5-2013

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Americans from rural areas, in which 20 percent of our population resides, have historically answered the call to military service at higher rates than residents of urban communities. Over 44 percent of recruits come from rural areas compared to 14 percent from major cities.[1] Due to their higher rates of military service, rural Americans represent a significant proportion of the veteran population, with 30 percent of U.S. veterans living in rural areas.[2] This figure is expected to increase in the years to come.

Rural veterans face numerous barriers to their access of health care, including: long travel distances to community and U. S. Department of Veterans Affairs (VA) services; limited provider choice; lack of specialty services; and inadequate provider supply. In addition, many providers lack "cultural sensitivity" to veterans' issues, which creates a system that is less effective in meeting rural veterans' needs.

The geographic distribution of veterans across rural areas is one of many challenges faced by the VA in fulfilling its obligations to these individuals. Rural veterans suffer higher rates of depression, chronic disease and physical health problems than other rural residents. In response to these issues, the VA has identified rural veterans as a population of interest for focused attention.[3]

DEMOGRAPHY OF RURAL VETERANS

Using the 2010 American Community Survey, the National Center for Veterans Analysis and Statistics provided a demographic overview of America's 6.3 million rural veterans.[4] It shows that, in general, rural veterans are older, less racially diverse, less educated, more disabled and have greater health disparities than urban veterans. Rural male veterans are older than female veterans, with 70.5 percent of rural male veterans aged 55 and older compared to only 30.4 percent of rural female veterans. The age difference is explained by the influence of World War II, Korea and Vietnam veterans on the age profile of rural male veterans and the growth of the number of women in the military. Rural veterans are less racially diverse than rural nonveterans, with 91 percent white, 5.7 percent black, 2.7 percent Hispanic, 1 percent American Indian/Alaskan Native, and 1.1 percent Asian, native Hawaiian/other Pacific islander or other race.

Almost 10 percent have not completed high school, 33.9 percent have a high school diploma, 35 percent have an associate's degree or some college, and 21.6 percent have a bachelor's degree or higher. Almost 67 percent are employed, 6.4 percent are unemployed and 27.1 percent are not in the workforce. Approximately 6 percent live below the poverty level. Nearly 27 percent report one or more disabilities.

In terms of periods of service, 26.4 percent served in peacetime, 6.5 percent in World War II, 10.4 percent in Korea, 36.4 percent in Vietnam, 11.8 percent in Gulf War I, and 9.2 percent in Gulf War II (Iraq and Afghanistan).

Three evolving population trends place significant demands on VA and rural delivery systems. The first involves the aging of rural veterans, with 68 percent aged 55 and older.[5] This trend will continue as the cohort of rural veterans between 55 years old and 65 years old (26.9 percent) ages up.

The second trend involves the growing number of female veterans. Women account for 8 percent (1.8 million) of veterans and are the fastest growing veteran cohort.[6]

The third trend involves homeless veterans, an estimated 131,000-200,000 on any given night and 262,000-400,000 annually.[7] Homeless veterans represent all periods of service, with 47 percent having served during the Vietnam era and 5 percent residing in rural areas. Although the majority are single males, women, often with children, are the fastest growing segment of homeless veterans.[8]


"I have become foul, and
I cannot become clean again."

HEALTH CARE ISSUES

A longitudinal study of veterans' physical and mental health-related quality of life indicates that rural veterans had lower physical scores than urban veterans, and those differences persisted over time.[9] Rural veterans had better mental scores, but these differences declined over time. Although the Millennium Cohort Study, composed of current and recent military personnel, found little evidence for rural/urban differences in health-related quality of life measurements, the authors acknowledged previous studies that found rural/urban difference in older veterans.[10] They suggested that the differential effect of residency progresses slowly and only begins to show up over time. Health-related quality of life scores are based on a self-reported assessment of an individual's multidimensional physical and mental status, including health risks and conditions. The data was collected through the VA's "Survey of Healthcare Experiences of Patients" between 2002 and 2006. Lower scores indicated lower perceptions of health and are associated with increased demand for health care services.

Growing numbers of aging veterans further burden already stressed rural long-term care services.

Among rural veterans treated in VA outpatient settings, the most common diagnoses are hypertension, type II diabetes, hyperlipidemia, post-traumatic stress disorder (PTSD) and depression.[11] Rural veterans also experience combat-related medical conditions including mild traumatic brain injury, PTSD and amputations. Rural areas have the highest percentage of veterans with service-related disabilities at 1.73 percent (compared to 1.47 percent for the U.S.).[12]

The needs of aging, women and homeless veterans have significant implications for rural and VA delivery systems. Growing numbers of aging veterans further burden already stressed rural long-term care services. More female veterans stimulate demand for gender-specific and mental health services. They also challenge the VA to evolve beyond its traditional service base of older men.[13]

The complex issues of homeless veterans, including substance abuse and mental health disorders, require rural and VA delivery systems to provide a comprehensive array of primary care, behavioral health, case management, housing, prevention and supportive services. The growth in the number of homeless female veterans further adds to this burden.

The health care needs of veterans from different periods of service often are more directly related to their stages of life or socio-economic characteristics than their period of service. As discussed earlier, aging veterans increase the demand for long-term care and other support services, while homeless veterans require a range of health care and supportive services. The link between period of service and ongoing health needs is most obvious for veterans of the Gulf War and of the Iraq War who experience a range of physical and behavioral health issues that include injuries associated with blast exposure (e.g., mild traumatic brain injury), PTSD, chronic joint pain (associated with carrying heavy packs), depression, substance abuse, sleep issues and long-term effects of environmental and chemical exposure to pesticides, chemical and biological warfare agents, prophylactic drugs and vaccines, radiation, smoke from oil fires and open air burn pits, and occupational hazards (from working with chemicals, paints, and machinery during service).[14]

ACCESS BARRIERS

Barriers to health care access include travel issues (involving time, distance and cost), lack of transportation, limited availability of VA services, lack of behavioral health and other specialty services, inadequate provider supply, coordination of care issues, imperfect understanding of VA benefits and limited cultural sensitivity among community providers regarding veterans' needs.[15] Travel and transportation issues are significant barriers, with reported one-way travel distances to VA primary care services averaging 45 to 54 miles.[16] Veterans living more than 30 miles from VA services rely more heavily on local emergency department and primary care services for acute care issues.

Twenty-five percent of veterans report that transportation considerations affect their ability to access care. Approximately 54 percent have only one car, 5.6 percent have no car and 11.1 percent lack a valid driver's license. Thirteen percent rely on friends or family for transportation, and 11 percent use Disabled American Veterans van services when available. Limited availability of specialty and diagnostic services and concerns about the capacity of VA facilities were also identified barriers to care.[17]

Another significant barrier is the limited provider understanding of military culture, service-connected health care issues and the post-deployment health and behavioral health care needs of rural veterans.[18] This is a significant issue in light of the needs of veterans who served in the Gulf War and in Iraq. In testimony before the House Committee on Veterans' Affairs, Jacob Gadd, the American Legion's deputy director for health care, called for the development of military culture and awareness training for non-VA providers to raise their awareness of military injuries/illnesses, reduce barriers to care, improve veterans' satisfaction with services and the increase the effectiveness of service systems.[19]

EVOLVING NEEDS

It is no long possible to view rural veterans as a homogenous group. Changes

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in enlistment patterns are creating a more diverse population of rural veterans that includes a growing number of women, an aging cohort of veterans and a younger cohort of Gulf War and Iraq War veterans with potentially longer term consequences from their combat service. These changes are challenging traditional veteran services systems to revise their programs and community providers to broaden their capacity to address the evolving needs of rural veterans.

To best meet our obligations to those who have served our country, it is critical to focus on opportunities to expand access to accessible, culturally sensitive primary care, behavioral health, specialty care and other support services; improve coordination and co-management of veterans between community and VA-based service systems; increase the availability of community-based services; explore the use of technology and transportation programs to expand access to care; expand veteran outreach programs; improve the cultural competence of community providers; and enhance our understanding of the needs of the most vulnerable rural veterans.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

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Reprinted from *Health Progress*, May-June 2013