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National Rural Health Association

Written Testimony

By

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2005 NRHA President

For the

Health Subcommittee of the  
House Committee on Veterans' Affairs

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

June 27, 2006

The NRHA is a national nonprofit, non partisan, membership organization with approximately 10,000 members that provides leadership on rural health issues. The Association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research. The NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

I am Hilda R. Heady, associate vice president for rural health at West Virginia University and the immediate past president of the NRHA. On behalf of the Association, I appreciate the opportunity to provide this written testimony to the committee.

The members of the National Rural Health Association have maintained a special concern for the health and mental health care needs of rural veterans for many years. NRHA was one of the first non-veteran service organizations to develop a policy statement on rural veterans and this policy work is evidence of our memberships' concerns for rural veterans.

This testimony provided by NRHA discusses current VA successes in providing quality care for rural veterans, and suggestions for further improvements in quality of care. NRHA respectfully requests that the Committee give consideration to the following steps that would improve quality and access to care for rural veterans:

1. Increase the numbers of Vet Centers, Outreach Health Centers, and CBOCs in rural areas.
2. Increasing health care access points for rural veterans by building on current successes of both VA service approaches and existing rural health approaches. Fully implement the contracting of services from the VA to Community Health Centers (CHCs) in rural areas and develop approaches to link VA services and quality to existing rural health providers willing to provide care to rural veterans that follow standards of care and evidence-based medicine, including Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and mental health providers.
3. Increase the number of VHA Traumatic Brain Injury Case Managers in predominately rural states.
4. Use the high quality of the VA system to provide targeted and culturally competent care to rural, minority, and women veterans and to train future rural health providers in these rural VA facilities.

Following is additional background information and discussion of our recommendations.

## **Background**

Since the founding of our country, rural Americans have always responded when our nation has gone to war. Whether motivated by their values, patriotism, and/or economic concerns, the picture has not changed much in 230 years as rural individuals, along with American Indians, urban African Americans and Hispanics, serve at rates higher than their percentage of the population. Forty-four percent of all soldiers killed during Operation Iraqi Freedom were from small communities with populations under 20,000.<sup>1</sup>

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<sup>1</sup> "Iraq War Takes Uneven Toll at Home," April 3, 2004: NPR All Things Considered.

Many rural and non-metropolitan counties had the highest concentration of veterans in the civilian population aged 18 and over<sup>2</sup> from 1990 to 2000 according to the 2000 US Census.<sup>3</sup> The proportion of veterans living in rural areas in 18 states is higher than the national average of veterans. These rates include Montana (16.2%), Nevada (16.1%), Wyoming (16%), and Maine (15.9%) to West Virginia (14.4%), Arkansas (14.2%), South Carolina (14.2%), and Colorado (14.1%). The remainder of the 18 states fall in between these ranges, however, all these states are above the national average of 12.7%.<sup>4</sup>

The disproportionate representation among rural Americans serving in the military has created disproportionate need for care<sup>5 6</sup> in rural areas in order to serve these veterans. National rural health leaders are especially concerned about access to care for this special population of rural individuals, because the normal barriers to health and mental health care access for rural individuals<sup>7</sup> are compounded if the person is a combat veteran.

There is a national misconception that all veterans have automatic access to comprehensive care because they are served by the Veterans' Administration.<sup>8</sup> For many small town and isolated rural veterans, and those isolated by living in rural remote areas or isolated by choice<sup>9</sup> due to the complicated symptoms of PTSD, access to VA services is not always easy. While the quality of VHA care is equivalent to, or better than, care in other systems<sup>10</sup>, it might not be accessible to many rural and frontier veterans. There is great concern that the current modest budget increases in the VA budget are not adequate to maintain current services.<sup>11</sup> 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 likely need services upon their return home (many to rural communities), and still need these benefits in 2060.<sup>12</sup>

### **Increasing Health Care Access Points for Rural Veterans: Building on Current Successes**

NRHA recognizes and appreciates the successes of vet centers and health care outreach centers in meeting the needs of rural veterans. We should seize the opportunity to build upon this success and further improve quality of and access to care.

Community Based Outreach Centers (CBOCs) open the door for many veterans to obtain primary care services within their home community. While outcomes research on CBOCs is mixed, some findings suggest that CBOCs have been successful in improving

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<sup>2</sup>“Veterans: 2000 Census Brief,” p. 7.

<sup>3</sup><http://factfinder.census.gov/servlet/SAFFP>

<sup>4</sup> “Veterans: 2000 Census Brief,” p. 5.

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> Demakis, JG., Jan. 2000, “Rural Health-Improving Access to Improve Outcomes”, Management Brief Health Services Research & Development Service, NO. 13: 1-3.

<sup>8</sup> Gardner, Jonathan, Nov. 1998, “Politics, Veterans' Needs Shape System”, Modern Healthcare, Vol. 28, Issue 47: 50.

<sup>9</sup> Sorenson, G., “Hinterlands are home, not a hideaway, for Vietnam veterans,” Vet Center Voice, Vol. VI, No. 9, October, 1985, p.1.

<sup>10</sup> The Independent Budget for 2005: Medical Care. Veterans Service Organizations.

<http://www.pva.org/independentbudget/index.htm>

<sup>11</sup> The Independent Budget for 2005: Medical Care. p. 44

<sup>12</sup> The Independent Budget for 2005: Medical Care. p. 45.

geographic access, an important objective of expanding community-based care to veterans.”<sup>13</sup> The VHA has improved procedures for planning and activating CBOCs and established consistent criteria and standard expectations for the over 450 CBOCs created since 1995.<sup>14</sup> CBOCs have also been successful in some states, such as West Virginia; however, Directive 2001-06 made this solution less available to more rural and remote veterans and other rural providers by raising the ceiling on the number of priority users in a given area. Outreach Health Centers provide an appropriate model to deal with the loss of CBOC eligibility to smaller and more remote rural areas, and their expansion should be considered.

Furthermore, outreach efforts with rural veterans that focus on benefit education and psycho-social education of veterans and their family members can increase the effectiveness of services currently available through the VA system.

### **Increasing Health Care Access Points for Rural Veterans: Expand Access at Community Health Centers, Rural Health Clinics, Critical Access Hospitals, and Mental Health Providers.**

Time and distance prevent many rural veterans from getting their healthcare benefits through a Veterans Hospital Administration (VHA) facility. There are approaches readily available in the VA system and in the rural health landscape that could improve this situation. These approaches include Vet Centers, Outreach Health Centers, and CBOCs, as mentioned above, as well as Community Health Centers (CHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs), and mental health providers. Policy regarding services to rural veterans needs to provide access through a variety of existing rural health facilities and access points because not all rural communities have access to all types of facilities. Quality through consistent applications of standards of care and evidence-based medicine, however, must guide all approaches to care for rural veterans.

Federally funded Community Health Centers (CHCs) serve millions of rural Americans, but 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. Congress has passed legislation encouraging collaborations (P.L.106-74 and P.L. 106-117 § 102(e), The Veterans Millennium Health Care & Benefits Act). Despite the legislative intent however, a national policy advocating VHA-CHC collaboration has not emerged in an effective way. 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. Successful contracts exist in Wisconsin, Missouri, and Utah. In other states, contracts were successful but were discontinued for reasons not related to operational success. This model of collaboration between VHA and CHCs might do well in other rural states and with other rural providers and systems of care and should be implemented further.

Critical Access Hospitals provide comprehensive and essential services to rural communities and are specific to rural states. This model provides a great opportunity for

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<sup>13</sup> Maciejewski, M., et al. CBOC Performance Evaluation Report 2, VA HSR&D, March 2000. [http://www.hsr.d.research.va.gov/publications/internal/cbocprt2/cboc\\_performance\\_report2.htm](http://www.hsr.d.research.va.gov/publications/internal/cbocprt2/cboc_performance_report2.htm)

<sup>14</sup> “VHA Handbook 1006.1,” April 11, 2003. Department of Veterans Affairs, Veterans Health Administration. Washington, D.C.

policy makers to expand services to rural veterans in communities where CAHs are located. For instance, Montana has 45 Critical Access Hospitals and the highest percentage of veterans in the nation. Working through existing health care access points such as the CAHs, CHCs, and RHCs through linkages with the VA's system of high quality care, can greatly enhance services to rural veterans.

Designation as a RHC provides enhanced reimbursement for Medicare and Medicaid services for private physicians who provide enhanced services to rural communities. RHCs are often physician-owned or sometimes owned by small, rural hospitals, including Critical Access Hospitals. In many rural and frontier communities, RHCs represent the only source of primary care available.

The literature provides much evidence that linking the quality of VA services with civilian services provides opportunities to improve the quality of health care services for all citizens. Linkages can improve the use of evidence based medicine in chronic disease management, in screening and diagnosis, and in treatment of many health conditions. Linkages also provide greater opportunities for the dissemination of VA supported research. These are additional benefits of any collaboration between VHA and the existing rural health safety net infrastructure.

### **Traumatic Brain Injury**

Throughout our history all citizens in our nation have benefited from medical research focused on the signature wounds of war. Currently, it appears that Traumatic Brain Injury (TBI) will most likely become the signature wound of the Afghanistan and Iraqi wars. While the VA is gearing up for returning veterans with this condition, the importance of the TBI case manager network and other services in the provision of quality care for these rural veterans cannot be understated.

The Defense and Veterans Brain Injury Network of nine VA and one civilian center provides the needed and highly specialized services that these disabled veterans require. However, only three of these network centers are located in two of the 18 states with high rates of rural veterans, Virginia and Florida. Eleven western states with many rural and frontier veterans, and the other southern states with high numbers of rural veterans have very limited access to these centers once discharged from in patient care. Therefore, the VHA TBI Case Managers Network is vital to these veterans and their families. A review of the number and location of TBI case managers finds them very limited in coverage in states with high numbers of rural veterans -- expansion is needed.

### **Require Family Therapists**

Rural individuals value their families and have strong bonds and ties to their home place and home communities. Our returning veterans adjusting to disabilities and the stressors of combat need the security and support of their families in making their transitions back into civilian life and to manage life style changes due to disabling conditions. The Vet Centers do a tremendous job in assisting veterans with this readjustment and some find ways to hire family therapists on staff to further assist the veteran and his/her family. However, a family therapist is not required of the centers' services and those centers that do have these therapists must cut other programs to find

the money to hire them. Increased funding for these centers to hire family therapists would go a long way to help families increase the effectiveness of their support and help for their veterans.

### **Addressing Needs of Rural Minority Veterans and Women**

The VA's tradition of quality efforts is also vital to addressing the unique needs of rural minority veterans and women. The VA offers a golden opportunity to train rural providers through rural rotations in all VA facilities and programs, thereby exposing our future rural providers to the unique needs of rural, minority, and female veterans. Currently, we have the largest number of women ever in our history to serve in a war theater. In just four years, women are expected to make up over 10 percent of the total veteran population. Minority women are in high numbers in the military services. While African American women make up about 12.7 percent of the U.S. female population, they represent 34 percent (more than twice) of the military's female enlisted personnel according to a series on women in the military published by the *Sacramento Bee* in December 2004. The break down on these women by rural and urban residents is not readily available however, it is reasonable that a higher number of both genders from rural areas go into military service.

### **Conclusion**

While NRHA recognizes the purpose of this hearing is not to discuss specific legislation, we do recognize that H.R. 5524, the Rural Veterans Health Care Act of 2006 includes many of the items long recommended by NRHA. H.R. 5244 calls for expansion and improved quality of services provided by Vet Centers, Outreach Health Centers, and CBOCs in rural areas; a heightened focus on the needs of rural minority veterans; a focus on rural medical education for VA residents, and new research and outreach efforts. We applaud these efforts.

Thank you for the opportunity to submit this testimony.