BEYOND THE CITY LIMITS: DELIVERING FOR RURAL VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

FRIDAY, JULY 25, 2025

BEYOND THE CITY LIMITS: DELIVERING FOR RURAL VETERANS

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SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., at Chez Veterans Center, 908 West Nevada Street, Urbana, Illinois, Hon. Tom Barrett (chairman of the subcommittee) presiding.

Present: Representatives Barrett and Budzinski.

OPENING STATEMENT OF TOM BARRETT, CHAIRMAN

Mr. BARRETT. Good morning, everyone. How are you?

Thank you so much and thank you for the opportunity to join you today.

The Subcommittee on Technology Modernization will come to order. I want to start by thanking our ranking member and the host today in your district, Ranking Member Budzinski, for welcoming us to Illinois' 13th District. I appreciate the hospitality and the welcome, and everyone, and really just the warmth that I can feel for how you care for veterans and how you have welcomed us on the committee here today, and I really deeply appreciate all of that.

I would also like to thank the University of Illinois and the Chez Veterans Center for hosting us, and for all of the staff at the university that helped make this hearing possible. I know many of you went out of your way to put this together. Colonel, I appreciate your willingness to help pull this together and everything that you did. Even though you were voluntold, I appreciate your willingness to step up and do that.

I appreciate our conversation earlier, really about that transition from military back into civilian life, and the challenges that some of our veterans face, whether they are on campus or not, and how we can do a better job of really making that transition easier for our veterans.

I also want to thank Garrett Anderson who is here. Where is Garrett? Very good. Garrett, thank you so much for taking me on the tour this morning. Really appreciate all of your very, very clear commitment to veterans and making sure that they are welcomed home and treated with the dignity that they need and really transition as effectively as possible. I can tell that you take a great deal of pride in that, and we appreciate your work in that regard, so thank you.

The mission of the Technology Modernization Subcommittee is to make sure that U.S. Department of Veterans Affairs (VA) is buying, using, and developing the right information technology (IT) in order to deliver the best care and services for our veterans. That is the task that we have on this subcommittee and plays into why we are here today.

Technology plays a huge role in delivering VA care to rural veterans because VA simply cannot give all the care and services they need at traditional brick and mortar facilities that are often too far for veterans to reach or might not be as convenient to them because of their limitations for travel.

This topic is also personal to me. I served 22 years in the United States Army, and I am now building a family in a rural part of Michigan myself. I also represent Michigan State University in my district, so I do have to say a "Go Green" while I am here.

I know firsthand the frustration that veterans feel when the care they have earned is out of reach simply because of where they live. I actually do not have a VA hospital facility in the district that I represent. The 800,000 or so residents of my district and the veterans there have to travel outside of my congressional district if they go to a VA hospital.

That is what today is about, making sure rural veterans are not left behind. The reality is veterans in rural communities face serious barriers to accessing VA care. Nearly one third of VA-enrolled veterans live in rural communities. They drive longer distances. They wait longer for appointments, have fewer providers to choose from, and deal with limited broadband and transportation options. However each community is different, and rural veterans do not all have the same experience with the VA. I am glad the ranking member and I were able to take our subcommittee on the road and talk to you all where you live and learn about the specific challenges that you face.

In Washington, we hear a lot of experiences from people. I think we all benefit from going directly to the source for where things are happening. That is a good reason why we are here today.

One of the most important tools that exists for rural veterans is the Community Care Program. Community care allows veterans, especially those in rural and underserved areas to see outside providers when brick and mortar VA facilities cannot meet their needs. Community care is VA care, and millions of veterans rely on it every single year.

Having used community care personally, I know there is room for improvement. I want to ensure every veteran watching this hearing knows they only need to meet one of the several criteria to qualify for community care. One is if the VA does not offer the service that is needed. Another is if the VA facility is not in the area in which they are located. If the VA cannot schedule an appointment quickly enough or close enough to them. Or if community care is in the veteran's best medical interest.

Under the leadership of Chairman Mike Bost, chairman of this committee, whose district is not too far south of here, this committee is working hard to ensure that rural veterans are able to make their own choice on whether community care is the right option for them, if they are eligible.

In addition to community care, VA has many other resources that are important for rural veterans, including telehealth, mobile medical units, and much more that we will hear about today. Technology has a big role to play here, and that is where this subcommittee comes in.

There are a lot of exciting opportunities for technology to drive better VA care and services in rural communities. A great example is the External Provider Scheduling (EPS) System, which allows VA staff to see realtime appointment availability and book directly with community providers or within the VA system, depending on which is available first and closer to home. While it is only active at around 50 VA medical centers currently, it has empowered staff to schedule up to four times more appointments per day by eliminating delays, confusion, and honestly a game of telephone that goes back and forth.

Another great example is telemedicine. When it comes to mental health, where isolation is a real risk, tools like tele-mental health and remote monitoring are essential lifelines for veterans who otherwise might fall through the cracks. I want to say I am very impressed by the services that you have here that allow veterans to access those services around other veterans who may have had a shared experience to them. I think that is another important community aspect of this.

Even with these tools, there is room for improvement. Reports from Government Accountability Office (GAO) and the VA Inspector General have shown that rural health programs lack clear performance goals, outreach strategies that are inconsistent at the Veterans Integrated Service Network (VISN) level, and community care referrals still take too long, especially in high-need areas like mental health and women's care that we are still trying to make strides in.

Provider participation in VA's cellular networks is also lagging, with some rural providers walking away due to red tape, poor communication, or late payments. We cannot let bureaucracy or outdated processes get in the way of quality and timely health care.

This subcommittee is committed to ensuring that VA's rural health programs are well managed, accountable, and truly reaching the veterans they are meant to serve. That means cutting the red tape, improving access to care, ensuring every veteran understands their options for quality care, and that we leave no veteran behind to figure this out for themselves. It also means ensuring the resources are there to sustain proven services and tools, like the external provider scheduling system, telehealth, transportation services, and others.

My goal is to ensure every program is driven by measurable outcomes that validate better health outcomes, not just good intentions. In fact, we talked about that today earlier. There are so many veteran organizations out there, each with good intentions, sometimes duplicating services, sometimes duplicating intentions. Having a real drive to find out where we can get that done in the best way is really important.

The bottom line is this-Geography should never be a barrier to care. If a veteran qualifies for VA health care, it is our job to make sure they can get it without delays, without confusion, without

frustration, and without giving up. We hear too many stories about veterans who have simply abandoned the benefits that they have earned because they cannot untangle the confusion.

I look forward to hearing from you all about how we can accomplish this today.

Before I turn it over to the ranking member, I just want to remind everyone here that this is not an open forum but is a oversight hearing for Members of Congress and the witnesses that are before us today. They will be testifying under oath. This is not a forum for individuals to participate. I know, seeing as how we are in the ranking member's district, if you do have questions of your own, I am sure she is available to work with you on those.

With that, I will yield to the ranking member for her opening statement. Thank you again for having us.

OPENING STATEMENT OF NIKKI BUDZINSKI, RANKING MEMBER

Ms. BUDZINSKI. Thank you very much, Chairman Barrett, for coming to the 13th District. Welcome to Urbana. It is really great to have you here. I appreciate you making that trip.

I also want to just echo a sincere thank you to the Chez Veterans Center and the leadership. I have had the privilege of visiting the center and I know the important work that you are doing for veterans, student veterans on campus, and just want to say it is so special to be here, having you host us for this field hearing. I want to say a sincere thank you. Thank you to the University of Illinois.

You know, Chairman Barrett's district and mine are probably very similar. He mentioned Michigan State, so I have to say, "Go Illini."

Very similar in a lot of different ways. I think that this forum, this panel is going to be, I think, really important to both of us and we will take all of this information back with us to Washington. I look forward to a robust conversation about the experiences specifically for our rural veterans, gaps in access to care and benefits, and resources that are available to bridge them.

I want to also welcome our diverse panel of witnesses representing VA leadership, veterans service organizations, county and State programs, and most importantly veterans. I am grateful to all of you for being here, and I know that many of you traveled long distances to participate. Please know that I appreciate those efforts, and this conversation would not be as productive without you. Thank you.

For the rural veterans in the room, this type of travel is nothing new. Whether it is driving hours to the closest VA medical center, or even farther for a compensation and pension exam, rural veterans are unfortunately used to traveling to access the care and benefits they have earned through their service to our Nation. I think something the chairman mentioned I share in common, Danville, Illinois is actually outside of my district, about 45 minutes from here, but is the closest VA hospital. The 13th District is serviced by VA hospitals, but just outside of it.

This is the biggest reason that I believe that community care, though, has to remain available to rural veterans. Unfortunately, community care access in rural America is not guaranteed. Due to

financial issues and national provider and nursing shortages, rural health care is dying. Changes to Medicaid will only make it worse.

According to the Center for Health Care Quality and Payment Reform, 700 rural hospitals, a third of all rural hospitals in the country, are at risk of closing in the near future. Almost half of those are deemed at immediate risk of closing. In fact, Illinois has already lost three community hospitals in recent years, and nine more have been deemed at immediate risk. We cannot have a conversation about community care without addressing the fact that it may not be there to take care of our veterans.

I hope to hear from VA regarding its plans to ensure that veterans continue to have access to care. The work that Chairman Barrett and I do on the Technology Modernization Subcommittee seeks to help VA bridge some of these gaps through the use of technology. VA has long been a pioneer of telehealth, and during the COVID–19 pandemic, the Department quickly pivoted to expand telehealth, which allowed many veterans to continue to receive much of their care. Unfortunately, telehealth is only a solution for veterans who have access to sufficient internet and the technical knowledge to use it.

It is sad that in 2025, there are still parts of Illinois and the country that do not have access to broadband internet. Sadly, it is not just a rural America issue, either. Even in places where broadband internet is available, it can be prohibitively expensive, especially for veterans living on a fixed income.

I am looking forward to hearing about our efforts to address the access and cost to make internet available to veterans so that they can access their care and benefits.

I hope that we can have a fruitful conversation about these issues and possible solutions.

Thank you again, Mr. Chairman, for being here, and I will yield back.

Mr. BARRETT. Thank you, Ranking Member Budzinski. I will now introduce our witnesses.

From the Department of Veterans Affairs, we have Mr. Daniel Zomchek, the Executive Director of VISN 12 for this region. Thank you for being here.

Accompanying Mr. Zomchek is Dr. Staci Williams, the Executive Director of the Illiana Healthcare System—did I say that right? Illiana, sorry. My apologies. They even spelled it phonetically for me. Yes. I am an Army grunt, so—I was in the artillery. We just got to get close.

[Laughter.]

Mr. BARRETT. Dr. Peter Kaboli, Executive Director of the Office of Rural Health. Thank you.

We also have Mr. John Lawson, Army veteran and Superintendent of the St. Clair County Veterans Assistance Commission. Thank you.

Ms. Hillary Rains from the Illinois Department of Commerce and Economic Opportunity. We met back in the coffee room earlier. Thank you. I think you told me you traveled a bit of a distance to get here today, so appreciate it. Thank you for being here.

Finally, we have Mr. Kim Kirchner, an Air Force veteran from Girard, Illinois, and Ms. Christina Schauer, an Army veteran and

co-founder of Tri-State Women Warriors. Thank you both for being here as well.

At this time, we will ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. BARRETT. Very good, thank you. Let the record reflect that all witnesses have answered in the affirmative.

Mr. Zomchek, you are now recognized for 5 minutes to deliver your opening statement on behalf of VA.

STATEMENT OF DANIEL ZOMCHEK

Dr. ZOMCHEK. Well, thank you very much. Good morning, Chairman Barrett, Ranking Member Budzinski, and our distinguished guests. Thank you for this opportunity to discuss VA's efforts to enhance the well-being of our rural veterans, especially within the VA Illiana Healthcare System.

As you announced, my name is Dan Zomchek. I am the network director of VISN 12. Joining me today are Dr. Staci Williams, from the VA Illiana Healthcare System, and Dr. Peter Kaboli from the Office of Rural Health in Veterans Health Administration (VHA).

I would like to take some time to share some highlights about the work that we are doing within VA, VISN 12, and specifically the VA Illiana Healthcare System in providing essential care to our rural veterans. Having been with the VA for over 20 years and serving as the network director of VISN 12 for almost 3 years, I am deeply committed to our veterans and to our mission. We strive to ensure that veterans, no matter where they live, receive the top notch care that they have earned and deserve.

I will start with the health care services provided by the VA Illiana Healthcare System. This system has been a cornerstone within the Danville community for over 125 years, with a dedicated team of over 1,500 health care professionals taking care of about 30,000 veterans in the community. Covering 34 counties in east-central Illinois and west-central Indiana, we reach vets in both urban and rural areas.

Over two dozen of our sites across VISN 12 serve a population where more than half of those veterans are enrolled from rural areas. Given that 4.2 million of the 16.5 million U.S. veterans live in rural areas, our services play a crucial role in ensuring these veterans have access to the health care that they have earned and deserve.

It is also important to note that veterans in rural areas enroll in VHA care at higher rates, that is 65 percent, compared to 47 percent for their urban counterparts.

I would like to touch on a few key initiatives that support rural veterans, starting with community care as you mentioned. Through the Veterans Community Care Program, we ensure timely care closer to home via a network of over 1.4 million non-VA providers. The network here is vital for delivering hospital care, medical services, and specialty care, especially for those vets that need to travel long distances. We have streamlined referrals and improved care coordination to ensure quality and continuity.

Next, telehealth, which was also mentioned earlier, and virtual mental health services have truly been a game changer for our vet-

erans in rural and remote areas. VA has invested in telehealth infrastructure, enabling veterans to connect with primary care providers and specialists through platforms like VA Video Connect, that we call VVC, reducing travel and improving health outcomes. We have also ramped up on virtual mental health services, including therapy, medication management, and crisis intervention, all critical for addressing mental health needs of our veterans. As a former VA psychologist and intern, this is a particular area that is of importance to me, is mental health.

Last, on beneficiary travel, we recognize that getting to appointments can be challenging for our veterans in rural areas. VA's Veterans Transportation Service, or VTS, provides door-to-door rides for eligible veterans. Our Highly Rural Transportation Grants Program helps vets to travel to VA medical centers. The Volunteer Transportation Network, backed primarily by the Disabled American Veterans Organization, which is a fantastic partner for us and our veterans, offers free rides through volunteers.

That is it, Chairman Barrett and Ranking Member Budzinski. I want to thank you for allowing me and us to share our efforts in assisting our rural veterans. With your backing, VA continues to expand its reach, ensuring more veterans receive the care that they have earned and deserve. We appreciate your commitment, and we look forward to discussing these points further during today's field hearing.

[THE PREPARED STATEMENT OF DANIEL ZOMCHEK APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you. The written statement of Mr. Zomchek will be entered into the hearing record, and appreciate your testimony.

Mr. Lawson, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF JOHN LAWSON

Mr. LAWSON. Chairman Barrett, Ranking Member Budzinski and the members of the subcommittee, on behalf of the Veterans of St. Clair County, thank you for the opportunity to provide remarks on challenges faced by veterans residing in rural America and, in our opinion, the best State for veterans, the Land of Lincoln, the great State of Illinois.

My name is John Lawson. I am the superintendent of the Veterans Assistance Commission of St. Clair County, Illinois. I am a VA-accredited government veterans service officer (VSO) through the National Association of County Veterans Service Officers (NACVSO). I am also a life member of the Veterans of Foreign Wars of the United States (VFW) Post 1739 in Belleville, Illinois, and currently serving as the VFW State of Illinois legislative co-chairman, and a life member of the Disabled American Veterans Chapter 24 in Freeburg, Illinois.

I lead a small team of five other full-time veterans service officers who are fully invested in ensuring our veterans receive the benefits that they have earned, and safeguarding them from predatory, unaccredited claims consultants.

St. Clair County is unique in that, while we do have a suburban feel and a significant active military presence at Scott Air Force

Base, much of our veteran population exists in the small towns that dot rural Illinois. We consider ourselves very fortunate to have our VA community-based outpatient clinic, the CBOC, in Shiloh, Illinois, and one more forecasted to open on Scott Air Force Base.

Even with these two facilities, our population of veterans from St. Clair County and surrounding counties have eclipsed the safe patient load of our great care providers at the CBOC. Many veterans cannot use this facility due to these patient load caps. Coupling this limiting factor is the limited scope of care available at the CBOC that nearly always leads to a veteran being referred to a VA medical center for specialty or advanced care needs. Our veterans are served by the St. Louis Veterans Administration Medical Center (VAMC) that also serves over 110,000 eligible veterans on the Missouri side of the river.

Although we understand that full-service VAMC on the Illinois side of the St. Louis metro may not necessarily be in the cards for the nearly 104,000 eligible veterans of the Illinois 12th and 13th congressional Districts, we do need a much larger footprint and improved service capacity for our veterans by way of a higher level of care facility that is able to accommodate our needs beyond routine physicals and blood draws.

At my last count, we had five patient-aligned care teams (PACT) at the St. Clair County CBOC with a max patient load of 6,000 veterans, with two additional patient-aligned care teams forecasted for the future Scott Air Force Base CBOC. This combined maximum patient load of 8,400 only represents about 33 percent of the eligible veteran population of St. Clair County, according to the 2023 VA Georgraphic Distribution of VA Expenditures (GDX) and roughly 8 percent of the eligible veterans of the 12th and 13th congressional Districts.

The non-forecasted number is even more disappointing at approximately 24 percent for St. Clair County and 5 percent for the combined congressional districts without inclusion of the forecasted Scott Air Force Base CBOC.

We do believe that H.R. 740, the Veterans' Assuring Critical Care Expansions to Support Servicemembers (ACCESS) Act of 2025 will be a good start for St. Clair County veterans, especially as our CBOC in Shiloh sits directly between two full-service hospitals less than two miles to the east or west, much closer than the nearest VAMC in St. Louis, Missouri, at 45 minutes to an hour away.

We look forward to the subcommittee's help to help our veterans by working with the VA to direct the development of automated approvals of community care applications to reduce the time to approval, reduce travel, reduce the delays in receiving care, and also supporting the local community by veterans utilizing their earned VA compensation where it was intended, in that veteran's local community, not in another State.

Additionally, we would like to ensure that the veterans do not receive bills for this care when applicable. Negotiated reimbursements and payment submission portals for providers should be developed to ensure clarity of responsibility of payment for the provider and patient.

Last, ensuring our VA electronic health records (EHR) are two way accessible to the VA primary care providers and the community care providers is essential in ensuring the best possible outcomes for our veteran patients. In situations involving advanced or specialty care, miscommunication between providers can cause irreparable harm to the veteran.

I wish to emphasize that our support for the Veterans' ACCESS Act of 2025 is not to be an indication that we support substitution or privatization for direct VA care for our veterans. To be straightforward, we do not. Our support of this proposal is as a supplemental partnership with the community medical providers to ensure timely access to care and the best possible health outcomes for our veterans.

It is important to remember that providing resources for care only in the community and not also for VA direct care can lead to a less capable VA, which is a detriment to our veteran care. In military terms, community care is a force multiplier when leveraged correctly, not a substitution.

Chairman Barrett, Ranking Member Budzinski, this concludes my testimony. I have also submitted written testimony on other pending legislation matters for your review.

I welcome any questions from you or members of the subcommittee.

[THE PREPARED STATEMENT OF JOHN LAWSON APPEARS IN THE APPENDIX]

Mr. BARRETT. With 2 seconds to spare, we appreciate your testimony today. Did you time that out?

Mr. LAWSON. Yes, sir, I did. I am a slow talker from the Ozarks; I am surprised I got it out that fast.

Mr. BARRETT. Thank you for your testimony. Thank you for being here. The written statement of Mr. Lawson will be entered into the hearing record. Thank you.

Ms. Rains, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF HILLARY RAINS

Ms. RAINS. Thank you so much, Mr. Chairman. Chairman Barrett, Ranking Member Budzinski, and distinguished guests, thank you for the opportunity to testify today on behalf of the Illinois Department of Commerce and Economic Opportunity, and the Illinois Office of Broadband. I am here to talk about the critical intersection of telehealth access for rural veterans and the impact of the digital divide on their health and well-being.

When we talk about the digital divide in 2025, we are talking about a disparity in access to fast, affordable, and robust internet, as well as to the devices, tools, and skills that allow people to connect to critical supports throughout their lives. Vulnerable populations often find themselves on the wrong side of this divide, and veterans, of course, are one of them, with only about 67 percent of Illinois veterans having and using broadband access.

Veterans are often also part of more than one vulnerable population, as 56 percent are over the age of 60 and 26 percent nationwide, over 4 million people, live in rural areas. Rural residents have their own challenges where internet connectivity is concerned.

The Federal Communications Commission (FCC) estimates that 28 percent, almost a third, of rural residents lack broadband access.

Fifty-seven percent of rural locations in Illinois alone are entirely unserved or underserved, receiving internet speeds below the FCC's minimum recommendation of 100 by 20 megabits per second. This recommendation is indeed the bare minimum, as it is only often adequate for one user at a time to do everyday tasks like videoconferencing, streaming, and emailing. The inability to complete these tasks from home disadvantages rural veterans, especially when trying to access telemedicine resources.

The VA obviously provides vital care centers and hospitals across the country. When we look at veterans who live in rural areas, they live an average of 45 miles—and that is an average—to be seen in person at a VA center. As veterans are twice as likely as non-veterans to suffer from two or more chronic health conditions, frequent checkups and appointments are especially important.

Telehealth resources began to be promoted heavily just before the pandemic to alleviate those challenges with transportation and provider availability. Adoption rates in rural areas suffered because of the lack of broadband access. When considering additional complications such as subscription affordability, device ownership, and varying degrees of digital literacy and skill, especially in the more than half of veterans over 60, the problem is laid out in stark relief.

Illinois has already worked diligently to increase broadband access for rural residents through the Connect Illinois broadband infrastructure grant. Connect Illinois allows internet service providers to build high-speed fiber infrastructure in rural areas that often have low population or subscriber density and are isolated from middle mile infrastructure.

As of today, three State and federally funded rounds of this program have connected approximately 7,500 households, with 46,000 total more to be connected over the next 3 years. The fourth round is currently being funded by the Federal Broadband Access Equity and Deployment Act, you might have heard BAED, Program, and stands to connect over 165,000 Illinois residents and almost 5 million other households across the country without adequate connectivity.

While the BAED program is in progress, there is another program that can fund veteran-serving organizations on the ground and helped to provide rural residents with device access, digital skill building, one-on-one troubleshooting support, and more. That program is the Digital Equity Act. This program was poised to provide $2.75 billion to states to support programming and sub-grants to direct service organizations with veterans being targeted as one of the vulnerable populations most affected by the digital divide. Illinois was to receive more than $23 million to equip households and residents with the skills, resources, and tools needed to use the high-speed internet.

Illinois received over 260 sub-grant applications throughout the State, with the full ask over $100 million, far outstripping the available funds, showing the need. Some of the programs proposed were to support telehealth and resource access for recently separated women veterans in the rural southwest central region, vet-

eran-focused digital literacy classes, mobile skill-building hubs, and secure community telehealth rooms. Unfortunately, the Digital Equity Act and its $2.75 billion of appropriated funding were terminated by executive order, leaving these programs unfunded.

Expanding access is the key to health and well-being of rural veterans. Thank you so much and thank you for having us today.

[THE PREPARED STATEMENT OF HILLARY RAINS APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you for your testimony. Thank you for being here.

The written statement of Ms. Rains will be entered into the hearing record.

Mr. Kirchner, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF KIM KIRCHNER

Mr. KIRCHNER. Good morning. Thank you everyone for taking the time out of your day to listen to my testimony. My name is Kim Kirchner, and I am a proud veteran who served in the United States Air Force, Illinois Air National Guard, and served in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). I am currently a sergeant with the Macoupin County Sheriff's Department.

I am writing the testimony in regard to the care that I have received at a compensation and pension exam. I drove over 30 minutes to an exam that the VA scheduled for me with a contract provider. When I arrived, the medical provider informed me that I was not on her schedule and that she could not find my medical records. I told her that the VA had called me and asked me to come in at an earlier date due to an opening. She finally found my records, but had an attitude through the entire exam, which lasted a total of 3 minutes. At no time did she conduct a medical exam on me. She only reviewed my medical record. Based on that exam, VA denied my claim. In order to finally get my claim awarded, I had to do a whole other medical exam. This was a massive waste of my time and taxpayers' money.

I firmly believe that I am not the only veteran this has happened to, and the outsourcing of these exams definitely needs to be looked into. When a veteran goes for an exam, they should be treated with the utmost respect they deserved, especially for putting their lives on the line for our country. When I walked out of that exam that did not last approximately 3 minutes, I have never felt so disrespected in my life. It was very frustrating to get treated this way, especially having to drive 30 minutes to the exam due to living in a small town and nowhere close to a VA clinic.

I firmly believe that the VA need to pay more attention to the care we are receiving from them outsourcing their compensation and pension exams.

Thank you everyone, and I am happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF KIM KIRCHNER APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Mr. Kirchner, and thank you for your service then and your service now. I have heard from other veterans with similar experiences to yours with that compensation

and pension, so I want to make sure that we correct that. I hope your experience since then has been far better and far more respectful. If not, I know the ranking member and I would be very interested in ensuring that that happens for you going forward.

Your written statement will be entered into the hearing record, and again I appreciate your willingness to come and testify today.

Ms. Schauer, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF CHRISTINA SCHAUER

Ms. SCHAUER. Chairman Barrett, Ranking Member Budzinski, and members of the subcommittee, thank you for the opportunity to speak today. My name is Christina Schauer. I am a U.S. Army Iraq War veteran and president of the Tri-State Women Warriors, a nonprofit with a mission to provide connection and advocacy for the unique needs of women veterans and service members.

Today, I will focus on three key areas of impact for rural veterans: Enhanced community outreach, coordinated and purposeful community care utilization, and a strong rural VA presence.

Community outreach is vital to ensure veterans understand their benefits, how to access them, and why they matter, especially in isolated rural areas. The VA's community engagement and partnerships for suicide prevention program has been essential in supporting local coalitions like ours working to prevent veteran suicide.

Our local engagement coordinator has been a behind-the-scenes champion of the Tri-State Women Warriors, which has now served over 100 local women through live events and helped many access VA care for the first time. Some, for trauma experienced decades ago. These outreach programs serve a vital role in ensuring rural communities stay informed and engaged with the VA.

While many of our members prefer VA care, almost all of us have relied on VA community care at some point, due to specialty care needs, wait times, or distance. Despite its necessity, community care is not optimized. Research shows that community care clinicians often report learning about policy and workflow changes only through error notifications and request denials, which is consistent with reports we hear from veterans in our community.

Any policy change that impacts community care partners, such as the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act, should follow an effective standardized communication process that includes clinical services as well as billing departments to safeguard veteran care and prevent them from receiving medical bills in error.

Care continuity is also an ongoing issue. Successful implementation of a comprehensive EHR is paramount to ensure the seamless flow of communication across care teams.

Lack of cultural competency has also been a pain point for community care. Unfortunately initiatives to improve this are resource intensive. With 48 percent of rural hospitals operating at a financial loss in 2023, and the recent passing of H.R. 1, most rural hospitals are strategizing ways to ensure their doors stay open and would struggle to absorb any additional financial strain.

With health care viability in mind, it is also important to acknowledge that 92 rural hospitals have closed or have been unable to continue providing inpatient services in the last decade. A recent study showed that even in major cities, average wait times across specialties are increasing, and nearly 62 percent of mental health provider shortage areas in the United States are rural. Expanding community care without addressing provider shortages could exacerbate current access issues if VA resources are lost within these communities.

Our local CBOC is a trusted anchor, and this committee's greatest focus should be ensuring rural veterans have access to VHA's veteran-centered patient care. Research shows rural veterans report higher satisfaction with VA care than community care, and that VA facilities often outperform or match non-VA providers in quality and safety.

When a permanent, physical VA presence is not possible, strategic telehealth can extend resources and build connections. Evaluating when face-to-face interactions are most critical to building trust, and supplementing with telehealth can broaden the meaningful—sorry.

Evaluating when face-to-face interactions are most critical to building trust, and supplementing with telehealth, can broaden the meaningful reach of these CBOCs.

Finally, we must protect the psychological safety of the VA workforce, many of whom are veterans themselves. Successful deployment of a modernized EHR will rely heavily on a strong, confident workforce, which is only possible when employees feel valued and supported.

This subcommittee is uniquely positioned to lead in expanding VA access to rural veterans through technology. Community care is vital, but history shows that even well-intended privatization can lead to inequitable services for rural communities, as resources naturally shift to more profitable urban areas. As we see this disparity in the broader health care system today, the VA remains a vital equalizer. A balanced, bipartisan approach can strengthen both VA and community care to ensure our most vulnerable veterans are not forgotten.

The VA I returned to in 2004 after my deployment to Iraq as a student on this campus, where I was told by the VA in Danville that my new breathing issues were likely from anxiety, is not the VA we have today. The progress we have made has been intentional and remarkable. Let us continue investing in this transformation and use modern tools to bring care and benefits closer to rural veterans who have earned them. Thank you.

[THE PREPARED STATEMENT OF CHRISTINA SCHAUER APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Ms. Schauer. I appreciate your testimony, and your written statement will be also entered into the hearing record.

We will now proceed to questioning, and I will recognize myself for 5 minutes. I forgot to advise you ahead of time, but we have a light system here in front of you, green, yellow, and red. Pretty self-explanatory. Yellow is you are getting close and red is you are out of time. We will begin questioning.

We genuinely appreciate each of you that are here today and the testimony that you offered today.

Ms. Schauer, you say you were deployed in Iraq, 2003, 2004 sometime? Where were you operating out of there?

Ms. SCHAUER. Baghdad International Airport.

Mr. BARRETT. Okay, and what was your job?

Ms. SCHAUER. I was a combat medic.

Mr. BARRETT. Oh, very good. Well, thank you. I was there a few years after you and certainly appreciate your service there. Thank you.

Ms. SCHAUER. Thank you.

Mr. BARRETT. Mr. Kirchner, you say you were Army as well?

Mr. KIRCHNER. No, sir. Air Force.

Mr. BARRETT. Air Force, okay. Where were you deployed when you were in service?

Mr. KIRCHNER. Incirlik, Turkey.

Mr. BARRETT. Okay. I did kind of a layover there one time. I was in Guantanamo Bay, on my way to Afghanistan. It was great, because they had a Taco Bell there, so it was good for morale.

Ms. Rains, I wanted to ask you, I know you mentioned a lot of the access to telemedicine and some of the extension of broadband. You mentioned access to fiber for rural residents. I live in a pretty rural part of Michigan. In fact, I am not joking, my neighbors across the street from me are Amish. They are not so into the broadband. Nonetheless, in the community that I live in, we have folks like me that need access to internet and broadband.

Do you know, you said you had connected about 7,500 homes that way. Do you know what the cost for that 7,500 homes was?

Ms. RAINS. That 7,500 with the 46,000 altogether will be about $350 million, and most of that is—I believe all of that has been fiber, yes. We were with the United States Department of Agriculture (USDA) Rural Development Opportunity Fund, which is in Illinois mostly wireless.

Mr. BARRETT. How many millions again?

Ms. RAINS. Three hundred and fifty million dollars, about, for those were State and Federal funds in the first three rounds of the Connect Illinois program.

Mr. BARRETT. $350 million for how many homes are going to be connected for that?

Ms. RAINS. It is just over 50,000.

Mr. BARRETT. Okay. That would be a substantial cost per home with fiber.

Ms. RAINS. Yes.

Mr. BARRETT. I guess Dr. Kaboli, maybe you could help me answer this. Is there any opportunity, perhaps, or we could just outfit veterans who are accessing telehealth with a fixed wireless connection? I have one of those in my home. It works pretty well, actually. It allows me to use, you know, if I were using telehealth, I can use Zoom. My wife works from home and is able to do her work that way.

I feel like for $350 million, we could buy a lot of people a home internet, you know, fixed wireless provider type of thing and pay $50 a month for them and not hit $350 million for a great long time.

Either one of you.

Ms. RAINS. Wireless internet is an excellent stopgap, yes. In areas in Illinois, especially where I am from down in Crawford County, Robbins, Illinois, there is no cell signal in a lot of the county. Even if you had a hotspot, you are not able to access it. Wireless internet is coming but wireless is slower speeds, it is interrupted by any kind of weather, rainstorm or thunderstorms, which are very common on the prairie, as you know.

It is an opportunity to get people connected faster.

Mr. BARRETT. I actually found—I mean, I had cable, copper, it was not fiber, but it was like a lower speed, but it was into the home through the phone line—I do not know. I have actually had more reliable service through the Verizon—not just a little hockey puck hot spot that you would take while you are traveling, but like the fixed, plug-into-the-wall kind of service that comes over the air. I feel like delivering to those folks you talk about that are the most stranded, I mean, it is going to be a huge expense to run fiber to them, and I almost wonder if we would be better served putting more of that into some of the more accessible already options available.

Ms. RAINS. Yes. The wireless tower that provides the Verizon service is served by fiber middle mile infrastructure. Middle mile infrastructure still needs to go out to provide that wireless service. Fiberoptic, of course, is more expensive at the installation. It is also what we call kind of future proof. It is 50 years is its serviceable life in the ground, and it is still being tested, so it could be even longer than that.

As speeds increase over time and technology improvement, the cable does not need to be upgraded, just the data centers on either side, because it carries information at the speed of light.

Mr. BARRETT. Sure. Not to cut you off, I just wanted to get Dr. Kaboli's thoughts really quick——

Ms. RAINS. Oh, of course.

Mr. BARRETT.—before I yield to the ranking member. Then we can come back after that. Go ahead.

Dr. KABOLI. Yes, real quickly, I think the other thing to think about is low Earth orbit satellite internet. We looked into this the last couple years to see if we could, the Office of Rural Health, could provide that service for veterans. Unfortunately, there is no legislative mandate to allow us, or authority to allow us to actually pay for it. You are right, the cost per month would be much less if we could just subsidize it, but we cannot.

Mr. BARRETT. Okay.

Dr. KABOLI. We do have a pilot with a company to sort of identify sort of what the challenges are. One of the challenges in rural areas is actually the installation. You know, you have to get somebody to come in, drive in, set up the satellite and all that kind of thing. I will stop there, but I think there is a lot of other options out there.

Mr. BARRETT. Thank you. Thank you.

Ms. RAINS. Just to finish, in Illinois and across the country, we are using a mix of technologies. Of course, we are looking toward the future. That is why we prioritize fiber, but it is definitely going

to be a mix of all these things, as well as low Earth orbit, to deliver service.

Mr. BARRETT. Sure, thank you.

I am going to yield to the ranking member for 5 minutes for her questions.

Ms. BUDZINSKI. Thank you, Mr. Chairman.

My first kind of set of questions is really just to the panelists from the VA directly. I would love to hear from each of your perspectives just a general question about gaps in care, access to care, that you see within the VA and what those barriers are that exist in filling those gaps, especially in our rural communities, obviously, with the topic today. Then just to ask you in addition what kind of feedback you get from veterans as it relates to these gaps and filling them.

Dr. ZOMCHEK. Well, thank you, Congresswoman. I would say there are certainly less opportunities for rural veterans, especially the more specialized the services that they are. Throughout VISN 12, we have a fair amount of rural areas, not only in VA Illiana but in Iron Mountain, particularly, where it is literally a four and a half hour drive from Sault Ste. Marie, the CBOC, to the main campus.

I think—I think when it comes to primary care and mental health treatment, both virtual and face to face is where we have really been able to close the gap more so. We are continuing to expand our CBOCs, not only growing them and doing construction, but also trying to create new specialty services there.

Certainly across the board, that is why I think community care, as was stated, is so critical. We can do a lot in the VA. We have a lot of opportunities that we can offer for our vets. There are some things that we cannot. Having that partnership of community care can really help us.

There is a lot of mobile opportunities that we do, too. I think maybe Dr. Kaboli could talk a bit more about that.

Dr. WILLIAMS. Here at VA Illiana, and I actually have spent over 30 years in health care specifically relating to providing services to individuals in rural areas, so rural health care is a passion for me. At VA Illiana, we have actually implemented a screening program titled ACORN, which stands for Assessing Circumstances and Offering Resources for Needs.

To speak to some of the testimony that we have already heard, when we have done this screening through our social work team, it really addresses some of the social determinants of health like food, housing, utilities, transportation, education, employment, digital needs and the like. We have actually found that 19 percent of our veterans are positive for digital needs, and another 65 percent positive for social isolation and loneliness.

Since we are a rural Department of Veterans Affairs hospital, we do have CBOCs spread throughout this area. We certainly recognize the needs of our veterans to try to remain connected with not only health care but with one another.

Dr. Kaboli. I just want to say to start out, though, I am actually from Iowa City, Iowa. I grew up across the river from Illinois in southeast Iowa, so "Go Hawks." We have the Big 10 covered here. I did wear my Illini colors today because I knew where I was.

No, I think to answer your question about access and gaps, I think it comes down to sort of, kind of like Ms. Rains said, about you just—you use every possible thing you have. You know, what do we have that we can get veterans access to care? It is face-to-face care with us, face-to-face care in the community, telemedicine, instant messaging, you know, we have all these things offered out there. The thing is not every veteran wants telemedicine. Of veterans that have used telemedicine, 80 percent say, yes, I want this. Twenty percent say, you know, I tried it, it is not for me. Pretty much all of us had some form of telemedicine during the pandemic, so we have had experiences with it. Really, veterans want more telemedicine.

Again, what do they want? Let us either bring them to care or bring the care to them.

Ms. BUDZINSKI. Could I ask just one follow-up question? One thing I have noticed within the district just within health care in general, just even beyond providing care to veterans, is we lack the ability to attract specialty care, health care professionals, doctors, nurses. We have a shortage of health care professionals just within our hospital systems.

Is that reflected as well at the VA in Danville that you have those shortages or a hard time kind of attracting those professionals?

Dr. WILLIAMS. We have very similar challenges to what are experienced in the private sector in the community care network, yes.

Dr. KABOLI. If I can add to that, we think one of the things that we do have is because we are a national network of providers, we actually do not have a shortage, say, of primary care providers. Even though there are shortages everywhere. We just do not have them all in the right places at the right time.

Like you were talking about PACT teams and how many providers they have. You know, we can supplement that through the clinical resource hub program, so we can supplement primary care, mental health, specialty care. A nephrologist in Boston who has extra effort to give can provide care in rural Illinois, and that is——

Ms. BUDZINSKI. By telehealth.

Dr. KABOLI. By telehealth, yes.

Ms. BUDZINSKI. Telehealth is key to that, yes. Okay.

I will go ahead and yield back.

Mr. BARRETT. Sure, thank you.

I will now recognize myself for 5 minutes.

I know a couple of you, I think Mr. Lawson and Ms. Schauer, you mentioned the electronic health record upgrades that are necessary to kind of integrate that community care and VA care together, because oftentimes veterans will, even if they are using community care, will also have a segment of their health care through VA. That has been a major subject of consideration by our subcommittee. I feel like it has taken up 80 percent of my life these days.

If you can give us any of your perspective as to your expectations for that? I know Cerner has now been acquired by Oracle. The VISN that I live in specifically in Michigan is the next region to receive this update and, you know, it has frankly not gone well in

the places it has been rolled out in the past, minus the exception here in Illinois. I am curious if you have any thoughts on how that will take place and what would be things we ought to look for on this committee to make sure that it is done appropriately?

Mr. LAWSON. Yes. When we think about, you know, those electronic health records, even speaking from the private sector experience in my previous life before the superintendency here, the systems do not talk with one another. You might have one health care facility using—I do not want to endorse any places here—but Epic and then one may be on Cerner. Those two hospitals might even be owned by the same ownership group but do not communicate with one another with those records because they do not intermix.

I think what we would be looking here is, you know, we look to like software as service type of mechanisms, to where maybe providers might be provided login access, something along those lines, to direct access those records from the VA.

On that software rollout from Oracle and Cerner, we did get an update about that last week at the NACVSO annual conference. When we think about those records coming in from the active duty component of the U.S. Armed Forces, it is happening. It seems or appears or we have been told that those bugs have been worked out. Time will tell. However, we are looking at 18 months to 24 months of full rollout, you know. Illinois is not among the next states, by the way. We would like to see that happen.

That really kind of covers that active duty component. I think what we really need to really focus on is how do we make access for those community care providers, either through a software service platform or some other type of agreement with those providers.

Mr. BARRETT. You are saying instead of like sending the file back and forth, having an access portal for the community care providers to access your VA record?

Mr. LAWSON. Yes.

Mr. BARRETT. Make maybe even some edit privileges to that for the community care work that is being done?

Mr. LAWSON. Correct. Very similar to how a VSO has Veterans Benefits Management System (VBMS) access. I can get in there and I can kind of see what is going on with a case file. I think something very similar to that but with a bit more privilege, you know, from a provider end, to add to and edit.

Mr. BARRETT. Sure. Very good.

Ms. Schauer, I do not know if you have any thoughts on that yourself?

Ms. SCHAUER. My background is nursing and not IT, so I want to give that caveat. As a clinician, just being able to access the records you need when you need them is especially helpful. It goes two ways. It is the VA EHR, but then also figuring out with the community care, as you mentioned. Everybody is working on different systems. Making sure it works with a variety of systems.

Another additional thing just to point out, I know up until recently, we did have an EHR change in my organization. When that interoperability is not there, sometimes it does rely on actually making a phone call to the CBOC or to the primary care team, which that relies on that CBOC being open. Weekends, holidays, nights, you do not always have that ability to access those records.

If this was ever a possibility, I would love to see a future where not only do we ensure that any veteran that is eligible for community care receives the information about what they are eligible for and where they can go, but alternatively we have a lot of veterans that are not using their VA care; they are using the community on their private insurance. They may not have any awareness. I would love to see some way for some sort of integration that would allow community providers to easily screen and then refer to VA when somebody meets those criteria.

Mr. BARRETT. Yes, I do not disagree with you. One of the bills that I introduced was the Veterans Community Care Scheduling Improvement Act to allow for that integration with community care providers within the VA, so they could see that matrix of what is available. One of the revisions we made to that bill was a requirement that if a veteran called for a scheduled appointment, they would be advised of both options available to them, so that they would know what is available, so that they would then be able to choose between I am willing to travel a little bit further to get an appointment maybe sooner, or I am going to stay closer for an appointment a little bit later. Or just that entire decision matrix that they may have. Or maybe they are like a lot of folks in my district who travel to Florida in the wintertime, and they spend part of their time there, part of their time in Michigan, and having, you know, other options available to them is really something that is important. We are working through a lot of this electronic health record, you know, tangled issue right now.

I know, Mr. Lawson, you pointed out in your testimony just that certainty that if you have, for example, a referral for a critical need, that it is not getting lost in that gap, perhaps, before this is fully integrated. That we know if you send a referral for a test or a service, it is going to be received on the other end and actioned appropriately in a timely way to make sure that it is not falling through the cracks. I appreciate that.

I want to yield to the ranking member for 5 minutes.

Ms. BUDZINSKI. Great, thank you. Thank you again.

My next question, Mr. Lawson, actually, we could spend probably this entire hearing talking about health care. I do want to talk about access to benefits. I just was curious if you could speak a little bit to that, and what you are hearing from your fellow service members just about access to benefits, barriers to that, challenges with it in our more rural communities, obviously.

Mr. LAWSON. Sure. I think the first priority is ensuring that we have got access to accredited veterans service officers for these veterans in rural areas. In my office, we are going through quite a bit of a transformation to make ourselves available to veterans wherever they may be. We even service veterans outside of our county. We have got clients as far away as Ireland that we are able to do remotely, work through the claims process with them.

Part of what we do, you know, is educating veterans on that. They have to be into the system first. If you have not entered the VA system, meaning that you have not applied for a VA home loan, if you have not entered VA care, if you have not used education benefits, you are not counted and you are not in the system.

We need to make sure that you are enrolled and counted in the system. One, it gives our VA administrative staff and planning staff some better head count of numbers so we know where to center our care and where to look to build facilities or expand out options. You know, but for us, the challenge is, especially as we stand up here in Illinois are veterans assistance commissions, making sure that we have got an accredited veterans service officer in every county. These veterans service offices are free for the veteran to use. They should use free veterans services officers at all times and never pay for the service. That is a benefit that they have earned, and they should not be charged to access it. That is that.

Ms. BUDZINSKI. Thank you. Yes, one of the things we have tried to do in my office is host resource center, you know, resource fairs, connecting veterans to the VA, to services. It is challenging. It is challenging. We did it at one of our community colleges not far from here. We had light attendance. Any observations or kind of suggestions you might have on how we can better connect?

Mr. LAWSON. Yes, that is one thing we have been wrestling with. We attended one of your resource fairs as well at the Legion in Edwardsville. We have noticed that as well, that the resource fairs—the face of the veteran is changing. We have to look at the demographics of these veterans, how they access care, how they consume information.

Resource fairs used to work back when the internet did not exist. Now that veteran has more access to information through their handheld computer on their phone than they ever will at a resource fair.

There is so much, as Congressman Barrett mentioned, so many groups out there that are trying to do good things. It is just not a very coordinated effort in my opinion. That we need to, you know, figure out what that next generation of outreach is. Is it through social media? Is it through other platforms? It is just it takes money, quite honestly, to commit to those types of things.

We are looking and exploring how do we offer these things or these services or education opportunities in a more modern setting to appeal to the OIF/OEF generation, which is ours, and currently in the most need for care at this point.

Ms. BUDZINSKI. I would love to keep working with you, working with you on that to figure that out, for sure.

Mr. LAWSON. I would be happy to.

Ms. BUDZINSKI. Thank you.

Dr. Williams, I wanted to ask, I know you are currently the medical center director up in Chicago at the Jesse Brown VAMC. I was just wondering if you could maybe, since we are talking about rural health care, obviously Chicago not being rural, if you could kind of just talk to us a little bit about, you know, as you are practicing working up north, kind of the comparison between resources, any things you see different between what can be offered in a community that is more rural, the challenges or the lesser of the resources that might be down here, or maybe we have adequate, you know, same amount of resources than Chicago. I was just curious if you could reflect on that?

Dr. WILLIAMS. Actually, what is very interesting about my time at Chicago is that the Jesse Brown VA actually hosts the clinical

resource hub for VISN 12. Some of the rural health care that Dr. Kaboli was mentioning being provided through the clinical resource hub, I see the opposite end of that care. I see those providers and those specialists in my role as the medical center director at Jesse Brown. Then I see my home site, VA Illiana, as a consumer of those services. That partnership with the clinical resource hub is critical.

There are some, you know, obviously, differences between urban and rural health care. One other noticeable difference is the relationship or affiliations with the educational institutions in the different communities. Because a larger VA medical center obviously has typically a broader range of services, including specialties, there is a much tighter relationship with their academic affiliate.

We do have a great partnership down here at VA Illiana with the University of Illinois Urbana-Champaign, so we are very fortunate to that. It is a different relationship than what I see in Chicago.

Ms. BUDZINSKI. Okay, thank you. I will yield back.

Mr. BARRETT. Sure, thank you. I wanted to follow up a little bit more, Dr. Zomchek, about the EPS scheduling and how that has been integrated. I know it is not fully at every facility yet. I am curious in your VISN where it is being used and how it is being utilized, and if you have any feedback for us as to how that is going in its real application sense now.

Dr. ZOMCHEK. Yes, thanks for that question. EPS, I am well aware of it. Part of being the governance board that has been discussed for a number of months now, and so I have been involved in those discussions and in the rollout, kind of input about the planning. At this point, we do not have any of our eight facilities in VISN 12 that are in the pilot, as you had mentioned. However, I think it is a great thing. I think it is a wonderful opportunity to provide more resources and access for our vets, and timeliness. I mean, literally it is moving appointment scheduling from days or weeks in some cases to the period of minutes.

I am encouraged about it. I do think it is a—it is a double-side-coin idea in terms of implementation, right? You really need the local medical center to be engaged in opening up those clinic slots. You also need the community partner, and a connection like Chief Executive Officer (CEO) to CEO, to open up those grids and then kind of get proof of concept so that it can be expanded.

Mr. BARRETT. Sure. For those that may be here today unfamiliar, basically when you call to schedule an appointment, often in community care, I had this example happen to me. I was at an audiology appointment, and they had to first call me and get my availability, then call these other providers that were available, then call me back. They scheduled it at a time I told them I was not available. Then they told me, well, when that happens, we just schedule you for the next appointment if we cannot meet your timeline that you are available.

I am like, I am literally going to be out of the State. You know, I am going to be in Washington, DC, and you scheduled me an appointment in Michigan at the same time. It was a very significant hassle. I think having that realtime awareness so you are not going through that game of telephone is really critically important.

I think you are right, though. You need both the VA scheduler as well as the community care provider to opt into that, that meshing of information, so that that scheduling is going to be available for people and they can know what is close to home, what is available, and what am I willing to travel farther for or what is nearby and timely and everything else. Think that is, you know, an important thing that we have got to kind of pull together, basically.

Dr. Kaboli, on that piece of it, and maybe I am not sure if you have awareness of this, do you feel like there is that awareness and buy-in by potential community care partners when we offer this to them that they have this willingness to participate?

Dr. KABOLI. Absolutely. Our office has kind of followed the external scheduling program for the last 3 years. You know, we have worked, for example, with the Nebraska Rural Health Association, because they are really tied into the rural communities and saying, we will partner with you to make sure that they are on the grids.

Like you said, if the scheduler has access to both grids at that exact moment in time when they are on the phone with the veteran, they can say, we can get you into the VA in 32 days or we can get you into this other clinic in 47 days. Which would you rather have?

I think if it works half as well as we hope it does, it will still be good. You know, I think they are up to, what, there were 4,000 appointments made last month in June. It is ramping up quickly. I think it will prove to be mutually beneficial, and that is where it will work.

Mr. BARRETT. Yes. I am not sure if this is the best question for you or not. The community care partners, do you feel that they feel like they are getting a—everybody always wants a greater reimbursement. Do you feel it at least is a market reimbursement rate that is something that will draw in community care partnerships?

Dr. KABOLI. Yes, so we have gone around and met with community partners. I still practice in Iowa, and I talk to these other providers all the time. They are happy with the rates that we provide. It is just you have to make it easy.

Mr. BARRETT. Right.

Dr. KABOLI. The harder you make it, especially, you know, with record exchange, the harder we make it, it just becomes a hassle. I think they are really committed to the veterans in their community, and I have never heard anybody in the community ever say, you know what? Taking care of veterans is not a priority for us. They always want to care for veterans.

Mr. BARRETT. We want to draw in the best that we can by having a reimbursement rate that is reflective of the service that is provided, that does that to really strengthen those particularly rural community partners that we have. Thank you.

I can yield to the ranking member. Do you have other questions? Go ahead.

Ms. BUDZINSKI. I was just going to follow up on telehealth, actually, and maybe ask Dr. Zomchek, when you are talking about telehealth and using it specifically for mental health challenges, do you find that there are still a lot of barriers around stigma related to seeking this care? Barriers to, you know, a veteran coming in in person or utilizing telehealth? Is telehealth making it more easily

accessible for a veteran that might be trying to get over a stigma about seeking that care?

Dr. ZOMCHEK. Well, I think, first of all, VA care and mental health is second to none. I think the plethora of services that we offer and modalities that we offer mitigates stigma that historically was there.

I think it is still there, certainly. I think candidly, I think it is part of the disease process to some extent for people to be reluctant to seek care when they really need it. I think we will never stop in terms of that outreach and finding connectivity for our vets, whether it is through VVC or coming to a local CBOC and using telehealth.

One of the programs that we have related to this broadband discussion we have been having is what we call the digital divide program. That is where we have literally issued VA-loaned iPads, tablets that have internet connectivity for veterans that are in rural areas who cannot afford it. Then that gives them the ability to connect with their clinician at their kitchen table.

Ms. BUDZINSKI. Right.

Dr. ZOMCHEK. We have distributed thousands of those across the network.

Ms. BUDZINSKI. That is great. Yes, that is great.

Can I open the question up to—I know we have a number of veterans, obviously, on the panel—specifically around barriers. Anything you could speak to as far as barriers that we could help overcome in helping connect veterans to telehealth services, mental health services?

Mr. LAWSON. I think, when we think about the telehealth services, I used telehealth, telehealth mental health, even. I am not ashamed to admit it. It was wonderful. It worked. I am at work. I am a working adult. I am still in the workforce. I think sometimes there is this misconception that, you know, oh, you can just take off work to go to an appointment.

Here in Illinois, we have got legislation pushing forward to kind of help those veterans take some extra time off, compensated, to go to these appointments for service-related conditions. A lot of this is going to come on educating, especially for some of our older veterans who are just not quite at the technology level maybe some of us are.

You know, we are still seeing Vietnam-era veterans that are now coming in for the first time for Post-Traumatic Stress Disorder (PTSD). You know, it breaks your heart to see them dealing with that for so long. We have got to figure out ways to also, as we issue out those iPads and pieces of technology, how do we educate them to use it?

You know, one of the things we do in our office is, you know, when they come to see us for claims, do you have VA.gov app on your phone? Most veterans do have phones at this point, even the older ones. How do we educate them to use that VA app? They can communicate with their primary care provider on there. They can retrieve records, letters, medical records, decision notices. They get notices for appointments coming up on their app. It is really a great tool, and we really do love that app. It is just, again, how do we educate those veterans on using it?

Making sure that we have got access, critical. Also education on how to use the tool.

Ms. BUDZINSKI. Any others? Yes.

Ms. SCHAUER. One of the biggest barriers I see is just a lack of awareness of eligibility. I think that the veterans that are within the VA somehow or have ever been connected with VA will get some information. You can access so much information on the internet. It is almost too much, it is hard to digest, you do not know what is worth going after. Not everybody even realizes that it is something that they should pursue.

I think again that outreach is so important. Going to where the veterans are. We find a lot of luck meeting women veterans in places like the farmers market. You know, like places just that veterans are, versus having a fair where they come to you. If I do not believe—we have a lot of veterans that do not even understand that they are a veteran, they do not identify as a veteran. That resource fair for them is not for them.

Finding ways to meet the veterans where they are and make sure that you have those conversations about what you are eligible for. Most of our women, that is why they have now gotten VA care is because they learned that they could. They did not even know that it was a possibility before.

Ms. BUDZINSKI. Okay, thank you. I will go ahead and yield back.

Mr. BARRETT. Sure, thank you. Thank you for that. I think you are right. I think it speaks to a thing—when I, prior to coming to Congress, I was in the State legislature in Michigan. We would always model our outreach and instead of asking, are you a veteran, because you are right, because people will self-select out of that definition, you ask, did you ever serve in the military, and then you can kind of explore that from there.

It is hard to hold a resource fair and advertise it as a did-you-ever-serve-in-the-military fair. It is a little bit harder to package. I think it is part of that, going where people are instead of expecting them to come to us. I think there is a lot of—part of this is an inertia thing. You begin unpacking this and then you work through the process and maybe obtain the benefits that you have kind of had on the back burner. Life comes at you, you are transitioning to civilian life. Things are difficult. It is like being in a batting cage and you are figuring out how to get stood up again. Then you think you will worry about it later. Then life comes in and you have a lot of other priorities.

Even for our Vietnam generation coming home, they were treated so poorly when they came back that many of them just kind of packed it away and then life took over. Then they moved to a different phase of life and those things they had tried to pack away come to kind of percolate back out.

I really hope, and I think we are making the strident effort of making up the lost ground that we had with that generation. They truly did suffer unnecessarily.

I will say, I am grateful that that generation made sure that our generation was welcomed back respectfully and with the dignity that all veterans deserve. I think that each of our Vietnam veterans are owed a great deal of appreciation for that.

Mr. Kirchner, I wanted to ask you a question. Since your really tragic experience with that provider, have you found or have you gone back into any community care services? What have your experiences been like more recently, and can you give us any insight into how that may or may not have improved, and where you think those improvements ought to go?

Mr. KIRCHNER. Sure. First of all, community care, excellent. Excellent. Every time they call about the appointment, like you said, we will get back with you, 24 or 48 hours. It is within 10 minutes they are calling. You know, they are bringing their A game.

Where I see that could be a benefit for the veterans and the VA is if I am going to an audiology appointment, I want my records to be reviewed by an audiologist, not a heart doctor or a person that is had the training. I do not believe the people that are doing these exams are the right people doing the exams. I think that is where the——

Mr. BARRETT. You are talking for the compensation, pension?

Mr. KIRCHNER. Correct.

Mr. BARRETT. Okay. Not the community care ongoing medical——

Mr. KIRCHNER. No, the community care, they are doing everything to get you there.

Mr. BARRETT. Sure. Sure.

Mr. KIRCHNER. You know, that is where community care is on top of their game. I think that is where it is falling apart, is whenever community care is done, that is where it is falling off the board.

Mr. BARRETT. We will take that back, because I am not sure, sitting here, what the qualifications for those delegated outsourced, you know, compensation and benefit exams, what a requirement is for that person to be. I am sure they have to be a medical doctor, but I am not sure in which specialty or what that would involve. We will take that back for consideration, for some questions to VA about that. I appreciate your insight there.

Dr. Zomchek, one thing, I know you have talked about outreach with mental health and that being important, and I think that is a continuing effort we have to keep working toward. One population that we found some success in Michigan was actually reaching out to spouses of veterans as well, because oftentimes they are observing the behavioral challenges that veterans may have in a more, you know, intimate setting back home that they are not displaying out in public at their job, or they are, you know, taking that hardship back home with them. I think that that outreach to the spouses of saying, hey, here are some benefits that may be available to your loved one, may be that soft encouragement that they need to, you know, make the decision to come in to receive the help that they should have and that certainly have earned. I do not know if that is anything you have explored at all or if it is worthy of your consideration or not.

Dr. ZOMCHEK. Yes, that is a great point. We know the connectivity with our veterans is often with family members, often children. Could be a neighbor. I think, as I hear this discussion about outreach and connectivity with our veterans, of course we have telehealth coordinators, we have people to talk and to train

and to teach our veterans and family members. I really think that a multifaceted approach is what is needed.

There can be some of these standardized approaches that we are doing. What I have seen in my network is I have very rural and very urban centers, and even some of the hospitals that are very urban have very rural CBOCs. Having a group—each of the facilities does, I think, a great job of even with town hall meetings in reaching out and opening up our connections. Sometimes it is in person, sometimes it is with Facebook.

Whenever possible, we certainly invite spouses and family members to be involved in the care, so long as it is, you know, it is okay from a health information standpoint.

Mr. BARRETT. Do you know of any way that we kind of tried to do the direct outreach to the spouses or near close family members of veterans, you know, with resources from the VA, to encourage them to try and encourage their veteran loved one to explore their benefits?

Dr. ZOMCHEK. I would have to take that back.

Mr. BARRETT. Okay.

Dr. ZOMCHEK. I would be happy to follow up with you about any specific program or initiative about that.

Mr. BARRETT. Sure.

Dr. ZOMCHEK. I think mostly what we do, it is all encompassing, so all of the outreach that we do, we do not turn down if someone is asking about their father or mother or a sibling.

Mr. BARRETT. I just think it might be a useful inroad with veterans. As it turns out, I have a wife, and she thinks I am rather stubborn. Maybe I am the only one, I do not know. Thank you. Appreciate it.

Dr. ZOMCHEK. Thank you.

Mr. BARRETT. Ranking Member Budzinski, go ahead.

Ms. BUDZINSKI. Sure, I just had a final question for Ms. Schauer. I was wondering if you could speak about specifically women veterans? We have had a lot of conversation, obviously, focused on rural health care. I think that those challenges to access for women is probably greater. I was wondering if you could speak a little bit to that experience?

Ms. SCHAUER. Yes, our women veteran population, of course, we have a lot of unique needs. Military sexual trauma is probably one of the most prominent, though not isolated to women veterans, a higher percentage of women veterans. What I find in our community is hesitance toward using the VA because of experiences they had 10, 20 years ago, you know, when you dig into it. Just trying to encourage them that today's VA is different and you are in a place where you will be welcomed.

Once they try it again, they see and they believe, and they socialize it with each other. I think it is getting them in that door.

I think the social isolation that you are talking about, I love—I want to learn more about that program, because that is really why our community was created, and hearing about the high suicide rates for women veterans which, as a nurse, having been a nurse for 15 years at that point, I was completely unaware of.

When we started our group, we had immediate energy behind it. It just keeps growing and it just shows that need for people. Often,

it does take asking them two, three, four times to come. Once they come, they are like so excited for the next meetup.

I do think women have unique needs that have gone a little bit unnoticed and unrecognized for a while. I am really happy that today's VA is seeing that and addressing that.

Ms. BUDZINSKI. Thank you very much. I will yield back, Mr. Chairman.

Mr. BARRETT. Sure, thank you. I appreciate that insight as well. I think maybe doing some public service outreach to women to really—like having firsthand testimonials of women who have come back and now received care at the VA to advocate for other women to, hey, this is not—number one, this is not the military. Whatever trauma you may have experienced there is not—I get that this is still the U.S. Government and there is a hill we have to climb to reestablish trust in many ways. This is not the same VA that may have been unprepared during those early days of the War on Terror and the war in Iraq and coming back home, and a lack of capacity and understanding and, you know, kind of a little bit of a legacy VA that has since transformed, and through a lot of work that was done and paths that were forged by women like yourself and other veterans coming back home, and advocates like many of you here and folks that work within the VA. We appreciate your work doing that.

I now want to yield to the ranking member for your closing statement.

Ms. BUDZINSKI. Yes, thank you, Mr. Chairman. I just want to say again, thank you for coming to the 13th District. I really appreciate that.

Thank you to all the panelists. This was very informative on the work that we have ahead of us back in Washington. I really appreciate all of your time in making the trip here.

As the ranking member on the subcommittee with Chairman Barrett on Tech and Modernization, it was great to hear some of that conversation and how that is integrated into the rural experience for our veterans. I think we both know we have a long way to go, and we are a partner in that work because it is just so critical, whether it is scheduling or the electronic health records system, getting that fully operational within the VA is something that is critically important and will be to the benefit of the services that the veterans so well deserve.

Thank you again for being here. To the veterans, thank you for your service. I will yield back to the chairman.

Mr. BARRETT. Thank you. Thank you, Ranking Member Budzinski, for hosting us today and for allowing me to see a little bit of a glimpse of your district, and appreciate both similarities and some of the differences between communities that we represent and how things are done. I really cannot say enough about how impressed I am by this facility, the outreach that is done, and the success stories that you have all had and the work that is ongoing that you are doing.

Kind of like we talked about earlier, Colonel, allowing veterans to find that next sense of real purpose, and I appreciate the work that you are doing here to make that happen.

One thing that I think can give us some really focused motivation for this is there are statistics around this. Of course, during that 20-year-long span of the War on Terror, we had just over 7,000 troops die on the battlefield. Every single one of them is an absolute tragedy. I have friends, and many of us who served have friends that were lost in that effort. We lost 35,000 more to suicide during the same period of time.

That really to me speaks about that total—the real total human cost of war that we have yet to fully appreciate. We have a lot further to go in that and how we can prevent those, each of which are preventable with the right intervention and the right outreach and the right care and treatment. That is a real mission of what we on this committee are focused on. A piece of that is this technology aspect of how we deliver benefits to veterans and how we really do a better job of making sure that they have the adequate access that they have all earned, to really head off at the pass the next veteran who may be going down that path.

Then also looking at veterans who are not contemplating suicide, but still need help for, you know, the back injury they sustained or the other service-connected conditions they may be facing or dealing with. What education benefits do they have that are available to them? What compensation and benefits are available for that continuation? All of the other services that VA provides that are really truly important and fall under this rather broad umbrella of the subcommittee and the work that we do.

I cannot tell you how much we appreciate each of you being, you know, really on-the-ground advocates, and with the firsthand knowledge and experience that you have of how we go about that.

You know, Washington, DC, is an 11-hour drive from here. We almost had to drive because of the weather with the flights yesterday. It is a long ways away from here, and it is a long ways away from everyday America. These are the communities that we represent.

I say this in my own district. It is my job to be my district's representative in Washington, DC, not Washington's representative back home in my district. That should really be a one-way street where we take our voices of our constituents and the folks that we represent and go advocate for them in our Nation's capital, and not come back here and tell you, well, you know, this is how it really works, and you have just got to get on board with it. That is not the role of Congress and that is never going to be what we do on this subcommittee.

This field hearing today really allows us to gather that insight from all of you here and take this with us back to our Nation's capital to really do our best and strive to make the best public policy that we can on behalf of our veterans and on behalf of the communities that we represent.

I thank you again for hosting us today, and we look forward to welcoming you to Michigan in the future to do another hearing in my district. Certainly for those of you that have further insight or thoughts for us, we welcome your insight. If you make it to Washington, we would love to have you in our hearing there as well.

Thank you again to everyone. Thank you to the staff, both committee staff on both sides, as well as the staff for arranging all of

this, for those that were here providing other services, for hosting us today. I really do appreciate each and every one of you.

With that, I will ask unanimous consent that all members have five legislative days to revise and extend the remarks and include extraneous material. Without objection, it is so ordered.

And this hearing is adjourned.

[Whereupon, at 11:37 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Daniel Zomchek

Good morning, Chairman Barrett, Ranking Member Budzinski, and distinguished guests, thank you for the opportunity to discuss the Department of Veterans Affairs' (VA) extensive efforts to enhance the well-being of Veterans living in rural areas broadly as well as in the VA Illiana Healthcare System service area. My name is Daniel Zomchek, and I am the Network Director of Veterans Integrated Service Network (VISN) 12. I am accompanied today by Dr. Staci Williams, Executive Director of VA Illiana Healthcare System, and Dr. Peter Kaboli, Executive Director, Office of Rural Health (ORH), VHA.

Today, I will discuss key initiatives within the VA Illiana Healthcare System, VISN 12, and VA that exemplify our commitment to Veterans living in rural areas. From implementing advanced telehealth services to expanding our reach through community collaborations, VA, VISN 12, and the VA Illiana Healthcare System continually strive to bridge the gap in health care access faced by Veterans living in rural areas.

Our goal across VA, and certainly here in VISN 12, is to ensure that Veterans residing in rural areas have the same access to high-quality care as those in urban centers. ORH is instrumental in addressing the challenges faced by Veterans living in rural areas. VA is dedicated to putting Veterans first, prioritizing their needs, and continually improving access to care – especially for Veterans in rural areas. ORH supports 34 innovative enterprise-wide initiatives (EWI), which are field-based solutions that have been tested in multiple locations – including here in VISN 12 – and shown to be effective and efficient methods for standardized care delivery.

We understand the unique circumstances and needs of Veterans living in rural areas and are dedicated to developing sustainable and impactful solutions to meet those needs. By sharing our experiences and strategies, we hope to provide a clearer understanding of both the challenges faced and the progress made in delivering high-quality health care to Veterans living in rural areas.

Status of Rural Health in the VA Illiana Healthcare System

We are proud of the comprehensive range of health care services we provide to Veterans through the VA Illiana Healthcare System. VA Illiana Healthcare System has been serving the Danville community for over 125 years. We employ over 1,500 health care professionals across our service area and deliver care to 30,000 Veterans annually. We are committed to expanding rural health access across our 34-county service area, reaching Veterans in both urban and rural areas in east-central Illinois and west-central Indiana.

Of the estimated 18 million Veterans living in the United States and its territories, approximately 4.7 million Veterans reside in rural areas. We also know that Veterans in rural areas enroll in VHA health care at a higher rate (65 percent) than their urban counterparts (47 percent). Out of the 62 VHA facilities in VISN 12, 43.5 percent (27 facilities) serve a population where 50 percent or more of enrolled Veterans are from rural areas. We understand the unique challenges they face, including difficulties accessing VA care due to geographical isolation.

I would like to highlight several areas of particular importance to us as we continue to put Veterans first and to enhance our outreach and capacity to reach Veterans living in rural areas: community care, telehealth to include virtual mental health care, and beneficiary travel.

Community Care

VA continues to enhance the Veterans Community Care Program (VCCP) to ensure Veterans – especially those in rural or underserved areas—receive timely, high-quality care closer to home. Through VCCP, VA uses a network of more than 1.4 million non-VA providers to deliver essential hospital care and medical services (including mental health and specialty care), as well as extended care services, to eligible Veterans when they elect to receive care from such providers. This network is

particularly vital for Veterans living in rural areas, who often face geographic and transportation barriers to care. VA has taken steps to streamline referrals, improve care coordination, and enhance oversight of community providers to ensure continuity and quality of care. The integration of community care with VA care reflects VA's commitment to meeting Veterans where they are and offering them more options while upholding the same high standards of Veteran-centered care.

Telehealth and Virtual Mental Health Services

Telehealth has become a lifeline for Veterans living in rural and remote areas, where distance and limited local health care options can make it difficult to access timely care. VA has invested significantly in the telehealth infrastructure, enabling Veterans and other beneficiaries in rural areas to connect with primary care providers, specialists, and care teams through platforms like VA Video Connect. This technology eliminates the need for long travel times, supports continuity of care, and improves the management of chronic conditions. By leveraging telehealth, VA is not only expanding access but also improving health outcomes for Veterans in rural areas, ensuring they receive high-quality care regardless of where they live.

An essential aspect of telehealth and virtual health services is its pivotal role in addressing the mental health needs of Veterans. Access to mental health care remains a critical need for Veterans living in rural areas, where provider shortages and geographic isolation can create significant barriers to timely treatment. Recognizing this, VA has significantly expanded its virtual mental health services, ensuring that such Veterans can connect with psychologists, psychiatrists, and counselors from the privacy and convenience of their homes. Through VA Video Connect, Veterans receive care ranging from therapy and medication management to crisis intervention, all while avoiding long travel times. This digital infrastructure is helping to close care gaps, reduce stigma, and provide continuous support for Veterans who might otherwise go without essential mental health services.

To further meet Veterans' needs, VA has launched several telehealth initiatives including the VA Clinical Resource Hub program; Accessing Telehealth through Local Area Stations, Digital Divide Consult, Mobile Connectivity Program, clinic-to-clinic telehealth links, and the My VA Images app. These initiatives help increase clinical capacity and enhance health care delivery in rural areas.

Beneficiary Travel

Veterans in rural areas can face significant barriers in accessing health care services due to longer travel distances. Recognizing these challenges, VA has developed a range of robust programs to facilitate transportation for Veterans designed to meet the diverse needs of Veterans and ensure that no Veteran – especially those living in rural areas – is left without options. VA operates several programs designed to meet the transportation needs of Veterans, including:

- **Veterans Transportation Service (VTS)**: Through VTS, VA transports eligible persons to or from a VA or VA-authorized facility or other place for the purpose of examination, treatment, or care. VTS offers safe, reliable door-to-door transportation for Veterans, particularly those with disabilities, through a fleet of vehicles at many VA medical centers.
- **Highly Rural Transportation Grants (HRTG)**: VA's HRTG program provides grants to eligible entities to assist Veterans in highly rural areas through innovative transportation services to travel to VA medical centers and to otherwise assist in providing transportation services in connection with the provision of VA medical care to these Veterans.
- **Volunteer Transportation Network (VTN)**: VTN, principally supported by the Veterans Service Organization, Disabled American Veterans, provides free transportation for Veterans through volunteers using personal or VA vehicles to ensure access to appointments.

VA's beneficiary travel program offers payments or allowances for eligible individuals. This includes both mileage reimbursement and special mode transportation, and beneficiaries can receive assistance when traveling for various examinations and care. This program helps reduce travel expenses, especially for those living in rural or remote areas.

Conclusion

Chairman Barrett and Ranking Member Budzinski, thank you for the opportunity to discuss VA's efforts to serve Veterans in rural areas and to highlight the work of VA broadly and here in the Urbana, Illinois area. Thanks to Congress' support, VA has expanded its reach, delivering more care to a greater number of Veterans

than ever before. We value your ongoing efforts as we strive to better serve those who have served.

Prepared Statement of John Lawson

H.R. 3132, CHOICE for Veterans Act of 2025

We adamantly oppose H.R. 3132, CHOICE for Veterans Act of 2025 as written. We do not view this proposal as a compromise contrary to some commentary being published and will continue to oppose any legislation that charges veterans for initial claims assistance based on their future benefits. This proposal has the likely outcome of putting veterans into debt before even receiving a single penny in their earned benefit. The companies engaging in this currently illegal activity should be punished, not rewarded with a disabled veterans compensation benefit. Congress' inaction on this matter has forced veterans to seek remedy at the statehouse, namely here in Illinois with the passage of SB3479 codified in Public Act 103–0783 under the Consumer Fraud and Deceptive Business Practices Act. Free VA accredited veterans service officers all over the country are ready to assist our fellow veterans without taking any part of their earned disability benefit. We expect our elected representatives to work with us to help serve the veterans in their districts and not to line pockets of claim sharks with money the taxpayers set aside to provide for the disabled veterans of the United States Armed Forces. We are extremely disappointed we must continue to have dialog on this topic, year after year after year. This legislation is also strongly opposed by the Veterans of Foreign Wars and Disabled American Veterans.

Veterans Benefits Improvement Act: Enhancing Communication

With regard to the implementation of the **Veterans Benefits Improvement Act: Enhancing Communication**, Veterans Service Officers are still not experiencing the mandated communication in Section 3 between Claims and Pension (C&P) Examiners and veteran's representatives. It is essential to the timely adjudication of a veteran's claim that when issues arise or clarity is needed, an examiner attempts to resolve the issue directly with the veteran's representative, not by sending more letters or kicking the can to another work queue. Additionally, Section 4 of the same Act mandates that the VA provides regular reports on how it can improve communication with veterans' representatives. This includes assigning veteran liaisons to local facilities and enhancing access to VA systems, all aimed at fostering better coordination and ensuring veterans have the support they deserve throughout their benefits process. To date, this has not occurred in any meaningful way with our accrediting body, the National Association of County Veterans Service Officers (NACVSO).

H.R. 3951, Rural Veterans' Improved Access to Benefits Act of 2025

We encourage support of this legislation to extend the license portability for contracted health care professionals to perform VA disability examinations to January 2031. The disability examination system has evolved and expanded over many years. In 1996, as part of a pilot program, VA granted temporary license portability to allow contracted physicians to assist with disability examinations. Since the fall of 2016, VA has transitioned from VA-conducted examinations in VA settings to contracted examinations in non-VA settings for nearly all disability examinations. Exceptions are examinations that VA personnel must specifically perform by law. By increasing the number of eligible providers, this legislation would accelerate the initial stage of the disability claims process, particularly for rural and tribal veterans who often have few examination options near their homes.

S. 784, Rural Veterans Transportation to Care Act

We encourage support of this legislation that would expand eligibility for the Highly Rural Transportation Grant (HRTG) program. It would also grant as much as $80,000 to State and county veterans service agencies, such as the Veterans Assistance Commission of St. Clair County and its Veterans Service Organization members to purchase vehicles, including those compliant with the *Americans with Disabilities Act of 1990* (Public Law 101–336) to provide innovative transportation options for veterans in rural or highly rural areas traveling to and from medical treatment.

Unique to the HRTG program is the definition of "highly rural" as a location that contains no more than seven persons per square mile, which is a highly restrictive

criterion. Other VA rural programs use the Rural-Urban Commuting Areas (RUCA) coding system to assess rurality. This bill would expand eligibility by including veterans who reside in either rural as defined by RUCA, or highly rural areas as defined by HRTG. This uniformity in standard will simplify processes and be more a more realistic approach to solving transportation issues in rural communities such as St. Clair County.

Our Public transportation options, taxis, and ridesharing companies that urban dwellers take for granted are virtually non-existent in rural St. Clair County, severely disadvantaging ill or injured veterans or those who do not drive or own a vehicle. This expanded program would satisfy a pressing need and ensure veterans could use their earned benefits regardless of where they live.

Prepared Statement of Hillary Rains

Illinois
Department of Commerce
& Economic Opportunity
OFFICE OF BROADBAND

United States House of Representatives
House Committee on Veterans' Affairs
Subcommittee on Technology Modernization
Beyond the City Limits: Delivering for Rural Veterans
Chez Veterans Center
908 West Nevada Street
Urbana IL, 61801
July 25, 2025, 10:00 am

Thank you, Mr. Chairman. Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee, thank you for the opportunity to testify today on behalf of the Illinois Department of Commerce and Economic Opportunity and the Illinois Office of Broadband. I am here to speak about the critical intersection of telehealth access for rural veterans, and the impact of the digital divide on their health and well-being.

When we talk about the digital divide in 2025, we are talking about a disparity in access to fast, affordable, and robust internet, as well as to the devices, tools, and skills that allow people to connect to critical supports throughout their lives. Vulnerable populations often find themselves on the wrong side of this divide, and veterans are one of them, with only 67% of Illinois veterans having and using broadband access[1]. Veterans are also often part of more than one vulnerable population, as 56% are over the age of 60 and 26%, over 4 million people, live in rural areas [2].

Rural residents have their own challenges where internet connectivity is concerned. The FCC estimates that 28% of rural residents lack broadband access. 57% of rural locations in Illinois alone are entirely unserved or underserved, receiving internet speeds below the FCC's minimum recommendation of 100/20 Mbps. This recommendation is indeed the bare minimum, and is often only adequate for one user at a time to do everyday tasks like video conferencing, streaming, and emailing. The inability to complete these tasks from home disadvantages rural veterans especially when trying to access telemedicine resources.

The VA provides vital care centers and hospitals across the country, but when we look at veterans who live in rural areas, they live an average of 45 miles to be seen in person at a center[3]. As veterans are twice as likely as nonveterans to suffer from two or more chronic health conditions[4], frequent checkups and appointments are especially important. Telehealth resources began to be promoted heavily just before the pandemic to alleviate challenges with transportation and provider availability, but adoption rates in rural areas suffered because of the lack of broadband access. When considering additional complications, such as subscription affordability, device ownership, and varying degrees of digital literacy and skill, especially in the more than half of veterans over 60, the problem is laid out in stark relief[5].

Illinois has already worked diligently to increase broadband access for rural residents through the Connect Illinois broadband infrastructure grant. Connect Illinois allows internet service providers to build high speed fiber infrastructure in rural areas that often have low population or subscriber density or are isolated from other middle mile internet infrastructure. As of today, three state and federally funded rounds of this program have

connected approximately 7,500 households, with 46,000 total to be connected in the next three years. A fourth round is being funded by the federal Broadband, Access, Equity and Deployment (BEAD) program, and stands to connect over 165,000 Illinois residents and almost 5 million other households across the country without adequate connectivity.

While the BEAD program is in progress, there is another program that can fund veteran serving organizations on the ground and help to provide rural veterans with device access, digital skill building, one on one troubleshooting support, and more. That program is the Digital Equity Act. This program was poised to provide $2.75 billion dollars to states to support programming and subgrants to direct service organizations, with veterans being targeted as one of the vulnerable populations most affected by the digital divide. Illinois was to receive more than $23 million to equip households and residents with the skills, resources, and tools needed to use high-speed internet.

Illinois received over 260 subgrant applications from around the state, with the full ask totaling over $100 million, far above the available funds, illustrating the incredible scale of the need of community organizations. Some of those proposed programs include:

- Supporting telehealth and resource access for recently separated women veterans in the rural west central region
- Veteran focused digital literacy classes and ongoing tech support to a rural library in the north central region
- A mobile digital skill building hub in the southeast visiting community organizations like the American Legion and other veteran serving organizations
- Secure community telehealth rooms in the southwest for those who can't yet connect from their homes
- Low cost or free refurbished laptops and tablets for veterans across the state

Unfortunately, the Digital Equity Act and its $2.75 billion dollars of appropriated funding were terminated by executive order on May 9, 2025. Without those funds, these proposed programs and many others are left without funding and most will not be realized, leaving veterans unserved.

Expanding access to broadband and telehealth resources is key to the health and well-being of rural veterans, not only in Illinois but across the nation. Thank you for the opportunity to speak with you today, and I welcome questions at this time.

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Prepared Statement of Kim Kirchner

Good morning and thank you everyone for taking the time out of your day to listen to my testimony. My name is Kim Kirchner and I am a proud veteran who served in the United States Air Force/Illinois Air National Guard and served in Operation Iraqi Freedom and Operation Enduring Freedom. I'm currently a Sergeant with the Macoupin County Sheriff's Department.

I am writing the testimony in regard to the care that I have received at a compensation and pension exam. I drove over thirty minutes to an exam that VA scheduled for me with a contract provider. When I arrived, the medical provider informed me that I was not on her schedule and that she couldn't find my medical records. I told her that VA called me and asked me to come at an earlier date due to an opening. She finally found my records but had an attitude through the entire exam, which lasted a total of 3 minutes.At no time did she conduct a medical exam on me, she only reviewed my medical record. Based on that exam VA denied my claim. In order to finally get my claim awarded, I had to do a whole other medical exam. This was a massive waste of my time and taxpayer money.

I firmly believe that I am not the only veteran this has happened to and the outsourcing of these exams definitely needs to be looked into. When a veteran goes for an exam they should be treated with the upmost respect they deserve especially for putting their lives on the line for our country. When I walked out of the exam that didn't last approximately 3 minutes I have never felt so disrespected in my life. It is very frustrating to get treated this way especially having to drive 30 minutes to the exam due to living in a small town and nowhere close to a VA Clinic. I firmly believe that the VA needs to pay more attention to the care we are receiving from them outsourcing their compensation and pension exams.

Thank you and I am happy to answer any questions you may have.

Prepared Statement of Christina Schauer

Statement of Christina Schauer, MSN, RN, ACNS-BC

President and Co-Founder

of

Tri-State Women Warriors

before the

House Veterans Affairs Subcommittee on

Technology Modernization

with respect to

"Beyond the City Limits: Delivering for Rural Veterans"

July 25, 2025

Statement of Christina Schauer
before the
House VA Subcommittee on Tech Modernization
July 25, 2025

Chairman Barret, Ranking Member Budzinski, and Members of the Subcommittee, thank you for the opportunity to speak today on behalf of rural veterans.

My name is Christina Schauer. I am a U.S. Army Iraq War veteran and co-founder and president of Tri-State Women Warriors, a nonprofit serving women veterans in rural Iowa, Illinois, and Wisconsin. Our mission is to provide connection and advocacy for the unique needs of women veterans and service members.

I have not always been a passionate advocate for veteran healthcare. Despite holding a master's degree in nursing, decades of clinical experience, and a military background, I didn't fully understand the systemic gaps in veteran care until 2019, 15 years after returning from Iraq, when I was asked to lead a military and veteran healthcare program at our community hospital. Recognition of these disparities inspired the creation of our nonprofit, ultimately leading me here today.

I hope my experiences as a veteran, nonprofit leader, and community health partner can provide direction for this subcommittee to improve care for our rural veterans. Today, I will focus on three key areas: Enhanced Community Outreach, Coordinated and Purposeful Community Care Utilization, and a Strong Rural VA Presence.

Enhanced Community Outreach

Community outreach is vital to ensure veterans understand their benefits, how to access them, and why they matter. This is especially true in rural areas, where geographic isolation and limited broadband access make communication difficult.

The VA's Community Engagement and Partnerships for Suicide Prevention program has been essential in keeping our community informed of changes, connecting us to resources, and supporting local coalitions working to prevent veteran suicide, which is disproportionately high in rural areas (Rural Health Information Hub, 2024). When the Compact Act went into effect in 2023, our Community Engagement and Partnership Coordinator, Deb Moeller, MSW, LCSW, LMSW, helped our healthcare organization understand the change, provided educational materials, and connected us to resources to ensure we followed the appropriate reporting and billing processes, proactively preventing veterans from receiving medical bills in error.

Deb has also supported the growth of Tri-State Women Warriors, which has served over 100 local women veterans through live events and helped many access VA care for the first time. Her outreach, along with support from our local Community-Based Outpatient Clinic, or CBOC, ensures our members receive accurate, up-to-date information. As a result, our women trust the VA, actively use virtual offerings like Whole Health, and many prefer VA care over community care even when offered the choice. Our connection to VA outreach keeps us strong and informed, and our members help educate and encourage each other to engage with VA services.

Coordinated and Purposeful Community Care Utilization

While many of our members prefer VA care, the VA Community Care Program is a necessary extension, especially for rural veterans who need specialty services or face long wait times. The Mission Act's 2018 expansion of Community Care helped reduce burdens like travel, time off work, and physical limitations for those of us who live far from the specialty services offered at VA Medical Centers.

To build on this progress, community care must be optimized. I was fortunate to have Deb's help navigating the Compact Act, but a policy change this significant should follow an effective, standardized communication process to community care billing departments, clinical services, social work, and all other areas impacted. While investigating the experiences of rural, non-VA clinicians providing care through VA community care, Patzel et al. (2023) found that multiple participants reported learning about policy and workflow changes only through error notifications and request denials. These administrative errors can have significant consequences for the veterans, who are frequently contacted by debt collectors because of improper billing.

Maintaining military and veteran cultural competency is also a challenge. Few healthcare organizations have standardized screening or training to ensure care is informed by veterans' unique experiences. I led this effort in a small community hospital as part of our military and veteran healthcare program, and can attest to its complexity. Updating the electronic health record (EHR), revising workflows, and educating hourly clinicians, many of whom have never received formal education on veteran care, is costly. Unfortunately, 48% of rural hospitals operated at a financial loss in 2023 and 92 rural hospitals have either closed or have been unable to continue providing inpatient services over the last decade (American Hospital Association, 2025). With the recent passing of H.R. 1, many rural hospitals are strategizing ways to ensure their doors stay open to serve their communities and would struggle to absorb the costs associated with closing these gaps for veterans.

Crucially, successful implementation of a comprehensive, interoperable EHR is paramount to ensuring the continuity of veterans' healthcare records. Community care providers report the lack of interoperability results in unclear and inconsistent processes for obtaining VA medical records that often lead to work arounds or sometimes duplication of services (Patzel et al.,

2023). This fragmented approach hinders effective treatment and can only be overcome through modernized IT infrastructure that enables real-time, comprehensive data exchange between VAD and community care providers.

Reliance on community care also assumes timely access to local providers, which is not a reality for many rural veterans. In our area, dermatology appointments through private insurance currently have a two to three-month wait time. A recent study showed that even in major cities, average wait times across six specialties were 31 days (Advisory Board, 2025). Over 66% of primary care and nearly 62% of mental health provider shortage areas in the United States are rural (Rural Health Information Hub, 2024). Expanding community care without addressing provider shortages may exacerbate current access issues in these communities if VA resources are lost.

We must acknowledge the value, limitations, and opportunities for improvement in community care. A balanced, bipartisan approach can strengthen this program and ensure it serves our most vulnerable veterans. VA should ensure all eligible veterans are aware of this program, and alternatively, community care providers should be expected to connect veterans to information about their VA eligibility. We know that many eligible veterans are not utilizing their benefits, and community care providers can serve as a vital bridge to VA. This committee should focus on technological solutions to ensure community care is used appropriately, quality standards are being met, and communication is flowing seamlessly between VA and community care providers.

Strong Rural VA Presence

Though community care is integral in ensuring rural veteran access to care, research shows rural veterans report higher satisfaction with VA care (Vanneman et al., 2020). Studies also indicate VA facilities often outperform or match non-VA providers in quality and safety (Apaydin et al., 2023). That's why I urge this committee to prioritize innovation that brings VA services closer to rural veterans.

While telehealth can't replace in-person care, it can extend resources and build connection when used strategically. One woman I served with receives care from three different CBOCs in rural Missouri, each 45 minutes away, but has only interacted with her primary care provider via telehealth. This leaves her feeling disconnected and highlights an opportunity to evaluate when face-to-face interactions are most critical to building trust.

We must also recognize the integral role VA technology teams serve in ensuring high quality patient outcomes. Clinician efficiency depends on streamlined systems. Poorly designed workflows and inadequate training result in precious time lost with patients, which is especially challenging in rural areas with limited tech support and connectivity.

Finally, we must protect the psychological safety of the VA workforce, many of whom are veterans themselves. Several women in our community have felt the impact of recent instability within the VA. Successful deployment of a modernized EHR will rely heavily on a strong, confident workforce, which is only possible when employees feel valued and supported.

This subcommittee is uniquely positioned to lead in developing technologies that expand VA access to our most remote veterans while preserving the human connection essential to care.

Community care is vital, but history shows that well-intended privatization can lead to inequitable services for rural communities, as resources naturally shift to more profitable, urban areas. We see this disparity in healthcare outside of the VA right now. Today, the VA is an equalizer. Despite long travel distances, rural veterans are more likely to use and prefer VA care (Vanneman et al., 2020).

The VA I returned to in 2004 is not the VA we have today. The progress has been intentional and remarkable. Let's continue investing in this transformation and use modern tools to bring care and benefits closer to the rural veterans who have earned them.

Thank you.

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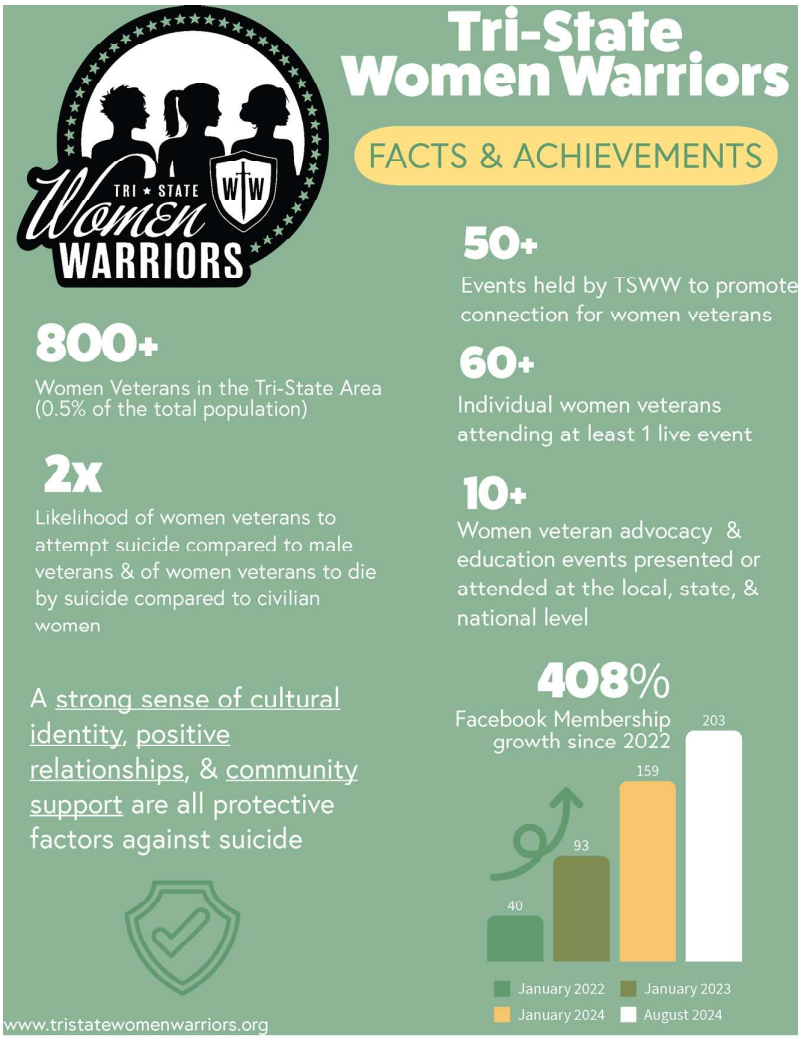
Tri-State Women Warriors
Mission, Vision, & Values

Brief History: Though women are the fastest growing demographic in the military, their lack of representation throughout history has led to significant gaps in support. Women veterans and service members will frequently report lacking a feeling of belonging and visibility, ultimately putting women veterans and service members at risk for a variety of adverse outcomes.
In 2022, several women veterans in the tri-state area not only recognized this gap, but were driven to create a solution. On September 10, 2022, a dozen women came together over brunch to develop a vision for a community created specifically to support women veterans and service members in our tri-state area, and the Tri-State Women Warriors was created.

Mission: Tri-State Women Warriors serve to provide connection and advocacy to support the unique needs of women veterans and service members.

Vision: Any military service members identifying as women will experience unconditional support throughout her time in service, her transition, and her life after service. She will be empowered, strong, and courageous in her journey.

Values:
- Connection
- Advocacy
- Courage
- Strength
- Empowerment


Tri-State Women Warriors
FACTS & ACHIEVEMENTS
TRI ★ STATE Women WARRIORS
800+
Women Veterans in the Tri-State Area (0.5% of the total population)
2x
Likelihood of women veterans to attempt suicide compared to male veterans & of women veterans to die by suicide compared to civilian women
A strong sense of cultural identity, positive relationships, & community support are all protective factors against suicide
www.tristatewomenwarriors.org
50+
Events held by TSWW to promote connection for women veterans
60+
Individual women veterans attending at least 1 live event
10+
Women veteran advocacy & education events presented or attended at the local, state, & national level
408%
Facebook Membership growth since 2022
40
93
159
203
January 2022
January 2023
January 2024
August 2024