Proposal to Congress

Sustaining availability of healthcare services for rurally-located veterans, utilizing established systems and infrastructure.

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It's somewhat ironic that the hospital where the nation's very first Veterans' Administration Clinic was established – the most innovative veterans' service of the time – is the very same organization that is leading the fight to ensure that veterans are able to maintain this important service, close to their home communities.

Twenty-two years ago, the very first VA Clinic opened its doors at Elizabethtown Community Hospital (ECH) in the Adirondack region of upstate New York. This hospital-based clinic has been considered the most innovative, convenient and appropriate way of delivering healthcare services to veterans living in this extremely rural area.

Over the years, other hospital-based and community clinic-based VA clinics were established; following the example originally set at ECH.

Sadly, the upstate New York area is on the verge of losing this award-winning clinic – and the important service that it provides our veterans. Once again, Elizabethtown Community Hospital is leading the charge to develop the most appropriate method of delivering healthcare to veterans located in the most rural areas of our nation.

Situation

The Veteran's Administration appears to be changing its manner of delivering healthcare services to the United States' veteran population. While somewhat unclear, it seems to be moving away from its model of rurally-based and hospital-based clinics and toward a model of free-standing clinics and urban hospitals. This is an inefficient and inconvenient method of delivering healthcare to veterans simply due to the fact that these men and women must travel great distances in order to access basic medical care.

The nation requires a collaborative approach to solving the sobering and long-standing problem of delivering primary care to our veterans. This is a group of people that have, quite literally, put their lives on the line for our nation and for others around the world. It is imperative that we do all we can to take care of their healthcare needs. ECH has developed a proposal that offers the best possible solution.

Proposal

Allow the rural-based, federally-designated Critical Access Hospitals (CAH) and Federal Qualified Health Centers (FQHC) to manage the veterans' care in rural areas; while allowing larger, urban-based hospitals the ability to manage the veterans' care in urban areas.

The federal government has determined that, generally, having hospitals located in rural areas is a necessity – providing access to healthcare for everyone. This is how the critical access model came into existence. In order to maintain viability of these hospitals, it developed a cost-based payment system to hospitals through the Medicare and Medicaid programs.

Since this system already exists, having been established by the federal government years ago, it is simply a matter of utilizing the established infrastructure. There are 1,300 Critical Access Hospitals and 1,100 Federal Qualified Health Centers located in rural communities across the nation. ECH proposes that three entities (CAH, FQHC and VA) work together, rather than establishing a new situation to provide care to the veterans – essentially, utilizing what's already in place:

- **Critical Access Hospital (CAH) – federally established**
- **Federally Qualified Health Center (FQHC) – federally established**
- **Veterans' Administration – federal program**

ECH also recommends that the Veterans' Administration work with the Center for Medicare and Medicaid Services (CMS) to adapt a similar healthcare management and payment structure for the veterans' care at the CAH and FQHC. This will serve three purposes:

- **allow the clinics to remain in rural areas, conveniently-located for many veterans;**
- **ensure that hospitals and clinics managing the program would not lose money doing so; and**
- **reduce overall costs to the VA by utilizing an already-existing system.**

Situation detail

Currently, there are large urban-based hospitals, some that are owned by the VA and others that are contracted by the VA to provide services to the veteran population. There are also rurally-based hospital clinics and free-standing community clinics that provide medical services to the veterans living in those areas. In some instances, the smaller hospitals and clinics provide primary care; and veterans occasionally travel for more extensive medical treatment, such as surgery.

The current shift in the way that healthcare is being delivered to veterans is marked by the closure or relocation of the rurally-based clinics, in favor of locating clinics closer to urban areas where there may be population clusters of veterans. It is also marked by relatively recent changes to services; specifically, encouraging veterans to travel to larger hospitals in order to receive treatment for many basic tests and conditions – things that can be easily and more cost-effectively managed by the rurally-based clinics (e.g. x-rays, lab work, MRI). Currently, lab work that is being initiated by the veterans' doctors at the rurally-based clinics is sent to larger hospitals via courier each day to have the testing completed, adding unnecessary time and expense. This service can easily be managed by rural hospitals that are close to the veterans' established physicians and home communities; but that is not the VA's procedure.

In many instances, the veterans are transported from their rural home to hospitals in urban areas by a driver hired or contracted by the VA. These veterans are instructed to park their vehicle at a designated point along the highway, where a VA van meets them. Each veteran, depending on where they live, will be parked at a different location and time along the route. The veterans are then transported to a hospital located in an urban area, where they meet with a doctor or physician's assistant and receive their medical care. Once all the veterans, who were brought together, have had their appointments, they return to the van and travel back to their vehicles that were left at different locations along the highway. In some instances, family members must come to meet them.

In upstate NY, there is a hospital in Albany that serves as one of the VA-contracted hospitals. Veterans meeting with a physician at this hospital may live in Rouses Point (3 ½ hours to the north), Ticonderoga (2 ½ hours to the northeast), Malone (4 hours to the northwest), or one of the other 105 rurally-located towns within the Adirondack Park. The point must also be made that these villages are not located along the main interstate; the veterans must travel for hours along secondary roads before they meet their VA driver on the interstate. Combining travel time to the interstate, the drive to Albany with stops along the

way to pick up others, waiting for the other veterans to meet with their doctor(s), travel back to the vehicle left along the interstate and then the drive home from there, it could quite easily take 12-14 hours to complete the day …and perhaps much longer.

Bear in mind that the Adirondack region (and, many other rural areas of the nation) does not offer cellular telephone coverage. Service may be available within the towns but once the user is outside the town (3-4 miles out), service ceases. There is often 20 miles or more between towns … again, along secondary roads where there may not be another traveler, business or home for many, many miles. It is an incredibly desolate area.

It's an exceedingly inconvenient process; not to mention that it does not allow for continuity of care, which is so important to the healthcare process. The physician or physician assistant veterans meet with at these distant hospitals is not their regular doctor; he or she knows nothing of the veterans' backgrounds, other than what is available on the chart in front of them. Physicians should have as much information as possible about a patient – establishing and maintaining a relationship with one's doctor provides insight into a patient's medical history and understanding of his or her overall situation … something that a physician simply cannot garner from a quick, occasional meeting. This lack of continuity of care is a significant problem; the ramifications of which should be taken into account when addressing veterans' healthcare issues.

Proposal detail

The ideal structure for a much-improved veterans' healthcare system is already in place; with its infrastructure established. ECH proposes that three entities (CAH, FQHC and VA) work together, rather than establishing a new situation to provide care to the veterans – utilize what's already in place:

- Critical Access Hospital (CAH) – federally established
- Federally Qualified Health Center (FQHC) – federally established
- Veterans' Administration – federal program

There are 1,300 Critical Access Hospitals (CAH) located throughout the United States. They exist due to the fact that the federal government believes that people who live in rural areas deserve access to quality healthcare – the federal government established them. These hospitals tend to be quite efficient at

delivering care. Many own and manage community clinics, separate from the hospital's primary location. These critical access hospitals and satellite clinics are reimbursed at reasonable cost (based on governmental determinations) through Medicare and Medicaid.

The rural areas also offer independent healthcare clinics that have been designated as Federally Qualified Health Centers (FQHC) – again, established by the federal government. The 1,100 FQHCs across the country are also reimbursed at cost for both Medicare and Medicaid.

ECH is proposing that the federally-established CAH, their satellite clinics in neighboring towns and the FQHC be able to manage veterans' primary care; and receive the payment structure currently in place from the federal government for doing so. This removes the need for extensive travel on the part of the patients, it allows them to maintain relationships with their current physicians and removes the need for the VA to lease or build free-standing clinics, saving the federal government money.

In many instances, the community-based clinics or the area critical access hospitals are the organizations that are currently delivering healthcare to veterans, under the VA brand. This is the case at Elizabethtown Community Hospital, where the VA operates a clinic that serves a population of roughly 900 veterans, living within the hospital's catchment of well over 600 square miles. These veterans typically live within a 40-mile radius of the hospital and find it much more convenient to meet with the physician or physician's assistant there than in Albany, a drive of 2-3 hours (one-way). This particular VA Clinic has been vigorously supported and appreciated by veterans who continue to utilize the services it provides.

If the veterans are able to visit ECH, or any of its clinics in Westport, Wilmington or Elizabethtown, it will be able to serve veterans in an area of approximately 1,000 square miles. Additionally, in the upstate New York area served by ECH, there are populations of veterans that are currently underserved, such as those in the Saranac Lake area. ECH is willing to establish a clinic, based on the proposed model, exclusively for the benefit of veterans, in that geographic area.

Critical Access Hospitals and community-based clinics have been delivering healthcare to those in rural areas for years; and have perfected the method of doing so. It simply makes sense for the Veterans' Administration take advantage of the federally-established infrastructure that is already in place, rather than developing a new system. ECH administration hopes that this proposal will allow it to, once again, lead the way in helping to develop the most comprehensive, logical, innovative and convenient system of delivering healthcare options to our nation's veteran population.