

National Rural Health Association

Issue Paper

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Rural Veterans: A Special Concern for Rural Health Advocates

Background

On December 31, 2006, the United States marked the milestone of the 3,000th casualty in the war in Iraq.¹ Spc. Dustin R. Donica, 22, of Spring, Texas, was killed in Baghdad. Spring is a town of just over 36,000 near Houston. While Donica was not from a rural or small town, 27 percent of those who have been killed in Iraq are from rural areas while only 19 percent [the NRHA cites more than 20%] of our nation lives in rural areas and small towns.² During World War II, 30 percent of all wounded soldiers died of their injuries, a number that dipped to 24 percent during the Vietnam War and then to 9 percent for the Iraq conflict. Though this is a positive development, it also means that more soldiers are coming home with life-changing injuries, including amputations and brain trauma. More than 22,000 soldiers have been wounded in Iraq.³ For those wounded veterans returning to their rural homes and small towns across this country, the specialized services they will need may be limited. Their access to primary care is critical to their readjustment to civilian life and adaptations to living with their injuries are also limited. Support programs for family members of veterans are also limited. As rural health advocates, members of the NRHA are deeply concerned about this issue.

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 fight the threat of loss to their families and their lands. During the American Civil War, rural Americans again responded to fight the threat of loss to their way of life, and to protect their families. However, during the Civil War the United States government instituted the first-ever military draft. Again, motivated by tradition and values, rural Americans responded. Rural people respond to such needs because they maintain value structures that are reflective of service to others and service to their country,⁴ volunteerism, care of home, and a sense of place. They also respond for economic concerns and certainly through patriotism. Whether motivated by their values, patriotism, and/or economic concerns, the picture has not changed much in 200 years. "More than 44 percent of U.S. military recruits come from rural areas, Pentagon figures show. In contrast, 14 percent come from major cities. Youths living in the most sparsely populated Zip Codes are 22 percent more likely to join the Army, with an opposite trend in cities. Regionally, most enlistees come from the South (40 percent) and West (24 percent)."⁵

¹ "U.S. Sustains 3,000th fatality in Iraq." Associated Press, January 1, 2007.

² Harriman, P. "Rural Areas Hardest Hit by War: SD Ranks Third Among States for Its Death Rate. Sioux Falls Argus Leader. December 18, 2006.

³ Alvarez, L. and Lehren, A. "3,000 deaths in Iraq, Countless Tears at Home. New York Times. January 2, 2007.

⁴ Harriman, P.

⁵ Tyson, Ann Scott. "Youths in Rural US Are Drawn to Military." The Washington Post. November 4, 2005.

Minorities serve in the U.S. military at higher rates than their representation in the U.S. population. 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.

Approximately 26 percent of those killed in Iraq are minorities. This is nearly the same as in the Gulf War at 24 percent, but much greater than in the Vietnam War at 14 percent or Afghanistan at 19 percent. Reservists and the National Guard are bearing a significant proportion of the casualties, accounting for about one-quarter of all U.S. deaths since the war began.⁶ The Afghanistan and Iraqi wars have engaged significantly higher numbers of women, and minority women, and reservists and guardsmen than at any other time in our history.

In April 2004 the popular press began reporting on the research of Robert Cushing that indicated that soldiers from rural areas were dying at twice the rate of military personnel from the cities and suburbs. Forty-four percent of all soldiers killed during Operation Iraqi Freedom (information as of February 5, 2004) were from communities under 20,000.⁷ In a Washington Post story by Bill Bishop, who also reported on Cushing's work, he stated that the toll of rural dead in Iraq appears to be a new phenomenon.⁸ Rural veteran advocates could argue with this statement. Only in very recent years has the military kept data on the size of the hometown of recruits, therefore, existing data from previous war eras could not prove otherwise. One

only needs to drive throughout rural American communities and towns to observe 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. However, these same individuals have cultural and personal values that also direct them into the service of others and for some rural people, the military is just another way to serve others and their nation. When the military draft was in use, some individuals could be exempted from service for a variety of reasons, that is, 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 a lack of resources, rarely had access to consultation on methods to avoid the draft⁹ 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.¹⁰ Following the attacks on September 11, 2001, the military saw significant voluntary enlistments to serve our nation, and many of these volunteers came from rural America. For these reasons, rural and disadvantaged people are disproportionately represented in today's veteran populations.^{11, 12}

Many rural and non-metropolitan counties had the highest concentration of veterans in the civilian population aged 18 and over¹³ from 1990

⁶ Friedman, JS. "The Iraq Index." *The Nation*. December 19, 2005.

⁷ "Iraq War Takes Uneven Toll at Home," April 3, 2004: NPR All Things Considered.

⁸ Bishop, B. "Who's Gone to War." November 16, 2003. *The Washington Post*. P. B05.

⁹ Peters, C., Lessard, S. "Let Those Hillbillies Go Get Shot." *The Washington Monthly*: April 1972: 6.

¹⁰ "Veterans: 2000 Census Brief." US Census Bureau, US Department of Commerce, Economics and Statistics Adm., May 2003: 2.

¹¹ "1990 Vet Population from 1990 Census Metropolitan Status by State," United States Census Bureau, 1990.

¹² "Veterans: 2000 Census Brief," p.p. 1-11.

¹³ "Veterans: 2000 Census Brief," p. 7.

to 2000, according to the 2000 U.S. Census.¹⁴ 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, is 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.¹⁵ The disproportionate representation among rural Americans serving in the military has created disproportionate care^{16, 17} 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 Alaska (17.1%), Montana (16.2%), Nevada (16.1%), Wyoming (16%), and Maine (15.9%). These states also have higher rates than the nation: Washington (15.5%), Florida (15.3% reflects retirees), Oregon (15.1%), Arizona (15% also reflects retirees), Virginia (15.1%), New Hampshire (15%), Idaho (14.8%), Oklahoma (14.8%), New Mexico (14.7%), South Dakota (14.5%), West Virginia (14.4%), Arkansas (14.2%), South Carolina (14.2%), and Colorado (14.1%). All of the rates in these states are above the national average of 12.7 percent.¹⁸

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 wars in Iraq and Afghanistan, number

in the millions. Only since 1980 has the American Psychiatric Association accepted the term "post-traumatic stress disorder or PTSD."¹⁹ Over the past few decades the mental health community began to study^{20, 21} 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 true for the returning Vietnam Veterans and this societal rejection complicates veteran identity and their openness to seek care.^{22, 23} 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 people²⁴ are compounded if the rural person is a combat veteran.

An independent non-government supported Commission on the Future for America's Veterans was established on September 11, 2006.²⁵ This commission began holding town hall meetings across the country to hear from veterans and their families on their current and future needs. The first of these commission meetings was in Charleston, West Virginia, on January 17, 2007. Sen. Robert C. Byrd, D-WV, in a letter to the commission, said access to VA programs should be expanded to rural areas. "Too often veterans in our state are effectively denied the best health-care options because specialized medical procedures have been con-

¹⁴ <http://factfinder.census.gov/servlet/SAFFP>

¹⁵ "Veterans: 2000 Census Brief." US Census Bureau, US Department of Commerce, Economics and Statistics Adm., May 2003: 5.

¹⁶ Veterans Health Administration, April 2000, "A Report By The Planning Systems Support Group, A Field Unit of the Veterans Health Administration Office of Policy and Planning-Geographic Access to Veterans Health Administration (VHA) Services in Fiscal Year 2000: A National and Network Perspective.

¹⁷ Miller, Laura J., June 2001, "Improving Access to Care in the VA Health System: A Progress Report", Forum, A publication of the Veterans Administration Office of Research & Development.

¹⁸ "Veterans: 2000 Census Brief," p. 5.

¹⁹ Kulka, RA, Schlenger, A., William, E, Fairbank, JA, Hough, RL, Jordan, BK, Marmar, C. Trauma and the Vietnam War Generation. Levittown, PA: Brunner/Mazel; 1990: v.

²⁰ Matsakis, A. Vietnam Wives. Lutherville, MD: The Sidran Press, 1996: 6.

²¹ Kulka, et. al., 3-15.

²² Barnett, A, Stanley, T. Shore, M, Sept/Oct. 1992, "Vietnam War Casualties Author's Notes." Ops research, Vol. 40, NO. 5

²³ Gelsomino, J., Spring 1992, "Veterans Resource Centers", NCP Clinical Quarterly, 2(2).

²⁴ Demakis, JG., Jan. 2000, "Rural Health-Improving Access to Improve Outcomes", Management Brief Health Services Research & Development Service, NO. 13:1-3.

²⁵ <http://future4vets.org/wordpress/about>

solidated in other states," Byrd wrote. "Driving five hours to a more distant VA hospital is simply not a realistic solution for many veterans."²⁶

There is a national misconception that all veterans have access to comprehensive care because they are served by the Veterans Administration.²⁷ 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 choice²⁸ due to the complicated symptoms of PTSD. The Veterans Hospital Administration (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,²⁹ 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.³⁰ The increase in 2003 was slight, and the VA's Under Secretary for Health estimate of a "13 percent to 14 percent increase fell short just to maintain current services."³¹ 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 2060.³²

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.³³ Today, there is some evidence that the military has learned from the Vietnam War veterans' experiences at reentry into society. Soldiers returning from our war in Iraq are receiving readjustment counseling with their family members. However, these services for returning soldiers are offered upon their immediate return and these soldiers are told they would have to stay at the base for these services for two weeks. When these soldiers and guardsmen return and are in the company of their family and loved ones, they just want to go home and, therefore, many reject this offer of voluntary services. In addition, many symptoms of PTSD and other emotional issues do not show up for months or sometimes years following the exposure to the traumatic events of war.³⁴

There are disparities and differences between rural and urban veterans in health status and this issue deserves further study. Researchers 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 U.S. 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."³⁵

Time and distance prevent up to 4 million rural veterans from getting their health care benefits through a VHA facility. There are two approaches readily available that could improve this situ-

²⁶ Steelhammer, Rick. January 17, 2007, "Veterans Panel Hears Suggestions." The Charleston Gazette.

²⁷ Gardner, Jonathan, Nov. 1998, "Politics, Veterans' Needs Shape System", Modern Healthcare, Vol. 28, Issue 47: 50.

²⁸ Sorenson, G., "Hinterlands are home, not a hideaway, for Vietnam veterans," Vet Center Voice, Vol. VI, No. 9, October, 1985, p.1.

²⁹ The Independent Budget for 2005: Medical Care. Veterans Service Organizations. <http://www.pva.org/independentbudget/index.htm>

³⁰ The Independent Budget for 2005: Medical Care. p. 42.

³¹ The Independent Budget for 2005: Medical Care. p. 44

³² The Independent Budget for 2005: Medical Care. p. 45.

³³ Kulka, et. al., 5.

³⁴ Friedman, MJ. "Posttraumatic Stress Disorder among Military Returnees from Afghanistan and Iraq," Am J Psychiatry 163:4. April 2006, p. 587.

³⁵ Weeks, WB, et. al. March 2004. Differences in Health Status in Rural and Urban Veterans. Presented to the 22nd National Meeting of HSR&D. Washington, D.C.

ation. These models include the VA's own Community-Based Outpatient Clinics (CBOCs); VA Outreach Centers and Clinics; and opening up existing Community Health Centers, Critical Access Hospitals, Rural Health Clinics and other rural health providers to collaborative models of care with the VA for those veterans who live in the service areas of these facilities.

The 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.³⁶ 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 Report². 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 Veterans Affairs Medical Center (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."³⁷

In addition, while federally funded Community Health Centers (CHCs), Rural Health Clinics (RHCs) and Critical Access Hospitals (CAHs) as well as other rural health facilities, serve millions of rural Americans, veterans cannot use their VA health benefits to receive care at these facilities. CHCs 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.

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 and other rural health provider services available and the potential benefits possible for veterans.

A limited number of collaborations between the VHA and CHCs already exist and have proven to be prudent and cost-effective solutions to serving eligible veterans in remote areas. 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.

Access to Specialized Rehabilitation, Physical Medicine, Neurology, and Mental Health Services for Traumatic Brain Injury (TBI), Polytrauma, Blindness, and PTSD

Every war throughout history has been marked by a "signature wound." A significantly high number of combat military personnel suffer from this signature wound and medical science studies the individuals with these wounds to add to knowledge of diagnosis and treatment.

³⁷ Maciejewski, M., et al. CBOC Performance Evaluation Report 2, VA HSR&D, March 2000. http://www.hsr.d.research.va.gov/publications/internal/cbocpt2/cboc_performance_report2.htm

For example, high tech body armor is saving lives in Iraq, yet the protective systems are not sufficiently preventing brain damage due to the high force and percussion of improvised explosive devices (IEDs). As of November 2006, 22,600 U.S. soldiers were wounded in Iraq and Afghanistan. Blast injuries from IEDs are by far the most frequent injuries, and 59% of the wounded at Walter Reed³⁸ were found to suffer traumatic brain injury (TBI) and 'polytrauma,' making TBI the signature wound of this current war. As of January 2006, 19,989 traumatic injuries were reported by the Department of Defense. More than 11,000 of these had been exposed to blast injuries (IEDs). Of these TBI studies, 24 percent were found to have sufficient TBI to have associated visual disorders, photophobia, and ocular-motor manifestations known as Post-Trauma Vision Syndrome (PTVS). The use of body and vehicle armor is attributed with the lowering of the death rate due to combat injury, however, the treatment costs for the resulting TBI and other physical disabilities, PTSD, and blindness are staggering. TBI can present life-long impairments and disabilities that are physical, cognitive, behavioral, emotional, and social. The impairments associated with TBI include communications disorders, cognitive and emotional disturbances, motor impairment, attention and memory impairment, sensory impairment, personality and intellectual changes, delirium, and mood psychotic and addictive disorders. Blinded Veterans Association data compiled between March 2003 and April 2005 found that 16 percent of all casualties evacuated from Iraq were due to direct eye injuries.³⁹

The Department of Defense and the VA have joined resources and expertise and have developed the Defense and Veterans Brain Injury Center and TBI care network to augment VA services. This network consists of 10 national

centers providing highly specialized diagnostic, treatment, and rehabilitation services for veterans suffering from TBI and PTSD.⁴⁰ Nine of these network centers are VA facilities and one is a civilian hospital. Only two of these facilities are located in states with high numbers of rural veterans—Virginia and Florida. The other seven facilities are all located in metropolitan areas on the east and west coasts in Texas, and Minnesota. For those rural veterans with TBI, access to these facilities will come at the cost of separation from their families for extended periods of time.

The VHA maintains a TBI Case Manager Network to assist veterans and their families to adjust to the return to home or other living situations.⁴¹ The current service protocols of this network include a five-year follow-up of intensive case manager services. The use of case managers through a network of VA services including outreach clinics and Vet Centers presents a satisfactory approach to assisting vets and their families to cope with these disabilities. However, it should be noted that the current numbers of TBI case managers is inadequate to cover the rural areas not in a service area of the VA facilities in the Brain Injury Center network. West Virginia with a 14.4 percent highly rural veteran population has only one TBI case manager.

Mental health resources for the general population are severely limited in rural areas and this fact makes access to these services for rural veterans very difficult. Compounding the problem is the fact that mental health providers are not always trained to recognize the symptoms of PTSD and TBI.⁴² Outpatient services may not be available to treat those who are diagnosed.^{43, 44}

The last national study of the readjustment issues of Vietnam Veterans was in 1988.⁴⁵ This study, "The National Vietnam Veteran

³⁸ Okie, Susan. "Reconstructing Lives—A tale of two soldiers," NEJM; Dec. 21, 2006: 2609.

³⁹ Zampieri, Thomas. Testimony before the Subcommittee on Health, House Committee on Veterans' Affairs, March 15, 2007. Blinded Veterans' Association.

⁴⁰ <http://www.dvbc.org/>

⁴¹ <http://www.dvbc.org/>

⁴² Herman, JL, Trauma and Recovery. New York: Basic Books; 1972: 112-129

⁴³ Demakis, JG.

⁴⁴ Gardner, J.

⁴⁵ Kulka, RA., et. al, xxiii.

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. they have clinically significant stress reaction symptoms of insufficient intensity or breath to qualify for full PTSD, but may warrant professional attention).⁴⁶ PTSD by definition is a delayed response and can have a long-term course.⁴⁷ These two facts could raise the number of veterans with full or "partial PTSD" in need of help and support to be 1.5 million.⁴⁸ These figures are based on data before the wars in Iraq and Afghanistan began. 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 for any person suffering from serious mental illness is not available through the VA, even to the many veterans who are service-connected for a serious mental illness."⁴⁹

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 60 years. The Vet Outreach Centers have made significant strides to help these veterans readjust and improve their coping skills with PTSD⁵⁰ 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 U.S. 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 U.S. Army and to 11.9 for the whole U.S. 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 100,000.⁵¹ The fact that the U.S. 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 healthy, 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, domestic violence, child abuse, and substance abuse, 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, if they have the funding to meet the demand and interest level; and again they are not required to do so by current VA service protocols and standards.

Women and Minorities

Currently women make up approximately 15 percent of the active military force, are serving in all branches of the military, and are eligible for assignment in most military occupational specialties except for direct combat roles. The highest numbers of women in history to serve in a war zone is currently serving in Iraq and

⁴⁶ Kulka, RA, et. al., xxvii.

⁴⁷ Schnurr, Paula, Winter 1994, "The Long-Term Course of PTSD", NCP Clinical Quarterly, 4(1).

⁴⁸ Kulka, RA., et. al., 52.

⁴⁹ The Independent Budget for 2005: Medical Care. p. 62

⁵⁰ Gelsomino, J., 2.

⁵¹ WPXI News. March 25, 2004. Pittsburgh, PA. <http://www.wpxi.com/news/2948372/detail.html>

Afghanistan and also represent the highest numbers in history among the wounded (500) and war casualties (83).⁵² African American women make up 37 percent of all women serving in the military. This same group represents only 12 percent of the population of the country as a whole. Many of these women are single mothers and National Guardsmen who enrolled in the Guard to receive health care benefits and a stable income for their families. The VA is beginning to address changes needed to serve an increased female veteran population. By the year 2010, the women veteran population is projected to be over 10 percent of the total veteran population.⁵³ Current military recruitment efforts frequently use Hispanic and African American women in their television and radio ads. This social phenomenon of increased numbers of women in the military is pushing policy change as the face of the American military family is rapidly changing.

NRHA's History of Support for Rural Veterans' Issues:

The NRHA established its first working group on rural veterans' issues in November 1997. NRHA provided Congressional testimony on rural aging on March 29, 2001, before the Hearing on Healthy Aging in Rural America to the Senate Special Committee on Aging and expressed concern for rural veterans and their families in that testimony. The NRHA again participated in a the Rural Caucus Congressional Staff briefing on April 19, 2004, and issued a press release on NRHA's concerns for rural vets on Veterans Day in 2005 and another registering NRHA concerns for those with traumatic brain injury on January 31, 2006. On June 27, 2006, the NRHA was called upon again to provide oral and written Congressional testimony on the implications of policy on rural veterans' access to health care and mental health services to the Health Subcommittee of the House Committee on Veterans' Affairs. NRHA supports the following pieces of legislation resulting from the 108th and 109th Congress: HR 2379 introduced by Tom Osborne, "Rural Veterans Access to Care Act of 2003," and HR 5524 introduced by

Michael Michaud, "Rural Veterans Health Care Act of 2006." NRHA also supports S 3421 "Veterans Benefits, Health Care, and Information Technology Act of 2006" passed at the end of the 109th Congress. This bill establishes the Office for Rural Veterans in the Veterans Administration. NRHA also supports H.R. 1527 introduced in March 2007 by Congressman Jerry Moran (KS). Entitled "The Rural Veterans Access to Care Act" this bill calls for extensive use of the existing rural primary care infrastructure in rural areas as a means to increase access for veterans termed "highly rural" as defined as living within specific mileage ranges from VA facilities.

Recommendations:

- The NRHA calls on Congress and the Veterans Administration to fully implement the functions of the newly created Office of Rural Veterans to develop and support an ongoing 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 calls upon the VA, through this office to issue a yearly update to the nation on the health/mental health status of rural veterans and their systems of care. The NRHA also calls upon the VA, through this office, to work cooperatively with the federal Office of Rural Health Policy within the Health Resources and Services Administration to learn more about rural health providers and systems of care and to develop a vehicle to communicate with rural health facilities and providers to improve access to care for rural veterans.
- The NRHA urges the Office of Rural Veterans to establish a national advisory committee on rural veterans.
- NRHA calls on Congress and the VA, given the age and signature wounds of the Iraq and Afghanistan Wars, to provide adequate funding and lifetime support for veterans with TBI

⁵² news.yahoo.com/s/afp/20070306/lf_afp/womenusiraqmilitary_070306170626 - 33k - Mar 15, 2007

⁵³ Center for Women Veterans - <http://www1.va.gov/womenvet>

and other war-related disabilities that live in rural areas of the nation. Specifically, NRHA calls on Congress and the VA to adequately expand the TBI Caseworker Network and fund and train TBI caseworkers in sufficient numbers to serve the rural veteran population with this disability.

- The NRHA urges the Veterans Administration to support the use of local rural providers by contracting with them for care delivery. 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 Community Health Centers, Rural Health Clinics, Critical Access Hospitals, Community Mental Health Centers, small rural hospitals, and other primary care providers in rural areas, to provide primary, mental health, and preventive health care to rural veterans who lack reasonable access to VHA facilities. NRHA supports existing legislation and regulatory policy that make local area care and services available and more accessible to veterans and calls on Congress to increase VA and VHA contracting with existing local rural health care providers who serve veterans.
- The NRHA calls on the VA to encourage coordinating with existing rural health providers to improve care for rural veterans.
- The NRHA calls on the VA and VHA to extend through these contracts access for rural health providers and facilities to the VA's exemplar health care quality improvements systems.
- The NRHA urges Congress and the VA to make sufficient policy changes to address the needs of the increased number of women and minorities who have combat-related disabilities and their families.
- The NRHA urges Congress to allocate funding for infrastructure development for rural providers who serve veterans to participate in the VHA's computerized patient record sys-

tem. This recommendation urges the VA to develop ways for entry into the record by primary care providers at various levels.

- The NRHA urges the VHA to reexamine 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 (such as rural areas) not eligible to apply for CBOCs.
- The NRHA supports the recommendation of the various Veterans Services Organizations that Congress incrementally augment funding for specialized treatment and support for veterans who have TBI, mental illness, PTSD, or substance abuse disorders by \$500 million each year from FY 2007 through FY 2009.
- The 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 to readjust to civilian life, accessing VHA services and local primary care services, and self-help support groups.
- The NRHA supports development of a mechanism to allow providers to access formulary benefits for veterans.

Conclusions

Rural health advocates and policy makers 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. Current health care access barriers for all rural people which include transportation, adequate work-force supply, and disparities in health status, etc. exist for rural veterans and their families as well. Therefore, these health and mental health care access issues can be compounded when the rural individual is a veteran, and a minority, and an aging person, and disabled, and so on. Policy makers need to be better prepared for the increased demands on our systems of health care for geriatric, psychiatric, rehabilitation, and all forms of long-term care for veter-

ans. Our largest group of veterans (Vietnam era) are aging and the demands for these services will continue to increase and continue into the future as our current generation of veterans age.

Our current wars in Iraq and Afghanistan are creating a new generation of rural veterans with significant traumatic brain injury and PTSD and these veterans will need care and support through 2060. Nursing home care policies, programs, and services will require continual monitoring and reassessment.⁵⁴

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,⁵⁵ and Iraq/Afghanistan veterans will require support through the next 50 years, 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.

⁵⁴ Klein, RE. "The Changing Veteran Population 1990-2020," March 2000: VA Office of Program and Data Analyses.

⁵⁵ Klein, RE.

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