



Rural Veterans: A Special Concern for Rural Health Advocates (2013 Update)

Introduction.

Rural Veterans: A Special Concern for Rural Health Advocates has served as the official NRHA policy position on issues of rural veteran health since its publication in February 2007. NRHA has consistently been a staunch advocate for expanding access to care for rural veterans, including improving availability of providers, care delivery mechanisms and provider understanding of the special needs of rural veterans. While national and state focus on rural veteran issues has increased since 2007, measurable progress on better meeting the needs of this important and often forgotten population remains elusive. This paper updates the February 2007 Issue Paper and provides an overview of the current demographic makeup of rural veterans and significant legislative and administrative policy action affecting rural veterans health since 2007.

Background.

As of 2000, there were approximately 26.4 million veterans living in the United States with the highest concentrations found in rural and non-metropolitan counties.¹ Currently, there are approximately 22 million living veterans in the United States with about 6.1 million (28%) living in rural areas.² It is well documented that a disproportionate number of those serving in the military come from rural communities.³ The ratio of military recruits to the general population aged 18-24 in rural areas is more than double that of completely urban areas.^{3(p1)} This overrepresentation is increasingly reflected in the veteran population with rural Americans currently comprising 19% of all U.S. veterans though they comprise only 16% of the general population.⁴ Data also indicate a continuing trend of increasing concentrations of veterans in rural areas even as the overall percentage of living veterans declines.⁵ The demographics of these rural veterans is also shifting as newly separated cohorts of younger veterans replace older veterans and as an increasing number of women and minorities serve and retire from the military. The percentage of women veterans residing in rural areas more than doubled between 1992 and

2011, rising from 3% to 7% and the percentage of rural minority veterans moved from 6% to 10%.^{4(p3)}

Within the Veterans Affairs system (VA) approximately 36% of the total enrolled veteran population and 15% of those seen for at least one service-connected disability are from rural or highly rural areas.^{2(p1)} Approximately 30% of the VA enrolled rural veteran population served in Operation Enduring Freedom, Operation Iraqi Freedom (OEF/OIF) and Operation New Dawn (OND).^{2(p1)} Of those receiving VA benefits, the most prevalent service-connected disabilities are tinnitus and hearing loss, post-traumatic stress order (PTSD), diabetes mellitus, musculoskeletal issues and traumatic arthritis.⁶ As of the end of fiscal year 2012, 1.35 million Gulf War era veterans were receiving service-related disability benefits, followed by 1.21 million Vietnam era veterans, 665,000 peacetime veterans, 145,000 Korean Conflict veterans and 168,000 World War II veterans.^{6(p5)} It is worth noting that PTSD is most prevalent among Vietnam era veterans at 7.5%.^{6(p20)} It is a likely and concerning reality that veterans of Gulf War I, OEF/OIF and the continuing global war on terror may at some point exceed this prevalence rate and it highlights the significance of improving timely access to mental health care in the veteran population.

Issues.

The healthcare issues affecting rural veterans today have consistent themes with issues previously identified. The single largest issue affecting rural veterans remains access to care. The issue of access can be considered in the context of three categories of barriers, (i) geographical barriers, (ii) availability of specialty and primary care providers, and (iii) benefit barriers.

Geographical barriers faced by rural veterans are significant. While data from the Veteran Health Administration (VHA) Office of Rural Health show that more than 75% of VA enrollees meet the VHA access standards of 30 minutes drive time to VA primary care and 90 minutes to secondary care, and slightly more than 90% meet the 240 minute standard for access to tertiary facilities, driving distance continues to be identified as the most important barrier for rural veterans seeking healthcare.^{7,8} In particular, while many rural veterans accept travel time as a

“way of life,” driving distance is reported as a significant barrier by, (i) patients with limited health, functional or financial resources, (ii) patients needing routine specialty or diagnostic services, and (iii) patients needing emergency care.^{8(p5663)} A contributing factor to the geographical barriers faced by rural veterans may be in how the VHA defines “rural.” West *et al*, compared VHA definitions of rural to those used by the Office of Management and Budget (OMB) and in the system of Rural-Urban Commuting Areas (RUCA).⁹ Their study showed that the VHA definition of “rural” is broader than both OMB and RUCA while definitions of “urban” and “highly rural” are more narrow.^{9(p304)} The potential implication of broadly defining rural is that in some contexts it may be possible for VHA travel time standards to be met for a required percentage of participants in a particular veteran integrated service area (VISN) even though travel times are not met for a large geographic component of the VISN.^{9(p308)} This results from inclusion in the definition of rural of certain higher populated areas that may be better classified as urban and may skew assessments by VHA of true service area needs. West *et al* suggest that more actionable rural health policy determinations may result if VHA supplements their analyses of rural by including classifications from other population classification schemes with more narrow definitions.^{9 (308)}

In addition to geographic barriers, rural veterans encounter significant barriers to receiving needed specialty services, particularly routine outpatient specialty services such as audiology, podiatry, physical therapy, gynecology and optometry.^{8(p5652)} A primary barrier to these services lies in the limitations of the VHA contracted provider network for fee-based care. Specifically, local providers are inconsistently included in VHA networks with the end result that many veterans do not have access to these routine specialty services unless they are willing and able to travel significant distance to a central VA facility.^{8(p5652)} Given the most prevalent conditions for which veterans seek treatment include hearing loss, diabetes, and various musculoskeletal conditions, the lack of availability of specialty providers in these areas is particularly concerning. Additionally, the increasing number of female veterans is creating new demand for women’s health services, including basic obstetric and gynecologic services. Given the critical shortage of ob-gyn providers in rural areas in general combined with the fact that VA sponsored community based outpatient clinics are not always staffed to provide ob-gyn services, female veterans are often forced to travel significant distances to VA Medical Centers for women’s

health services.^{8(p5651),10}

Access to mental health specialists is even more limited and warrants specific attention. Rural areas in general suffer from a shortage of mental health specialists and face significant difficulties in recruiting and retaining qualified personnel to meet population needs.¹¹ In the context of the rural veteran these shortages are compounded by inadequate participation of available providers in VHA networks and a decreasing number of civilian providers who participate in the military's TRICARE system.^{12,13} Mental health services in states with largely rural areas typically rank near the bottom in a key VA measure of access.¹⁴ In addition, given the increasing prevalence of PTSD and the often accompanying outcomes of suicide, substance abuse, domestic violence and homelessness, the ability to see a provider trained in addressing PTSD is critical. It is worth noting that while homelessness has historically been significantly more prevalent in the urban veteran population, the issue is becoming an increasing concern in suburban and rural areas. The year-over-year increase for 2009-2010 in the number of sheltered homeless veterans, as reported by the VA in 2012, was approximately 18.5% for suburban and rural areas compared with only 1.3% for urban areas.¹⁵ Lingering effects from PTSD are often attributed as a significant cause of veteran homelessness and the lack of access to trained professionals in rural areas may be a contributing factor to the observed increase in homelessness in these areas.¹⁶

Access to professionals trained in working with PTSD is highly inconsistent.^{14(p1)} While VA has the most extensive expertise in evidence-based treatments for combat related PTSD this expertise is not routinely accessible in many geographic locations and the civilian provider community remains largely untrained in the unique aspects of PTSD in the military veteran.¹⁷ Additionally, veterans of both sexes, but particularly female veterans, encounter even more challenges due to the potential effects of military sexual trauma (MST) on development and severity of PTSD. The Institute of Medicine has recently cited MST as an important risk factor for PTSD development in female service members and a VA research study from 2008 showed a 59% increase in risk for mental health problems for women who experienced MST and a 40% increased risk for men.^{12(p10),18} Accordingly, there is a need for trained mental health and primary care providers who are sensitive to the role of MST in the broader issue of PTSD and

related mental health disorders. This need is particularly acute in rural areas where the population of female veterans is rapidly increasing.

In addition to awareness of experiential factors such as MST, there is evidence that in the rural veteran population, sensitivity to cultural factors may be important in the success of mental health treatment. Specifically, in their study of barriers to care effecting national guard and reserve troops in Appalachia, Bennett *et al* found that rural veterans had more negative views of mental health treatment itself but were less concerned than their non-rural peers with stigma potentially resulting from seeking treatment.¹⁹ The authors attribute this to localized cultural beliefs that individuals can better address issues on their own rather than through professional intervention, views that others are worse off, and trust in their known support system.^{19(p128)} The authors note the implication that mental health care interventions that have been effective in other contexts may be ineffective in various rural veteran populations due to regionalized cultural differences thus necessitating provider awareness of such differences and the ability to adapt intervention methodologies accordingly.^{19(p129)}

The VHA has been increasingly using telemental health services to provide specialty mental health services in underserved areas.²⁰ Telemental health services involves the use of communication technologies, particularly videoconferencing technology, to deliver various mental health services including diagnostic assessments, psychotherapy and medication management. One recent study focusing specifically on potential cost benefits of using telemedicine for delivery of psychotherapy to rural combat veterans suffering from PTSD found that use of clinical videoconferencing did enable veterans who would not otherwise have access to certain psychotherapy interventions to receive empirically based treatment.²¹ Telemedicine holds particular promise for identification and treatment of rural veterans suffering from traumatic brain injury (TBI). Timely treatment of TBI is important for maximizing recovery opportunities.²² TBI can, however, be challenging to diagnose due to co-occurrence with other injury, including PTSD, and symptoms are not always obvious.²³ Compounding the challenges in diagnosis is the fact that there is a shortage of TBI specialists both within the VA health system and the civilian system; a situation made more dire in the rural veteran context.^{23(p1024)} Advances in telemedicine capabilities holds potential to facilitate earlier identification and care

of geographically isolated veterans affected by TBI and potentially reduce negative outcomes, including rates of suicide and homelessness.

The third significant barrier to health care access facing rural veterans relates to medical and insurance benefits. As noted above, patient and provider confusion regarding exactly what VHA benefits are available for what services, particularly in the context of emergency services, creates a disincentive to seek care. This sentiment was reiterated in recent witness testimony during a House Veterans Affairs Committee hearing on the issue of removing barriers to mental health care for veterans.²⁴ Buzza *et al* point out that mistaken beliefs about VHA benefits may be creating a false barrier resulting in delays or avoidance of care.^{8(p5653)} Female veterans are particularly affected by misperceptions regarding eligibility for VA benefits and availability of VA services for women with many believing that the VA does not offer such services or that the health issue must be service connected for eligibility.²⁵ The second benefit related barrier to care is the lack of provider awareness and acceptance of TRICARE benefits. TRICARE is the military health system that leverages military health care resources and civilian resources with the objective of providing a comprehensive health care network for service members and their families. The previously cited Government Accountability Office (GAO) study released in April 2013 analyzed beneficiary survey data from 2008-2011 as part of a larger Congressionally directed effort to analyze adequacy of access to physical and mental health care for certain populations of TRICARE beneficiaries. The study found that 1 in 3 beneficiaries included in the study experienced problems finding a civilian provider who would accept TRICARE.^{13(p22)} The study further found that on average only 6 in 10 civilian providers were accepting new patients with the most common reason for non-acceptance being lack of awareness of the TRICARE program.^{13(p27)} Additionally, the study noted the downward trend in TRICARE acceptance by physicians with acceptance rates having declined by 6% over rates in the 2005-2007 period.^{13(p29)} Particularly concerning is that only 39% of civilian mental health providers were accepting TRICARE patients.^{13(p30)} While these data are not specific to the rural veteran population, given the overall VHA and civilian provider shortage in rural communities these statistics most likely have even more severe implications when applied in the rural context.

While other factors impact the well being of rural veterans, including employment and education opportunities, income level and post-deployment reintegration challenges, access to needed

physical and mental health care remains a top issue for ensuring rural veterans are able to maximize quality of life.


Political and Policy Environment.

Passage of the Veterans Benefits, Health Care and Information Technology Act of 2006 (in which NRHA played a major role) established the VHA Office of Rural Health (ORH) and was one of the most significant efforts by Congress to address concerns about rural veteran issues.²⁶ Since the establishment of the ORH Congress has remained interested in the specific issues affecting rural veterans and has passed significant legislation including, “The Veterans Mental Health and Other Care Improvements Act of 2008” mandating pilot project “ARCH” (Access Received Closer to Home) and “The Caregivers and Veterans Omnibus Health Services Act of 2010” authorizing multiple demonstration projects relating to improving care for rural veterans.^{27,28} In addition, Congress has passed legislation mandating and funding important studies and reports on veterans issues that, while not specific to rural veterans, have important implications for the rural veteran population. Specifically, as part of passage of the National Defense Authorization Act for fiscal year 2008 (2008 NDAA), Congress directed the Department of Defense and the Department of Veterans Affairs to study the health and readjustment needs of soldiers returning home from Iraq and Afghanistan.²⁹ This directive resulted in the previously cited Institute of Medicine Report released March 2013 assessing among other things barriers to physical and mental health care. The 2008 NDAA is also the source of direction to the GAO to produce periodic assessments like those cited herein regarding the ability of TRICARE beneficiaries to access care. Again, while not specific to the rural veteran populations, these reports provide insight into broader trends in service member and veteran health care, the effects of which are most likely magnified in the rural veteran setting. Most recently, on November 7, 2013, S. 1662 the “Veterans Health Care Improvement Act of 2013” was introduced and referred to committee.³⁰ S. 1662 provides for introduction of a pay for performance mechanism in VA contracts for provision of health care services through community based out patient clinics (CBOCs). CBOCs are fixed healthcare facilities that are geographically separate from their parent medical facility.³¹ They may be operated by VA staff and/or contracted staff and services provided may vary by site.^{31(p4)} The parent VA medical facility maintains certain administrative responsibilities for its’ CBOCs, including overall responsibility for maintaining quality of care.^{31(p5)} There are slightly more than 800 CBOCs in

operation with approximately 25% operated by contractors, 64% utilizing leased facilities staffed by VA personnel and 11% VA owned and staffed facilities.^{31(p5),32}

Congress has also evidenced the seriousness with which it views rural veteran issues through its funding and oversight of the ORH. Since inception ORH has received requested budgetary funding averaging around \$250 million per year. In April 2011, in response to a request from Congress, ORH published a Strategic Plan Refresh for Fiscal Years 2012-2014 more clearly articulating how funds are and will be applied to improve care for rural veterans. The clarified plan and the continuing interest of Congress in ORH activities provides rural health policy makers with better opportunity to participate with ORH in ensuring that funds are directed to areas where they can have the most benefit for the rural veteran.

It seems appropriate at this juncture to discuss the implications of the Patient Protection and Affordable Care Act of 2010 (ACA) on rural veteran health care. As a starting point, the ACA does not affect those enrolled in or eligible for VA benefits and has no direct impact on co-payments, benefits provided or other aspects of the VA system.³³ Similar to the non-veteran population, the ACA will provide uninsured veterans the opportunity to buy health insurance through the health insurance marketplace, may provide greater choice in provider access outside of the VA system, and may provide some cost advantages, though all of this remains to be seen. The Department of Veterans Affairs noted in its FY 2013 Funding and FY 2014 Advance Appropriations request that while VA hospitals outperform non-VA hospitals on most all performance metrics, the ACA will provide veterans with the ability to weigh cost, quality and accessibility in choosing their health care provider.³⁴ Choice may or may not be a positive development. Dr. Kenneth Kizer notes in the 2012 Viewpoint published in the Journal of the American Medical Association that choice may result in more fragmented care for veterans and may also result in some patients being seen by providers who are ill equipped to diagnose and address certain veteran specific issues such as combat related post-traumatic stress.³⁵ Additionally, the anticipated influx of previously uninsured non-military individuals to an already overstretched health care system may exacerbate access problems faced by veterans, particularly in rural areas that are already struggling to meet provider demand. The expanded coverage for mental health services provided under the ACA may have a particularly detrimental



affect on veterans as the already low number of available mental health professionals will now be encountering significantly larger non-veteran demand. This can reasonably be expected to be most acute in the already underserved rural veteran community.

On balance the ultimate impact of the ACA on rural veterans will not be known for several years. In the interim, it is incumbent on all veteran health advocates, especially rural veteran health advocates, to be attentive to ACA induced trends that may negatively affect veteran care. It is important that this special and deserving population of those who have served and sacrificed for their country do not get disadvantaged by a law intended to benefit all.

Conclusions and Recommendations.

In summary, health care for rural veterans continues to be most affected by issues of access. Barriers are most commonly related to geographic distance, availability of specialty and primary care providers, and health benefit considerations. There is a concerning lack of understanding by patients and providers regarding VA benefits (i.e. what is covered and where), and there is an equally concerning lack of awareness in the provider community of the TRICARE system. The VA continues to inconsistently utilize local non-VA providers, especially those providing much needed routine specialty services. Telemedicine and expansion of the VA CBOC network both have potential to improve rural veteran access to needed care but further research quantifying increases in access and the effect on health outcomes is needed, along with cost-effectiveness analysis. The political and policy environment is conducive to efforts to improve access to care for rural veterans with both Congress and the executive branch paying specific attention to this special class of veteran. The ACA has the potential to result in negative unintended consequences for veterans, particularly rural veterans, and merits watching by the veteran health advocacy community.

Set forth below are recommendations for action to ensure progress in meeting the health needs of rural veterans. While all of the recommendations are important for advancing the interests of rural veterans, priority attention must be given to addressing issues within the Non-VA Care Program. With that in mind, it is recommended that:

- The VA develop and implement policies that encourage use of the Non-VA Care Program in a consistent manner across all VISNs and that reflect a “best interest of the veteran” standard for utilization determinations.
- The VA evaluate and expand its network of fee based specialty providers within the Non-VA Care program to ensure alignment with the most prevalent out-patient specialty needs of rural veterans.
- The VA standardize and streamline policies regarding use of non-VA providers to better facilitate provider participation in the “Non-VA Care Program” and to expedite access for veterans to locally provided health care services, particularly specialty services.
- The VA evaluate and review its policies concerning contracting with local rural health providers to operate and manage CBOCs as a means to increase access points of care for rural veterans.
- The VA expand training programs for non-VA rural providers on evidence based military, deployment and post-deployment health and mental health diagnoses and treatment.
- The VA through its Office of Academic Affiliations increase its role in the training of undergraduate and post graduate health professionals’ education in evidence based diagnosis and treatment of military related health and mental health conditions and treatments across the trainee populations.
- The VA develop a benefit education outreach program that provides clear information for patients and providers on what services, especially emergency services, are covered by VHA. Materials need to be readily accessible, easy to understand, and structured to encourage rather than deter seeking of care, especially needed emergency care.
- The DoD and VA develop a TRICARE health care provider education and awareness program to inform providers about the TRICARE program and how to participate.
- The DoD and VA develop a strategy specifically focused to materially increase the percentage of mental health providers willing to participate in the TRICARE program.
- The VA develop a consistent methodology for assigning definitions of urban, rural and highly rural that uses a variety of recognized classification schemes in order to ensure classifications are assigned in a manner that maximizes the ability to deliver timely services to all veterans located within a particular VISN.

- The VA establish and report on quantitative and qualitative metrics that evaluate improvement in rural veteran health care access and health outcomes generated by ORH strategic plan initiatives.
- The VA actively monitors impacts of the ACA on rural veterans' access to care and takes proactive steps to mitigate any negative unintended consequences.
- The VA continue to invest in research and application of telemedicine technologies to advance care, particularly mental health and brain injury care, for rural veterans.
- Congress evaluates ORH progress against milestones and objectives set forth in the ORH Revised Strategic Plan for FY 2012 – 2014.
- Housing and Urban Development (HUD)continue efforts to implement policies to expand the classification of “chronic homeless” to maximize the number of rural homeless veterans eligible for homeless services within HUD, VA, and other federal, state and local programs.
- Congress continues its commitment to rural veterans by funding ORH at requested levels for FY2014 and FY2015, funding demonstration projects related to increasing use of telemedicine and related remote care delivery systems, and funding expansion of the CBOC network and alignment of service offerings with the needs of rural veterans.

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