# Rural Veterans:
## A Special Concern for Rural Health Advocates

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National Rural Health Association

NRHA Policy Brief

### Background

Since the founding of our country, rural Americans have always responded when our nation has gone to war. In the American Revolution, rural Americans left their homes and their families to protect their families and their lands. During the American Civil War, rural Americans again responded to preserve their way of life, and to protect their families. However, during the Civil War, the United States government instituted the military draft. Again, motivated by tradition and values, rural Americans responded in order to maintain value structures reflective of volunteerism, care of home, a sense of place, for economic concerns, and certainly through patriotism.

Whether motivated by their values, patriotism, and economic concerns, the picture has not changed much in 200 years as urban African Americans, Hispanics, American Indians and rural whites, serve and sometimes die at rates higher than their percentage of the population. American Indian veterans have served at these higher rates, and many have returned to their tribal lands located in rural and frontier parts of the country, communities with inadequate access to health care. During the Vietnam War when African Americans were dying at higher rates, Congressional pressure caused President Johnson to curtail the recruitment of African Americans.

As recent as April 3, 2004, NPR reported the research of Robert Cushing, which indicates that soldiers and Marines from rural areas are dying at twice the rate of military personnel from the cities and suburbs. According to a recent report, 44 percent of all soldiers killed during Operation Iraqi Freedom were from communities under 20,000.[1] In a Washington Post story by Bill Bishop, who also reported on Cushing's work, the toll of rural dead in Iraq appears to be a new phenomenon.[2] The military does not keep data on the size of the hometown of recruits or draftees; therefore, existing data could not prove otherwise. However, one could only drive by throughout rural American communities and towns and be struck by the number of memorial markers listing the hometown boys who died in generations of wars, and their numbers would appear large compared to the size of the community.

### Issue

In the history of military enlistment, rural Americans have viewed the military as an opportunity for skills training and a means to acquire educational benefits. For some rural individuals with low-income and limited education, military service was and continues to be seen as a way to gain employable skills. With the military draft, some individuals could be exempted from service for a variety of reasons, i.e., the only son of a family or an aging or widowed mother, college deferment, etc. During the Vietnam War era, however, low-income individuals who were not in college by choice or due to the lack of resources, rarely had access to consultation on methods to avoid the draft[3] and the dilemma of not serving was for many inconsistent with their family values. Vietnam era veterans represent the largest veteran population at

8.4 million or 31.7 percent of the total veteran population.[4] For these reasons, rural and disadvantaged people are disproportionately represented in today's veteran populations.[5, 6]

Many rural and non-metropolitan counties had the highest concentration of veterans in the civilian population aged 18 and over[7] from 1990 to 2000 according to the 2000 US Census.[8] Roughly 14.4 percent of the population of West Virginia, the second most rural state in the country as indicated by percentage of the state population living in rural areas, are veterans and for Vermont, the most rural state, this figure is 13.6 percent. Among the veteran populations in these rural states, 35.9 percent are Vietnam veterans in West Virginia, and 34.6 percent in Vermont.[9] The disproportionate representation among rural Americans serving in the military has created disproportionate care[10, 11] for our nation's veterans. The dispersed nature of the populations in rural and frontier areas should be a significant concern for rural health advocates, as the proportion of veterans living in rural areas is highest in Montana (16.2 percent), Nevada (16.1 percent), Wyoming (16 percent), and Maine (15.9 percent). These states also have higher rates than the nation: Florida (15.3 percent reflects retirees), Oregon (15.1 percent), Washington (15.1 percent), Arizona (15 percent also reflects retirees), Virginia (15.1 percent), New Hampshire (15 percent), Idaho (14.8 percent), Oklahoma (14.8 percent), New Mexico (14.7 percent), South Dakota (14.5 percent), West Virginia (14.4 percent), Arkansas (14.2 percent), South Carolina (14.2 percent), and Colorado (14.1 percent). All of the rates in these states are above the national average of 12.7 percent.[12]

The mental health needs of combat veterans deserve special attention and advocacy as well. Veterans from the baby boom generation through and to the present generation, i.e., those veterans from World War II, the Korean War, the Vietnam Conflict, the Gulf War, and the ongoing War on Terrorism number in the millions. Only since 1980 has the American Psychiatric Association accepted the term "post-traumatic stress disorder or PTSD."[13] Over the past few decades the mental health community began to study[14, 15] and appreciate the deep psychological impact of war and come to understand the ravages of PTSD. The problems of PTSD for many veterans and their loved ones are exacerbated by the fact that although previous and current war veterans receive the traditional heroes welcome upon their return from the war, such was not the case for the returning Vietnam Veteran, and this societal rejection complicates veteran identity and their openness to seek care.[16, 17]

National rural health leaders and advocates need to be especially concerned about access to care and services for this special population of rural people, because the normal barriers to health and mental health care access for rural people[18] are compounded if the rural person is a combat veteran. There is a national misconception that all veterans have access to comprehensive care because they are served by the Veterans' Administration.[19] While this may be true for many veterans, it is not true for many small town and isolated rural veterans; those isolated by living in rural remote areas or isolated by choice[20] due to the complicated symptoms of PTSD. The VHA provided health care to 4.5 million of the 7.2 enrolled veterans in fiscal year 2003. While the quality of VHA care is equivalent to, or better than, care in other systems[21], it might not be accessible to rural and frontier veterans. In addition, VA Services are not always adequately funded. The VA Medical Care appropriations from 1996 to 2000 were only increased by slightly more than 2 percent.[22] The increase in 2003 was slight, and the VA's Under Secretary for Health estimate of a "13 to 14 percent increase fell short just to maintain current services".[23] This should cause alarm for policy makers and rural health advocates because the young wounded American serving in Iraq, Afghanistan, and other theaters of our war on terror today, will still need these benefits in 2060.[24]

## Access to Primary Care

The Vietnam veterans' distrust of established governmental services, more pronounced than other generations of veterans, complicates access to available VA services. The distrust is one of the primary reasons that the Vet Readjustment Centers were created to provide "storefront" operations for veterans to ease access issues.[25] Today, there is some evidence that the military has learned from the Vietnam War veterans' experiences at re-entry into society. Soldiers returning from our war in Iraq are receiving readjustment counseling with their family members.

There are disparities and difference between rural and urban veterans in health status and this issue deserves further study. Researcher from the VA's Health Services Research and Development network have reported comparisons between rural and urban veterans and concluded that rural veterans "have worse physical and mental health related quality of life scores. Rural/urban differences within some service delivery networks and US Census regions are substantial…" "The impact of this research is that policy makers should anticipate greater health care demands from rural populations and pursue innovative strategies to meet their health care needs."[26]

Time and distance prevent up to four million rural veterans from getting their healthcare benefits through a Veterans Hospital Administration (VHA) facility. There are three approaches readily available that could improve this situation.

1. The Community-Based Outpatient Clinic (CBOC) program funded by the VA opens the door for many veterans to obtain primary care services within their home community. The VHA has established over 450 new CBOCs since 1995. In 2001 the VHA improved procedures for planning and activating CBOCs and established consistent criteria and standard expectations for CBOCs.[27] While successful, however, this change also included changes in market penetration levels, which may prevent many rural providers from being eligible to become a CBOC. This may force rural veterans to drive further distances to reach basic primary care needs and eliminate "willing providers" in rural areas access to VHS funding through the CBOC program. In March 2000, the VA Health Services Research and Development agency issued an internal publication on the CBOC Performance Evaluation Report 2. This study looked at a small number of CBOCs in the areas of cost of patient visits and access. Their findings indicate that, "CBOC patients appear to have higher primary care costs but lower total costs per patient than primary care clinic patients at the parent VAMC  CBOCs significantly improve geographic access for veterans. These findings suggest that CBOCs have been successful in improving geographic access, an important objective of expanding community-based care to veterans."[28]

2. In addition, while federally funded Community Health Centers (CHCs) serve millions of rural Americans, veterans cannot use their VA health benefits to receive care at these CHCs. These centers provide community oriented, primary and preventive health care and are located where rural veterans live. In some states, CHCs have received CBOC designation and funding for specialty veteran clinics, such as in New Mexico. Such models might do well in other rural states.

3. The VHA has a tremendous computerized patient record system that will give each veteran a password so that the veteran's records can be accessed through the Internet. If veterans were permitted to use their VA services through local rural providers, the veteran could give this password to the provider of their choice to get privileges to view this

patient record. This system could be used for e-mailed appointment reminders, specialty referrals, reports, and updates to the master patient record.

Congress has passed legislation encouraging collaborations (P.L.106-74 §1 Title§§108 (a) and P.L. 106-117 § 102(e) The Millennium Health Care & Benefits Act). Despite the expression of legislative intent and the successful outcomes of existing contracts, a national policy advocating VHA-CHC collaboration has not emerged. Local Veterans Affairs Medical Centers (VAMCs) lack knowledge of the CHC services available and the potential benefits possible for veterans.

A limited number of collaborations between the VHA and CHC's already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas. Successful contracts exist in Wisconsin, Missouri, and Utah. In other States, contracts were successful but were discontinued for reasons not related to operational success. CBOCs have also been successful in some states, such as West Virginia; however, the recent federal regulatory limits now make this solution less available to more rural and remote veterans and other rural providers.

**Mental Health Services**

Limited mental health resources in rural areas make access to these services difficult.[29] Compounding the problem is the fact that mental health providers are not always trained to recognize the symptoms of PTSD.[30] Outpatient services may not be available to treat those who are diagnosed.[31, 32]

The last national study of the readjustment issues of Vietnam Veterans was in 1988.[33] This study, The National Vietnam Veteran Readjustment Survey, found that 15.2 percent of male and 8.5 percent of female Vietnam veterans currently have PTSD, approximately 486,500 men and women. Added to the total are veterans who suffer from "partial PTSD" (i.e., clinically significant stress reaction symptoms of insufficient intensity or breath to quality for full PTSD, but may warrant professional attention).[34] PTSD by definition is a delayed response and can have a long-term course.[35] These two facts could raise the numbers of veterans with full or "partial PTSD" in need of help and support to be 1.5 million.[36] The VA's own committee on PTSD has reported that there are not enough specialized PTSD programs now to serve veterans' needs, that access is a problem in many areas, and that those veterans with substance abuse may be even more underserved. "But what is clear is that the professionally recognized standard of care that should be available of any person suffering from serious mental illness is not available through VA, even to the many veterans who are service-connected for a serious mental illness."[37]

In the intervening years since 1974, Vietnam era veterans have entered into mid-age and the early years of retirement age. The average age of the Vietnam veteran is now 56. The Vet Outreach Centers have made significant strides to help these veterans readjust and improve their coping skills with PTSD[38] and other disabilities associated with combat experience. There are some very encouraging efforts currently regarding the mental health needs of our present generation of combat veterans serving in Iraq and other fronts in the war on terrorism. The US Army sent a mental health assessment team to meet with soldiers in Iraq and Kuwait between August and October, 2003. Their findings released to the public on March 25, 2004 indicated that the suicide rate for U.S. soldiers in Iraq and Kuwait last year was 17.3 per 100,000. This compares to a rate of 12.8 for 2003 for the whole US Army and to 11.9 for the whole US Army from 1995 to 2002. In 2001 the civilian rate was 10.7 per 100,000 and for persons aged 18-34 (the age range of most soldiers) it was 21.5. per 100,000.[39] The fact that the US Army is studying this issue in a war

zone, which is very rare, is evidence of an increased awareness of and concerns for the mental health needs of combat veterans. Maybe this is a lesson learned from the experiences of our Vietnam War generation that now benefits our current generation of soldiers.

Knowing that the character of PTSD impacts not only the veteran but also his or her loved ones, the number of rural people now suffering with the impact of PTSD from combat related experiences is staggering, and represents a national crisis of health care. The veteran's need for a functional and integrated family support system becomes even more critical as he or she ages and coping skills decline. A healthy supportive family can become the first line of defense to prevent homelessness, and other more costly forms of care and services for these vets, yet Vet Outreach Centers (if they can afford it) can offer only psycho-social educational classes for family members and significant others, and are not required to do so. Only those Centers with substantial budgets hire trained family therapists, and again they are not required to do so.

**Recommendations**

- The NRHA calls on lawmakers to develop an on-going mechanism to study and articulate the needs of this population, seeking in particular the needs of rural veterans and their families. This information is needed for policy makers and service providers to continually adjust to the changing needs of this population as it ages.

- The NRHA urges Congress to review and consider the recommendations in the 2005 Independent Budget of the Veterans Service Organizations, which call for adequate funding for VA services.

- The NRHA urges the Veterans Administration to support the use of local providers by contracting with them for care delivery when necessary. NRHA also supports the education of providers about such avenues for CBOCs and other eligible contracting processes. Without access to VA care, care simply does not exist for our nation's rural veterans. This could be achieved by collaboration between The Department of Health and Human Services and the Department of Veterans Affairs to establish policy whereby the VHA will contract with local CHCs and other primary care providers in rural areas, to provide primary and preventive healthcare to rural veterans who lack reasonable access to VHA facilities.
    * Develop a joint DHHS-VA policy for contracting for services between the VAMCs and CHCs and other rural providers
    * Establish an interagency team to facilitate contracts
    * Educate CHC grantees and other rural providers about opportunities for such collaborations
    * Co-sponsor educational offerings with the Department of Veterans Affairs on the provision of services for underserved, rural populations, including VAMC/CHC collaborations
    * Allocate funding to contracted CHCs for necessary infrastructure to participate in the VHA's computerized patient record system

- NRHA urges Congress to allocate funding for infrastructure development for rural providers who serve veterans to participate in the VHA's computerized patient record system. This recommendation urges the VA to develop ways for entry into the record by primary care providers at various levels.

- NRHA urges the VHA to re-examine the rescission of VHA Directive 2001-060 which changed the Priority user levels for market penetrations in proposed CBOC market areas, making areas with lower penetrations not eligible to apply for CBOCs.

- The NRHA supports the recommendation of the Independent Budget for 2005 of the Veterans Services Organizations that Congress must incrementally augment funding for specialized treatment and support for veterans who have mental illness, PTSD, or substance abuse disorders by $500 million each year from FY 2005 through FY 2009.

- NRHA urges the VA to include funding and technical support to Vet Outreach Centers to provide supportive counseling services for veterans' families and significant others in an effort to increase the competency of the family members to provide support for the veteran. This competency would include increased capacities for resiliency, coping skills, and accessing self-help support groups.

- The NRHA calls on Congress to dedicate a reasonable percentage of the overall VA health care budget towards rural veterans' care. NRHA supports existing legislation and regulatory policy that make local area care and services available and more accessible to veterans. To this end, NRHA supports H.R. 2379, the Rural Veterans Access to Care Act, and H.R. 3777, the "HEALTHY Vets" Act of 2004.

- NRHA supports development of a mechanism to allow providers to access formulary benefits for veterans.

- The NRHA calls upon the Veterans Administration to issue a yearly update to the nation on the health/mental health status of rural veterans and their systems of care.

**Conclusions**

Rural health advocates and policymakers need to be aware of the special and unique needs of rural veterans and their families, and of the demands these needs present to the existing rural health care delivery system. The current barriers to access for all rural people exist for rural veterans and their families. Policy makers need to prepare for the demand for geriatric, psychiatric, and all forms of long-term care for veterans as these will increase significantly relative to acute care as the largest group of veterans (Vietnam era) age. Nursing home care policies, programs, and services will require continual monitoring and re-assessment.[40]

While the VA will continue to be a "safety net" for veterans with no insurance or with insurance coverage problems, policy makers need to take advantage of other rural health systems that could reach veterans in rural and frontier areas as these serve as the "safety net" for all rural people.

As the largest war period group, Vietnam era veterans will be making up an increasing proportion of veterans receiving VA pensions[41], policy makers need to be cognizant of the demands this presents to the federal budget and continually assess the needs of this population of veterans relative to their rates of poverty.

We must do a better job of caring for those rural individuals and their family members who by choice or otherwise pay a dear price for serving our country.

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