes enrollment applications within five days. In 2011, 92 percent of new primary care patients were seen within 14 days, but 151 patients waited longer than 30 days for their appointment. Ninety percent of patients referred to specialty care were seen within 14 days, and 83 percent of new specialty care patients were seen within 14 days. The medical center has performed 7,000 Compensation and Pension (C&P) exams in 2011.

There are currently 5,666 veterans, 624 female, in the Fort Harrison VAMC catchment area. In 2012, there have been 549

veterans seen for mental health, 860 veterans in primary care and 1,611 veterans in other specialty areas. Services provided include physical medicine and rehabilitation services through occupational, physical, speech and kinesis therapies. The medical center has a Community Living Center (CLC) located in Miles City, Montana. The CLC provides long-term and extended rehabilitation care following surgery or other hospital care. The facility provides home telehealth care, skilled and unskilled home care, home health aid, respite care, hospice care and home therapy.

Budget

In 2011, the Montana VAMC budget was \$208 million, and in FY 2012, its budget was \$224 million. In FY 2011, \$3 million was dedicated toward rural health programs and initiatives. In FY 2012, \$11 million is estimated for rural health programs. The medical center's fee-basis and purchased care expenditures in FY 2011 was \$33 million and an estimated \$41 million in FY 2012. The beneficiary travel budget was \$9 million in FY 2011 and a projected \$2 million in FY 2012.

Staffing

The medical center has problems filling staff for physicians, nurses and pharmacists. In addition the facility cannot recruit mental health staff due to limited space. To help with recruitment, the facility offers recruitment and retention bonuses, student loan repayment opportunities and retention incentives. Some positions that have been filled by the recruitment program are Intensive Care Unit nurses, ward nurses, and C&P examiners.



Telehealth

VA Montana Medical System provides telehealth through tele-buddy, telephone and CBOCs. Services available through telehealth include amputee clinic, womens health, wound management, endocrinology, physical therapy, sleep medicine, oxygen recertification, visually impaired, services team, low vision rehabilitation service, primary care, behavioral health services, pain management, dermatology and retinal imaging.

Specialty Care

Mental health services provided are consultation, evaluation and treatment for different issues regarding emotional well being. The facility provides treatment for depression, sadness, grief, anxiety, worry, nervousness, addictive behaviors, relationship problems and stress from medical problems, Post-Traumatic Stress Disorder, emotional problems, vocational issues, memory problems and self-harming behaviors.

Mental health employees receive training from the office of Operation Enduring Freedom and Operation Iraqi Freedom. The meeting with the OEF/OIF manager is based on a one-on-one encounter. The training received involves PTSD, Prolonged Exposure Therapy, Cognitive Processing Therapy and Evidence-Based Practice. OEF/OIF veterans are given priority to be assessed for PTSD. If veterans are found to have PTSD, then they are treated within 14 days.

Outreach

Medical center representatives attend Yellow Ribbon Programs from the OEF and OIF offices. When veterans enroll, they are provided with benefits, screenings and mental health appointments. The medical center has enlisted older veterans who have received care before and can provide positive encouragement. The outreach team attends monthly Transition Assistance Program briefings at Malmstrom Air Base in Great Falls. In 2011, Montana's VAMC has attended 56 OEF, OIF and OND outreach events. In November of 2011, the medical center supported the demobilization of 600 Army and Army National Guard at Fort Lewis, WA.

Recently there had been 700 returning soldiers from active duty; 10 percent had TBI and 16 percent had PTSD. Twelve percent were female and three percent were Native Americans. The VA operates 13 vans with 15 van drivers. There are 62 DAV vans

with 200 drivers. The 700 enrollees are a seven percent increase in veterans enrolled at the VA hospital in the last two years.

There are seven Native American reservations in Montana. There is a Memorandum of Understanding between the Veterans Health Administration and Indian Health Services for the Black Feet Reservation. The VA has to negotiate with each tribe because of the friction between some tribes. The Indian representatives need to be certified. The tribe has Tribal Outreach Workers called TOWS. The VA is actively setting up tele-site and tele-mental health at each reservation. There are 6,000 Native Americans, and only 3,500 live on the reservation.

Challenges

Fort Harrison has problems filling staff positions such as nurses and pharmacists. There is a need for mental health personnel, but space is limited. In order to meet the hiring needs, the director is forced to cut other areas of service. The facility is planning to cut nursing home beds to meet its needs. Part of the problem is unfunded mandates. The extra money given to rural health is for a two-year program. After two years, the cost becomes part of the medical hospitals budget. An emergency piece of equipment that would be used to save a life had to be cancelled.

One of the biggest complaints is the phone system needs re-vamping. The problem for telehealth is rural veterans do not have land line phones but have cell phones. The budget does not allow for expansion, even though the veterans population is increasing by seven percent. The VA has developed community partnerships to help veterans. Another problem is Veterans Affairs Central Office has taken over contracting from the local hospitals. The contractors are not being paid on time, and these contractors need to be paid so they can stay in business. The contractors eventually refuse to bid on VA contracts. There is no follow up to ensure sub-contractors are paid by the primary contractor. Some contractors are filing for bankruptcy.

Recommendations

The medical facility should offer attractive incentives and pay to acquire the professional staff needed. In addition, facility officials should pressure for additional funding to incorporate mental health personnel.

POCATELLO COMMUNITY BASED OUTPATIENT CLINIC | POCATELLO, ID

Date: January 11, 2012

National Task Force Member: Past National Commander, Paul A. Morin

National Field Service Representative: Jonathan M. Naraine

Background

The Pocatello CBOC is located 185 miles away from the Salt Lake City VAMC. It was built in 1997 with a square footage of 7,000. The CBOC serves Bingham, Bannock, Bear Lake, Caribou, Franklin, Oneida, and Power, Idaho. If the veteran has an emergency, the referral site is Pocatello Medical Center.

The CBOC is manned by 33 staff employees, with one interment clerk, two licensed social workers, a medical social worker and a clinical psychologist. Women mammograms and pregnancies are contracted out locally. The CBOC has an automated drug dispensing machine that stores medication that is often needed by veterans. When the CBOC needs refills, the Salt Lake City VAMC provides the refills. However, in case of an emergency, the CBOC receives emergency medication from a contract facility. The maximum range for a veteran traveling to Pocatello CBOC is 200 miles.

Services offered at the Pocatello CBOC are primary care, case management, automated drug dispensing, social work services, mental health services, counseling, retinal imaging, telehealth services such as mental health, speech, dietician, smoking cessation, diabetic, anticoagulation management and women's gynecological health care. Pocatello offers several four-week tele-health classes: Living Well with Heart Failure, Living Well with Diabetes, Living Well with Asthma and Living Well with Heart Disease.

Post Traumatic Stress Disorder and Traumatic Brain Injury classes are offered in anger management, peer to peer group with veteran counselors and women veteran groups.

In 2011, the CBOC has 3,000 unique and 8,000 visits. There are psychiatrists on staff and offer psychiatrist support to Idaho Falls. Social workers go to Idaho Falls and conduct PTSD sessions over the camera. Lab draws are conducted at the Pocatello CBOC but sent to Salt Lake City VAMC for analysis. The delivery is done through next day delivery with UPS and the results are usually received within the next day.

Challenges

There are 2,500 veterans residing around Idaho Falls Primary Care Telehealth Outpatient Clinic (PCTOC). The Idaho PCTOC can only hold 1,000 veterans; the rest have to travel to Pocatello CBOC. Idaho Falls is 1,200 square feet; therefore vet-

erans with the most service connected disabilities get seen first. Another concern involves a 3,000 returning troops that would evidently overload the CBOC's capacity.

Recommendations

The Idaho Falls PCTOC should be expanded, so veterans do not have to drive five hours to Pocatello CBOC. Salt Lake City VAMC should discuss possible expansion for the Pocatello CBOC in order to handle the 3,000 troops coming home.



NEPHI COMMUNITY BASED OUTPATIENT CLINIC | NEPHI, UT

Date: January 12, 2011

National Task Force Member: Past National Commander, Paul A. Morin

National Field Service Representative: Jonathan M. Naraine

Background

The Nephi CBOC is located 85 miles away from the Salt Lake City VAMC. The CBOC was activated in 2008, and the contract expires February 29, 2012. Counties that are served are Juab, Millard, Sanpete and Sevier. During emergencies, the CBOC uses the Central Valley Medical Center. Primary care and tele-medicine are the services provided. As of January 3, 2012, there were 371 unique and 694 visits. The CBOC is within the civilian Central Valley Medical Center.

Nephi has one Patient Alignment Care Team (PACT) consisting of a mid-level nurse practitioner, registered nurse care manager, clerk and Licensed Practical Nurse. All staff positions are full time. Veterans travel an average of 120 miles to reach the CBOC.

There is a proposed project of building a separate VA CBOC in 2012. The CBOC is estimated to be 2,000 square feet. Currently, primary care and mental health services are offered at

the CBOC. Sub-specialty care is offered through Salt Lake City VAMC. Lab work and X-rays are done at the Nephi CBOC. In 2012, tele-retinal will be offered and training will be offered. Tele-move is offered with a health assessment to help veterans lose weight. Tele-buddy equipment is sent to the veteran's home and is trained through tele-health.

Challenges

Most veterans visiting the CBOC do not drive; therefore, it would be beneficial to have more volunteer vans available. General challenges involve lack of specialty care and travel distance.

Recommendations

There needs to be a fully functioning VA CBOC built, instead of sharing a clinic with the local community. This expansion should have the appropriate space for specialty care and DAV vans.

ANACONDA COMMUNITY BASED OUTPATIENT CLINIC | ANACONDA, MT

Date: February 7, 2012

National Task Force Member: Past National Commander, Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine

Background

The Anaconda CBOC is located 78 miles away from Fort Harrison VAMC. In 2011, the Anaconda CBOC served 800 veterans (50 female), with a projected increase to 1,200 in FY 2012. There are no Native American reservations near the CBOC. Anaconda does provide telehealth services. There is only one Patient Alignment Care Team (PACT), which consists of a part-time Licensed Practical Nurse, full time Registered Nurse and a full-time mental health provider. The CBOC does not offer weekend or evening services. Most of the veterans enrolled live within a 100 mile radius from the CBOC.

Women veterans are offered the same primary care services as male veterans. Specialty services such as mammograms are contracted out to private hospitals. Out of 800 current veteran enrollees, 200 of them have Post-Traumatic Stress Disorder. Due to the growing number of veteran services, there has been additional stress on staffing.

Challenges

There has been an issue involving the transportation of frail veterans needing ambulatory care. Scheduling can be a problem to handle all appointments distributed from Fort Harrison VAMC. There is a need to expand specialty care and more funding to refer veterans to private hospitals. In rural areas there seems to be a communication barrier with civilian offices and VA. Currently, the Anaconda CBOC is not actively performing community outreach.

Recommendations

Anaconda CBOC should start performing outreach in the local community and beyond. To ensure proper health care and efficiency, communication between Anaconda CBOC and Fort Harrison needs to improve.

BILLINGS COMMUNITY BASED OUTPATIENT CLINIC | BILLINGS, MT

Date: February 8, 2012

National Task Force Member: Past National Commander, Ronald F. Conley

National Field Service Representative: Jonathan M. Naraine

Background

Billings CBOC is located in Yellow Stone County, the largest county in Montana. There are 14,000 veterans within county lines, and 516 of them are female veterans. The CBOC has eight primary care panels. The facility is 25,000 square feet, with a future addition of 50,000 square feet. Once the expansion is completed, the facility will provide specialty care equal to what is afforded at the Fort Harrison (VAMC). The CBOC has three female staff to administer female health care and one Veterans Benefits Administration representative.

There is a current need for a general surgeon and a radiologist. A general surgeon is available, but Fort Harrison does not have sufficient funds. The Air Force surgeon was ready to join the staff, but during the interview process he was discouraged, insulted and treated poorly. When the veteran is in need of such specialty, they have been sent to a private hospital for an average cost of \$7,000. Another problem involves telehealth and its usage. One suggestion involves using telehealth capabilities to administer VA conferences, which should help cut travel costs.

Challenges

Some veterans who are seen by the doctor do not want to be screened for Post-Traumatic Stress Disorder. They fear it may label them and eventually ruin their civilian career. On occasion patients have been sent to Seattle VAMC for major surgeries, but were often treated wrongfully. After surgery, veterans were sent on a grueling ride back to Montana on bus. After having a major surgery, veterans should not have to ride on a bus for 12 hours.

Recommendations

Both challenges mentioned have been an issue with The American Legion. It has been one of The American Legion's goals to erase labels that veterans may possess after acknowledging that they have a mental health condition. In situations such as Seattle, The American Legion will be investigating in the near future. However, involving both issues should be a group effort between Congress and The American Legion to solve these problems.

AMERICAN LEGION POST FOCUS GROUP | TORRINGTON, WY

Date: December 14, 2011

National Task Force Member: Thomas P. Mullan

Deputy Director of Healthcare: Jacob B. Gadd

National Field Service Representative: Jonathan M. Naraine

Background

The focus group was held at the local American Legion Travis Snow Post 5 in Torrington, WY on December 14, 2011. During the discussion, issues concerning veteran benefits and the application process arose. The common theme was that most veterans do not know or understand their earned VA benefits. The local veterans proposed a solution involving American Legion service officers coming to local legion posts to give a VA benefits presentation to veterans.

Veteran discussion included:

- If one wants to use the Tele-health Mobile Van, one has to stop using the VAMC
- Travel time average was 90 minutes to the nearest VAMC
- When a veteran signs up for telehealth, the veteran has to drive to the nearest VAMC to submit the application forms
- Cold War and other veterans are being neglected in the VA health care
- Korean veterans are the forgotten few



RECOMMENDATIONS

VISN Director

- Continue expansion of 10 new Primary Care Telehealth Out-patient Clinics (PCTOCs)

VISN Rural Health Consultant

- To improve metrics and data in determining travel cost, fee basis, and contract services should be organized by patient identifier.
- Two specific areas in scheduling that should be addressed are clinical video telehealth and ambulatory care.
- The Veterans Health Administration and Patient Aligned Care Team (PACT) should be integrated into the PCTOCs.
- Staffing and resources should be made more accessible for the Veterans Integrated Service Network Rural Health Consultant (VRHC). To make the VA system operate more effectively, processes and procedures should be standardized.

Rural Health Resource Center

- Collaborate with The American Legion to find areas where resources are needed
- Continue to partner with veterans' service organizations to gain intelligence of veteran issues formal counseling session.
- The Oregon VAMC is sending out webcams for veterans living in rural areas. Salt Lake City VAMC will be trying a similar approach, but will be using iPads instead of webcams.

Project ARCH

- The facility would like to see expansion of the project
- Some VA staff believe Project ARCH may eventually replace the VA healthcare system and proposed to limit its use but that Project ARCH funds be utilized for facility and personnel expansion.

VAMC

- Fill staff positions in physicians, nurses and pharmacists
- Expand facility space to incorporate mental health personnel
- Medical center would rather revert back to the previous system, where directors can distribute miscellaneous funds where needed

CBOCs

- Expand Idaho Falls CBOC so the veterans residing there do not have to drive to Pocatello
- Receive the necessary staff and space to handle the returning 3,000 troops
- Construct an actual VA CBOC separate from the private clinic
- Have more volunteer vans available
- Expand on specialty care
- Improve communication on scheduling appointments from Fort Harrison and Anaconda
- Expand specialty care
- Perform outreach activities in the local community
- In the local community, improve communication between private facilities and Anaconda
- Fill the general surgeon position
- Use telehealth capabilities to conduct conferences, instead of using other funds for travel

NATIVE AMERICAN RESERVATIONS

NAVAJO NATION, CHINLE & WINDOW ROCK, AZ & PUEBLO OF LAGUNA, NM

Date: January 31-February 2, 2012

National Task Force Member: Past National Commander, Ronald F. Conley

Director of Veterans Affairs & Rehabilitation: Verna L. Jones

Media Marketing Director: Phillip M. Callaghan

Background

The Native American and Alaskan Native American veterans served honorably in the U.S. armed services during all wars. There are many specific health issues that affect the Native American and veteran population such as depression, substance abuse and various other mental health illnesses.

It is important to take into account the different Native American cultures and traditions because they do not want to deal with the bureaucracy of the VA health care. They use their own Indian Health Services (IHS) because it is historically proven to be a more understanding system of their culture and personal health. It is important that the VA/IHS or other agencies take these cultural beliefs into consideration when conducting outreach and/or providing health care services.

According to the VAMC's Native American Program Coordinator, understanding the complicated Native American culture and health-care needs is fundamental for delivering proper health care to the community. This is accomplished by integrating health care through partnerships and collaborations with IHS, tribal medical centers, intertribal councils, tribal Department of Veterans Affairs and VA.

According to the 2010 U.S. Census, there are 200,000 Native American veterans residing in over 565 recognized tribal entities across the country. The VA Office of Tribal Government Relations was created in January 2011 in response to President Clinton's Executive Order 13175, and President Obama's Memorandum on Tribal Consultation dated November 5, 2009. VA officially established the Office of Tribal Government Relations (OTGR) in January 2011 as result of an increased Native American veteran population in order to connect tribal leaders of federally recognized Indian tribes, pueblos, bands, villages and nations to better provide services and benefits to a unique population of Native American and Alaska Native veterans. According to the VA Office of Tribal Government Relations, Native Americans and Alaska Native Americans have one of the highest representations in the armed forces when compared to other minority groups.

It is also important to fully understand the dynamic relationship between IHS and VA in regards to providing health care

to Native American veterans. On June 24, 2003, and October 10, 2010, VA signed an MOU with IHS in order to accomplish several goals for Native Americans and their health care, which include:

- Cultural awareness among Native American veterans
- Improve communication among the VA, Native American veterans and Tribal governments with assistance from Indian Health Services
- Encourage partnerships and sharing agreements among the Veteran Health Administration
- Ensure appropriate resources are available to support programs for Native American veterans
- Improve health-promotion and disease-prevention services
- Improve access to quality health care and services

The 2010 MOU continues to be implemented with various workgroups to put into place sharing agreements, and other interagency efforts that are contained under the current IHS and VA agreement. The workgroups between IHS and VA are to improve services for Native American veterans in regards to benefits, coordination of care, health information technology and new technologies (i.e. telehealth). By not making Native American veterans travel far through use of technologies such as telehealth initiatives, IHS and VA have enrolled and treated 700 new veterans, including 400 veterans accessing the mental health services. This has been accomplished by the innovative way the VA has introduced telehealth services in the health care facilities on the reservations.

According to the US Department of Health and Human Services Administration for Native Americans stated that many challenges facing Native Americans veterans are similar to those veterans of all ethnicities. Some of the needs are access to healthcare, unemployment, homelessness, and mental health issues including Post-Traumatic Stress Disorder (PTSD), depression, and substance abuse.

An American Legion System Worth Saving site visit was conducted on January 30- February 3, 2012, by Past National Commander Ron Conley; Verna Jones, Director of Veterans Affairs



and Rehabilitation; Phillip (Marty) Callaghan, Media Marketing Director; and Thomas Birdbear, VA Office of Tribal Government Relations (OTGR)-Southwest Specialist to the tribal lands on the Navajo Nation Reservation in Chinle and Window Rock, Arizona, Pueblo of Laguna and Pueblo of Santo Domingo in New Mexico to learn more about and better understand how access and quality of health-care services are delivered and are available to rural Native American veterans, and to find ways to help improve the provision of VA services for Native American (NA) veterans.

The first location visited was the Navajo Nation in Chinle, Arizona. During this visit the SWS representatives met and interviewed tribal leaders, tribal veteran officers and veterans about access to healthcare. The Navajo Nation was established on June 1, 1868, and is a semi-autonomous Native American governed territory that covers over 27,000 square miles in northeastern Arizona, southeastern Utah, and northwestern New Mexico. Navajo Nation has the largest land area assigned to a Native American jurisdiction within the United States. The Navajo Nation was reorganized in 1991, creating a three-branch government system: Executive, Legislative, and Judicial. The Navajo Nation is divided 16 chapters, in which approximately 10,000 veterans are living on the reservation. The veterans who reside on the reservation in Chinle have to travel four to six hours to the nearest VA facility located in Phoenix, Prescott and Tucson, Arizona.

They also met with tribal leadership and veterans at the Pueblo of Laguna reservation located in west-central New Mexico, which is approximately an hour and a half to the VAMC in Albuquerque. There are six tribes and 8,500 members within the reservation, of which 450 are veterans. The Department of Veterans Affairs for Tribes within the reservation assists and advocates for veterans. At the Pueblo of Laguna tribal veterans were satisfied with the VA's delivery of primary care that was offered at the rural Native American reservation.

Challenges

There are several challenges that Navajo veterans face in regards to receiving VA benefits and services such as: better coordination between the tribes and VA services such as Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA)

programs; consistent and dependable transportation to VA health care and/or integrated IHS/VA health-care services that are available on the reservations; training and accreditation of Navajo Nation Tribal Veteran Service Officers located in Arizona, New Mexico, Colorado and Utah on Veteran Benefits Administration (VBA) programs; restriction of state government in caring for Native American veterans that live in other states; greater need to integrate Native American cultural and traditional medicine in IHS/VA health-care regimen, which is more Western-based; identify patterns/paths of veterans' preferences for health care; identify referral patterns/paths of VA providers to non-VA providers for health care to veterans; involve VA CBOCs on/or near tribal land areas for triage of care to veterans; involve VA long-term care placement efforts with tribal health and IHS providers for placement of veterans in nursing homes/long-term care facilities; develop and maintain routine dialogue and communication with veteran service staff/officers on tribal lands; understand dual eligibility status (between IHS and VHA) and its application to veterans. According to the Office of Tribal Government Relations, although Native American veterans can receive health care from either VA and/or IHS they are four times more likely than other veterans to report unmet health care needs.

Several other challenges that Native American veterans who reside in rural and/or highly rural areas face in regards to receiving healthcare are: great distances to access VA health care services; technological barriers in communications in regards to computer and telephone service; scheduling early healthcare appointments for veterans; (causing veterans to get up at 4 am and leave their homes for an 8 am or 9 am appointment) at Vet Centers and/or VA Medical Centers; high percentages of homelessness; lack of local employment opportunities; lack of shelters for women veterans with children; and lack of affordable housing, just to name a few. The culture does not allow easy access to programs such as building homes or having transitional homes for homeless veterans due to the property restrictions. An example is that Native American reservations are considered sacred land to the Native American community.

Recommendations

- Better coordination is needed between the tribes and VA services such as VHA, VBA and NCA programs;

- Consistent and dependable transportation to VA health care and/or integrated IHS/VA health care services that are available on the reservations;
- Training and accreditation is needed for the Navajo Tribal Veteran Service Officers located in Arizona, New Mexico, Colorado and Utah on Veterans Benefits Administration program;
- IHS and the VA needs to continue to improve education and outreach to the Native American veteran population, so they become aware of their entitled federal and state benefits
- IHS and the VA need to provide Native American veterans that reside on reservations equal access to IHS/VA physicians and mental health care professionals in order to obtain VA health care benefits by addressing cultural differences
- VA and IHS need to collaborate with tribes in an effort to utilize the existing Native American health-care infrastructure in order to effectively serve the Native American veteran population who reside on reservations
- IHS and/or VA needs to train the Tribal Veterans Service Officers on the reservations to be certified and/or accredited in order to provide benefit claims and related assistance to Native American veterans



FINAL RECOMMENDATIONS

Office of Rural Health

- VA should develop its own definition of rural and highly rural veterans, and not be based on the Census Bureau, but based on access and driving times to VA facilities.
- The VA Office of Rural Health should work with the Office of Information and Technology scheduling package for share appointment information between the CBOCs and medical centers.
- Centralize/consolidate VISN Rural Health Consultants under the Office of Rural Health.
- VA should search for opportunities to expand telehealth services by collaborating with local post offices in rural areas that can share space.

VISN

- Should invest in more telehealth capabilities dependent on the influx of veterans from OEF and OIF.
- Should continue expansion of CBOCs and mobile clinics.

VISN Rural Health Consultant

- Needs to be a full-time position with a standardized job description with minimal collateral duties.
- Report directly to the ORH and funded by the ORH.
- Design innovative ways to survey rural veterans, while maintaining compliance with regulation and law.
- Conduct outreach and provide staff training at all VAMC locations within the VISN annually.

Rural Health Resource Center

- Expand breadth of services by translating research to clinical practice.
- Provide direct service to rural veterans from surveys, national hotline and connecting veterans living in rural communities with providers.
- Provide education to VISN rural health consultants and other facilities' rural healthstaff.

Project ARCH

- Increase advertising and educate rural veterans of eligible requirements.
- Establish a clearer communication path with the contracting facility, VAMCs and VACO.
- Should identify site locations that were successful, and continue services in these areas after completion of the pilot program.

VA Medical Centers

- Improve incentive programs to recruit and retain top talent in rural facilities.
- Implement a Veterans Transportation Service Department within each VA Medical Center to coordinate all veteran transportation programs for the hospital (i.e. staff to conduct transportation catchment area analysis, Veteran Transportation Service (VTS) program initiatives, Volunteer Transportation Drivers/Volunteers scheduling and Beneficiary Travel Programs.
- More effective communication between the CBOCs and medical centers.
- Conduct outreach in collaboration with VISN Rural Health Consultant to rural and highly rural areas.

CBOC

- Expand telehealth capabilities for veterans without telephone lines and Internet capability in their home.
- The clinical manager should work more closely with the rural health coordinator to improve communication between the medical centers and their CBOCs.
- Should conduct communication training on whom the CBOCs point of contact is and procedure for requesting resources.
- Increasing space and staff to meet the demands of veterans needs.



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