

# Veterans Rural Health Advisory Committee

Margaret Puccinelli, Chair



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Date: August 18, 2016

From: Margaret Puccinelli, Chair  
Veterans Rural Health Advisory Committee

Dear Secretary McDonald:

The Veterans Rural Health Advisory Committee respectfully submits for your consideration the following four recommendations resulting from our Fiscal Year (FY) 2016 efforts to advise you on issues most relevant to the health of our rural Veterans.

**Recommendation #1:** The Committee requests that the response time to our recommendations be reduced from 14 months to 90 days or less in order that the Committee receives more timely feedback with respect to their efforts in supporting and advising you on behalf of rural Veterans.

Historically it has taken greater than 6 months to guide a document through the VA concurrence system. This delay impedes a committee's ability to submit recommendations and receive feedback within the FY. As a result, there is a delay in the completion of subsequent follow up work in conjunction with committee recommendations.

**Recommendation #2:** The creation by Congress of the \$10 billion Veterans Choice program to address health care access problems has not adequately met the health care needs of rural Veterans. Wait times in scheduling a Veteran's care as well as reimbursement delays for non-VA health care providers have been well documented and continue to plague an already burdened system. In order to better serve rural Veterans and ultimately improve the health care experience and options available to individual Veterans, any future program must be tailored to the Veteran population and the rural communities in which they live.

To effectively serve our Nation's Veterans and provide the access and quality of care they deserve, a holistic approach to their delivery of care is needed. At a minimum, this holistic approach should:

- Take into account the unique situation(s) and availability of care for rural Veterans and ensure equity in quality and access of care, regardless of where the Veteran lives.
- Emphasize an integrated (VA and Non-VA care) and flexible overall care model with the proper delivery of care mix based on Veterans' needs, locale and availability and accessibility of services.

- Provide local VA control, oversight, responsibility and accountability.
- Include appropriate and sufficiently flexible legislative and regulatory authority to structure policies and place resources where individual Veterans may be best served. Adequate funding must be included as part of this legislative effort.
- Include comprehensive communication and education on available programs for Veterans, providers and VA employees.

**Specifically, the Committee recommends that the Veterans Administration:**

1. Conduct a comprehensive, nation-wide study of all VA provided care and VA purchased care (including Choice) to determine the optimum balance between both delivery methods for Veterans. This study should take into account rural and non-rural geographic considerations, cultural/demographic make-up and provider/medical specialty availability with respect to the individual locales where Veterans are served.
2. Immediately take all legislative and regulatory steps necessary to make VA the primary payer for care for Veterans under Choice. All across the nation there are Veterans placed in financial difficulties due to the payer of last resort requirement in the Choice Act. For example: a 100 percent service connected veteran who is covered for all medical conditions incurs no cost if care is provided at a VA facility. If this same Veteran is forced to use the Choice program due to either living location or inability to receive the service at the local VA facility, they could be liable for large deductibles imposed by their primary health insurance company. On the average, most Veterans impacted by the payer of last resort requirement incur \$3,000 to \$5,000 expenses per year.
3. To ensure accountability and verifiable oversight, designate VA as the locally managed scheduler and single point of contact for all care. VA should have the means to follow patient progress and their continuity of care regardless of where care may be received.
4. Implement enforceable and consistent quality of care standards that hold VA and outside providers to the same standard of care.
5. Address the illusion held by some that Choice is the solution for Veterans' healthcare. Since the implementation of the Choice Program, Veterans have complained that expansion projects for Community Based Outpatient Clinics (CBOC) have either been eliminated or put on hold. Veterans affected by these eliminations or delays have been told to utilize the Choice program. Such strategic infrastructure decisions should not be made based on what is, at best, tenuous funding of the Choice Program. The presence of CBOC's in rural areas and the providers they attract, oftentimes provide a higher level and availability of health care services than can be found in the surrounding community. The presence of a CBOC in many rural communities is therefore critical.

The current state of VA Healthcare (specifically Choice) and future state proposals do not provide the equity of service and care needed by rural Veterans. One size does not fit all and to better serve all Veterans and achieve the apparent intent of the Choice Act, the above recommendations should be implemented with particular care given to not creating more unintentional health care delivery disparities for rural Veterans.

**Recommendation #3:** Although advances in medical care technology and better access to physicians and hospitals have served to improve this country's health care overall, wide gaps and disparate outcomes continue to exist for rural communities and remain a major theme of rural/highly rural health care. For example, when compared to urban populations, rural/highly rural residents, who represent one-third of the total VA population, tend to have a greater proportion of elderly residents, increased rates of chronic disease, a greater number of uninsured, and underutilize preventative care services.

An additional challenge for rural/highly rural residents (again, who represent one-third of the total VA population) is the availability of the needed volume and mix of health care providers. Despite the fact that almost one fourth of all Americans live in rural areas, less than 12 percent of all physicians practice in rural settings. Limited income potential, professionally restrictive practice environments, fewer employment opportunities for spouses, longer work hours, etc. have been cited as contributing factors in the recruitment and retention of physicians as well as other primary care providers such as advanced nurse practitioners, physician assistants and qualified registered nurses.

The geographic barrier between the rural/highly rural Veteran's place of residence and the nearest VA health care facility represents a further challenge and serves to undermine the ability of many of these individuals to meet their basic health care needs. This geographic barrier can contribute to their experiencing greater illness severity, more complications and ultimately higher health care costs. Being a Veteran living in rural/highly rural America therefore, packs a triple threat in terms of the geographic difficulty in receiving disproportionately greater needed health care services from a professional workforce whose numbers and specialty skill sets are limited. Although no single approach guarantees a complete solution to VA and non-VA health care access, it is recommended that access to care be viewed from the perspective of timely recruitment and retention of well-qualified physicians, nurses, nurse practitioners and other essential health care providers serving rural/highly rural Veteran populations.

**Specifically, the Committee recommends that the Veterans Administration:**

1. Undertake a system-wide evaluation of the VA Health Care System's rural/highly rural healthcare workforce to identify geographic areas where staffing needs exist including identifying professional specialty shortages that are present within these geographic settings.
2. Determine salary disparities that exist for various VA health care disciplines working in rural versus urban delivery settings.
3. Determine factors that either contribute to or interfere with retention rates for VA health care workforce members serving rural/highly rural Veteran populations.

4. Evaluate and where necessary, revamp the entire VA Health Care system recruitment process that supports rural/highly rural health care delivery. Examples include reducing the onboard time to 30 days or less, streamlining and simplifying the USA Jobs online application process, removing unnecessary steps in the credentialing process, minimizing Human Resource duplication efforts, and establishing where needed, a dedicated recruiting staff and budget to support rural/highly rural health care provider positions.
5. Continue ongoing evaluation and improvement of the contracting process for rural health clinics and Federally Qualified Health Clinics (e.g., eliminating/reducing all duplicative and unnecessary requests imbedded in the current contracting process). Identify best practice models and disseminate in order to standardize where appropriate.

**Recommendation #4:** The U.S. Department of Veterans Affairs (VA) has made significant progress in recent years to extend healthcare access to Veterans using Tele-Medicine/Health technologies. However, the effectiveness and efficacy of these technologies depends on internet and/or cellular access with sufficient bandwidth to support required applications. Unlike urban areas, many rural/frontier areas across the country have inadequate infrastructure to support/sustain most telemedicine technologies. Appropriate bandwidth appears to exist at hospital and larger healthcare facilities, but that is not necessarily the case for the general public in many rural/frontier locations and the opportunity to utilize cell phone towers as an alternative is not always an option, given the lack of phone towers and resultant poor phone reception.

To build upon the progress VA has made to date in extending access to Veterans through telehealth technology, a full spectrum approach is needed that:

- Takes into account level of service (broadband, cellular, telephone, etc.) available in specific locales.
- Considers equipment availability and cost for individual Veterans and/or sites.
- Provides increased interoperability with private healthcare facilities and providers.
- Is sensitive to geographic, economic and cultural differences and diversity within our Veteran population.
- Allows for appropriate reimbursement for delivered services.
- Provides appropriate level of security/confidentiality for the service(s) being provided.

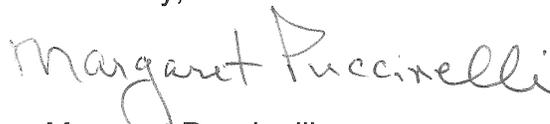
**Specifically, the Committee recommends that the Veterans Administration:**

1. Conduct a comprehensive geospatial analysis, overlaying rural Veteran and National communication coverage data that:
  - a. Utilizes existing data on where rural Veterans live.
  - b. Identifies/maps what technologies/services (broadband, cellular, etc.) are currently available in specific rural areas.

- c. Identifies, in cooperation with industry, what communication technology upgrades/enhancements are planned in the next 1-5 years.
- d. Identifies predominant conditions being treated in rural Veterans and identifies trends for future treatment(s) in specific locales.
2. Develop a comprehensive plan that identifies and leverages existing and future technologies and capabilities to use Tele-Medicine/Health services that are consistent with conditions being treated and deliverable through technology that is available in a given area. For example, appropriate care may be provided for many cases/conditions using cellular service in real-time and may not require full real-time diagnostic capability.
3. Partner with Congress, States and local governments to encourage increased funding and investment for broadband services in rural areas.
4. Increase funding for pilot projects that utilize existing technology.

Tele-Medicine/Health is not a panacea for providing all healthcare options to rural Veterans, however leveraging existing technology to deliver maximum access based on Veteran needs/conditions should be a high priority. VA must continue to seek partnerships at all levels to extend access to Veterans that secondarily might support initiatives to benefit the larger rural communities in which Veterans live and work.

Sincerely,



Margaret Puccinelli

CC: Gina Capra