

Written Testimony

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For the

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House Committee on Veterans' Affairs

Oversight Hearing to Examine the VA Efforts to Provide  
High Quality Health Care to Veterans in Rural Communities

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I am Graham Adams, Executive Director of the South Carolina Office of Rural Health and 2006 President of the National Organization of State Offices of Rural Health. All 50 State Offices of Rural Health serve rural communities by assisting rural providers, communities and policy makers in improving access to quality health care. I appreciate the opportunity to speak before you today to discuss this very important issue.

Rural Americans embody many wonderful traits from strong family values to numerous generations of military service. So often though, rural communities struggle with under-funded school systems, high unemployment rates and poor health status indicators. From a health care perspective, many rural communities suffer from aging health care facilities, a shortage of some key health care professionals, and a lack of specialty resources. Fortunately, rural health care providers and advocates have worked hard to address the disparity between urban and rural communities. While much progress has been made, much work still needs to be done.

Veterans that live in rural communities face even greater challenges when trying to receive care. Lack of an adequate number of Community Based Outpatient Clinics (CBOCs), Outreach Health Centers or other approved sources of care make it difficult for rural veterans to receive timely, appropriate care. According to the VA website, my home state of South Carolina only has 9 CBOCs, and 3 Vet Outreach Centers.<sup>1</sup> This is especially concerning given that South Carolina is one of the top twenty states in which veterans reside with 14.2% of the state's population being veterans. Scarcity of mental health and family counseling services is also a problem for rural veterans in need of these services.

Rural citizens have always heeded the call for military service. Currently, more than 44% of military recruits come from rural communities.<sup>2</sup> Sadly, recent statistics have also indicated that military personnel from rural communities are dying at twice the rate of their urban counterparts.<sup>3</sup> A 2004 NPR report, claimed that 44% of all soldiers killed during Operation Iraqi Freedom were from communities under 20,000 people.<sup>3</sup> Given this great commitment to service on behalf of rural communities, we need to do more to closely examine the health care barriers that face rural veterans. Developing solutions specific to rural veterans and their unique needs is the least we owe them.

### **Develop a proactive policy of the VA contracting with Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals and other small, rural hospitals to provide care to rural veterans.**

Approximately 20% of veterans who enroll to receive health care through the VA live in rural communities.<sup>4</sup> With an ever growing number of veterans returning home to their

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<sup>1</sup> VA Website, June 24, 2006.

<sup>2</sup> Washington Post, November 4, 2005.

<sup>3</sup>“Iraq War Takes Uneven Toll at Home,” April 3, 2004: NPR All Things Considered.

<sup>4</sup> American Journal of Public Health, October 2004.

rural communities after military service, these rural health care systems must be prepared to meet their needs. While CBOCs and Veteran Outreach Centers provide essential points of access, there are not enough of these facilities in rural communities. VA providers are known for providing good quality care to those they serve, however more providers are needed to serve the increasing number of rural veterans. One immediate and logical solution to this dilemma, would be to facilitate the VA contracting with existing rural health care facilities. Contracting with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for primary care and Critical Access Hospitals (CAHs) and other small rural hospitals for inpatient services would allow more rural veterans to receive care in their home communities. Inconvenience and transportation barriers caused by traveling considerable distances to receive care are often roadblocks for rural individuals seeking care. While Congress has adopted legislation encouraging VA collaborations (P.L.106-74 and P.L.106-117 § 102(e), The Veterans Millennium Health Care and Benefits Act), few examples exist today.

More needs to be done to facilitate these VA partnerships and engage and adequately reimburse existing local providers in rendering care to rural veterans. FQHCs and RHCs are the cornerstone of primary and preventive health care in many rural communities providing good quality care locally. Why reinvent the wheel by establishing new free-standing CBOCs or make rural veterans travel great distances? FQHCs and RHCs receive cost-based reimbursement or enhanced reimbursement, respectively, for Medicare and Medicaid encounters. Both have been proven models for increasing access to underserved populations in isolated communities for decades. Wisconsin, Missouri and Utah already have examples of these collaborations that are working well. Using evidenced-based medicine and uniform standards of care, the VA needs to sharply focus on developing more access points through these partnerships with FQHCs, RHCs, and CAHs.

### **Bolster rural mental health and family support services for veterans residing in small and rural communities.**

Access to mental health services is a problem in many small rural communities. A lack of qualified mental health professionals, shortage of psychiatric hospital beds and the negative stigma of mental illness, often result in many rural residents not getting the care they so desperately need. These problems are exacerbated for veterans who live in rural communities given the variety of severe issues which often confront them. In addition to the normal stressors which drive individuals to seek mental health care, veterans can have the added challenges of dealing with service-related situations or mental illnesses. Problems derived from combat situations, re-adjustment to civilian life and work, and family and marital issues related to long absences from home, often greet veterans as they return home from service. More resources need to be made available at the local community level to assist veterans in dealing with these issues. Although Vet Centers provide these services, they are not consistently available at the local level. Due to the lack of rural mental health providers and the scarcity of psychiatric hospital beds, some

individuals with mental illness end up being incarcerated in lieu of receiving proper treatment. Our broken mental health system is not unique for veterans, however given their service to our country and the unique needs that they often have, it is incumbent upon the VA and rural providers to do better. However, in order to improve the situation, more resources must be made available in order to contract with local mental health providers, hire additional mental health providers and contract with and adequately reimburse Critical Access Hospitals (CAHs) and other small rural hospitals to serve these patients.

The families of veterans also struggle with issues related to their absence, return and readjustment to society. Some Vet Centers employ family therapists and other counseling professionals although not all do. Family therapists, specifically, provide much needed services to veterans, their spouses and children. Requiring Vet Centers to hire family therapists and fully funding them to do so would enable more veterans to access this vital service.

### **Identify, fully-fund and replicate best practices in rendering health care, mental health and family support services to veterans in rural communities.**

Although veterans face many challenges in seeking and receiving care in rural communities, there are undoubtedly many communities where VA facilities, local health care providers and advocates have worked together to develop “models that work”. The VA needs to identify these models, study and analyze data of where and when veterans currently interact with the system and fund the replication of new and diverse efforts in rural communities. This analysis of the unique needs of rural veterans; what is working and what’s not; will educate and enrich the dialogue of providing care to those who’ve served our country. Examining the unique challenges inherent in providing health care in rural communities and crafting innovative solutions to meeting the needs of rural veterans, is of the utmost importance. The VA needs to collaborate with State Offices of Rural Health at the state level and HRSA’s federal Office of Rural Health Policy at the federal level, to coordinate these activities. These state and federal entities, respectively, are the best suited to assist with this broad endeavor.

### **Conclusion**

While many opportunities for improvement exist in providing care to veterans in rural communities, the VA is to be commended for the excellent service provided in many of its facilities. Providing health care in rural communities requires unique solutions, whether it is to veterans and their families or the general population. Adopting some of the strategies referenced in this written testimony would aid in addressing these rural needs.

While I am aware that this hearing is not designed to examine specific legislation, I recognize that H.R. 5524, the Rural Veterans Health Care Act of 2006, does encompass

many positive solutions to addressing the health care needs of rural veterans. I commend these strategies.

Thank you for the opportunity to speak with you today.