Osteopathic Family Physician (2009) 1, 37-40

ELSEVIER

acofp Osteopathic Family Physician

# Help Establish Access to Local Timely Health Care for Your Vets: (HEALTHY Vets) Act of 2007, H.R. 315, Rep. Stevan Pearce

**Damon Schranz, DO, FACOFP**

*From University of North Texas Health Science Center, Fort Worth, TX 76107.*

## Introduction

Providing quality, cost-effective health care has been the benchmark of the Veterans Administration's (VA) Health Care System since its inception. However, it should be noted that this quality, cost-effective health care is not available to all veterans as a result of myriad factors, primarily that of accessibility. Accessibility to VA health care benefits varies depending on location within the United States. Unfortunately, the group that comprises a majority of our armed forces reside in rural locations, often times 4 to 5 hours from the nearest VA hospital or Community-Based Outpatient Clinic (CBOC). Thus, current veterans under the age of 65 without Medicare/Medicaid or private insurance must rely on the services provided by the VA for their health care needs. Because we are currently involved in a major over seas conflict, our wounded soldiers are returning with injuries so severe that they require months, if not years, of rehabilitation to return to society. Unfortunately for some veterans, as they are released from the hospital they return to their home communities, only to continue to be plagued with health problems that require regular visits to the VA health system clinic that is neither near nor convenient to the veteran.

## Intent of the bill

H.R. 315 drafted by Rep. Stevan Pearce was created to assist veterans of any age with accessible health care. Although the contracting ability of the VA already allows community-based physicians to provide care to veterans, the service is not widely used. H.R. 315 will force the VA to contract with individual physicians, hospitals, and durable medical goods suppliers if the veteran in need fits a specific set of criteria based on distance to the nearest VA hospital or CBOC.

## History and background

The rural populations of the United States have nearly always responded to war by enlisting in the armed services. In fact, compared with the urban population, the rural population serves our nation through voluntary enlistment in the armed services at a higher rate per capita. More than 44% of new US military recruits come from rural areas, whereas only 14% come from urban areas.[1]

Although the rural ideology of serving the country in times of war is not well known, the statistics of rural service in the military is well documented. For instance, 27% of troops that have been killed in Iraq are from rural areas.[1] Yet, only 19% of the US population lives in rural areas.[1] With improvements in military uniforms, specifically body armor, troops are dying at a dramatically decreased rate in Iraq (9%) compared with the troops that served in both World War II (30%) and the Vietnam War (24%).[1] Because of this decreased death rate, the number of troops returning with injuries has surged. In addition, the injured troops returning from Iraq are often more seriously injured than troops in previous military conflicts. Traumatic brain injury (TBI) will most likely become the signature wound of the

Corresponding author: Damon A. Schranz, DO, FACOFP, 855 Montgomery Street, Fort Worth, TX 76107-2553.

E-mail address: dschranz@hsc.unt.edu.

1877-573X/$ -see front matter 
doi:10.1016/j.osfp.2009.06.002

Afghanistan and Iraqi wars.[2] In addition to TBI, posttraumatic stress disorder (PTSD), the signature wound of the Vietnam War, and other mental illnesses are reemerging as leading diagnoses in returning troops. One in three soldiers returning from war will develop PTSD or comparable mental health issues such as depression or anxiety.[3] Currently there are no rural outreach programs to assist the 30% of rural veterans who have PTSD. To further illustrate the mental health problems of returning war veterans, soldiers who have served in Iraq are committing suicide at a rate of 17.3/100,000 compared with the US civilian rate of 10.7/100,000.[1] Mental health issues will continue to be a major concern of the VA health care system as troops return home, and specifically for those returning to their rural communities.

Texas has a veteran population of 1.6 million, dispersed over the second largest land mass in the United State, covering 268,601 square miles.[3] Forty-five percent (739,696) of the Texas veteran population live in rural areas.[3] The VA operates ten major medical centers in Texas-Amarillo, Big Spring, Bonham, Dallas, El Paso, Houston, Kerrville, San Antonio, Temple and Waco. They spent more than $5.6 billion in Texas during fiscal year 2006[4] and provided care for nearly 49,000 inpatient admissions and more than 3.8 million outpatient visits.[4] However, time and distance prevent up to 4 million rural veterans nationally from accessing quality VA health care, a percentage of which are rural Texans.[1] To increase access to care for veterans, the VA funded the CBOC program in 1995. This has increased geographic access for primary care services to veterans both rural and urban; however, there are too few to meet the demands of our current rural veteran population.

Rural veterans who cannot access the VA health care system have significant health disparities with regards to leading causes of death compared with the US population as a whole. For instance, the rural mortality rate of ischemic heart disease is 5% higher than the US rate of 60%.[5] The rural mortality rate for chronic obstructive pulmonary disorder is 8% higher than the US rate.[5] The rural mortality rate for unintentional accidents and motor vehicle traffic-related injuries are 50% higher than the national rate.[5] The increased morbidity risk for rural veterans can be attributed in part to the detrimental health behaviors of that population. Smoking rate in the rural population is 15% higher than that of the general population.[5] They are more sedentary than the general population and thus have higher rates of obesity.[5] Because of inadequate primary health care services, the rural population has a higher proportion of chronic illnesses such as diabetes and for that reason are more likely to report fair/poor health compared with the general population.[5]

With an increasing number of veterans returning from war in Iraq and/or Afghanistan with what were once fatal injuries, general primary care, intensive rehabilitation, and mental health services are needed in the wounded veterans' hometowns to provide care or chronic management. United States Representative Stevan Pearce of New Mexico has sponsored legislation that would assist veterans with obtaining timely, quality health care in their communities, whether rural or metropolitan.

## H.R. 315, HEALTHY Vets Act of 2007

The HEALTHY Vets Acts of 2007 would amend Title 38, United States Code, to require the Secretary of Veterans Affairs to enter into contracts with community health care providers to improve access to health care for veterans in highly rural areas, and for other purposes.[6] CBOCs are health clinics set up to meet the demand of large veteran populations. Unfortunately, not all rural locations have sufficient numbers of veterans to justify a CBOC. Veterans who do not live within the proximity of a major VA health care system or CBOC will best be served by this bill. The bill sets forth four criteria to determine the geographical inaccessibility of rural veterans to VA health care systems. The criteria are as follows:

a) The residence is in a county with a population density of less than 7.0 people per square mile and is more than 75 miles from the nearest department health care facility.
b) The residence is in a county with a population density of more than 7.0 and less than 8.0 people per square mile and is more than 100 miles from the nearest VA health care facility.
c) The residence is in a county with a population density of more than 8.0 and less than 9.0 people per square mile and is more than 125 miles from the nearest VA health care facility.
d) The residence is more than 150 miles from the nearest VA health care facility.

If the veteran qualifies according to this criteria, the bill would require regional VA directors to contract with local physicians, hospitals, and nontherapeutic medical service providers. In addition, other medical services may be allowed if determined appropriate by the regional VA director after consultation with the department physician responsible for primary care of the veteran. H.R. 315 also would allow the Secretary to waive the geographical inaccessibility criteria on a case-by-case basis if the the Secretary can demonstrate on an individual basis through a detailed cost-benefit analysis that the costs to the VA of providing care to that veteran significantly outweigh the benefits of localized health care for the individual veteran.

## Stakeholders who support H.R. 315

Mr. Michael Amery, legislative counsel for the American Academy of Neurology (AAN), representing more than 20,000 neurologists and neuroscience professionals, supports the efforts to improve the VA's delivery of health care to rural veterans.[7] They would also like to see expansion in telehealth and telemental health services.

Ms. Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission, American Legion, "believes that, where there is very limited access to VA healthcare, it is in the best interest of veterans residing in highly rural areas that local care be made available to them."[8] Providing contracted care in highly rural communities where VA services are not available would alleviate the unwarranted hardships of excessive travel to veterans.

Mr. Dennis M. Cullinan, Director of the Veterans of Foreign Wars (VFW) National Legislative Service, strongly supports the intent of the legislation. There is some concern on the part of the VFW about the contracting aspect, and specifically the overuse of contracting care to the private sector. However, the VFW feels there is a need in certain areas, and any potential concerns will be outweighed by the potential benefits to rural veterans.[9]

The Honorable Ruben Hinojosa and the Honorable Solomon P. Ortiz, Representatives in Congress from Texas, strongly believe in access to care for rural veterans, especially their constituents.[10,11] Drive times to the nearest VA hospital can be up to five hours for residents living along the border of the United States and Mexico. They support the intent of H.R. 315, but also support the construction of a new veterans' hospital in south Texas through federal legislation in H.R. 538.

## Stakeholders who do not support H.R. 315

Gerald M. Cross, MD, FAAFP, Acting Principal Deputy Under Secretary for Health, US Department of Veterans Affairs, believes the bill would give rise to obstacles to further expansion of the VA's strategic plans, which focus on delivering health care services through sources that are nearest to a rural veteran's home.[12] The VA feels the bill would create administrative issues, and that implementation may simply be unworkable, leading to fragmentation of a veteran's medical care. However, should it be the will of the Congress to pass the legislation, the VA would like clarification of "nontherapeutic medical services."

Carl Blake, National Legislative Director of the group Paralyzed Veterans of America (PVA), is concerned that the bill's solution to the problem of access to care for veterans would threaten the long-term viability of the VA health care system.[13] PVA is concerned specifically with the spinal cord injury care program, which is unmatched in the private sector. They feel that if larger pools of veterans are sent into the private sector for health care, the diversity of services and expertise in different fields would be placed in jeopardy.

Mr. Richard F. Weidman, Executive Director for Policy and Government Affairs for Vietnam Veterans of America, states "the inelegantly named Help Establish Access to Local Timely Healthcare for Your Vets (HEALTHY Vets) Act of 2007 would add bureaucratic clutter to those whose responsibility it is to provide health care for veterans in 'geographically inaccessible areas.'"[14]

Disabled American Veterans (DAV) Assistant National Legislative Director, Mr. Adrian M. Atizado, feels that H.R. 315 would eventually constitute mandatory spending under the Budget Agreement of 1990's PAYGO policy, which requires increases in spending be balanced by decreases in other spending or increases in revenue.[15] The DAV does not support mandatory funding for private providers to care for veterans via a VA insurance function because this removes more money from current VA health programs and may decrease the future quality of VA health programs.

Kimo S. Hollingsworth, National Legislative Director of the American Veterans (AMVETS), supports the intent of the legislation, but believes mandating a requirement on the Secretary of Veterans Affairs to enter into contracts based on geography is unnecessary, because the Secretary already has this authority.[16]

## Recommendations

Accessibility to quality health care is promised to all career military personnel and wounded military veterans, and free medical care is a key selling point for those considering long-term service in the US military. With several major military conflicts occurring within the past four decades, military veterans are returning to their hometowns with psychiatric conditions such as PTSD, and serious neurological injures such as TBI. The US military is a voluntary fighting force that draws large numbers of recruits from rural areas throughout the United States. As military personnel retire or are medically discharged secondary to injury, both psychiatric and physical, they are returning to their rural roots only to find the high-quality health care promised to them is not easily accessible. H.R. 315 has addressed the issue of accessibility; however, many unintended consequences are probable if this legislation is passed.

The true monetary cost to the VA is unknown. However, it can be concluded that as those veterans in rural areas who are not currently using the VA systems of health care finally have easily accessible care, costs to the VA will rise. There are no provisions in H.R. 315 to address this paramount issue. Several veterans' rights groups insist that allowing H.R. 315 to pass will further endanger the quality of care veterans receive, because funding priorities will have to be reorganized to accommodate the influx of new veterans into the VA health care system.

In addition to the cost burden H.R. 315 will place on the VA health care system, the administrative task of negotiating contracts with individual physicians and hospitals throughout the United States is significant. This will add another layer to the bureaucracy of the VA, which is already overwhelmed with current military veterans, as can be noted by the recent scandalous headlines at Walter Reed Army hospital.[17]

As Americans, we honor the veterans who allow us to have the freedoms we currently enjoy. However, Americans are also

mindfully budget conscious and resist tax increases to pay for needed services. This is the quandary of H.R. 315. Americans want accessible health care for their veterans; however, they will resist the tax increases needed to ensure that accessible health care. Thus, unless new revenue streams for funding this dramatic increase in accessibility to US veterans occurs, there will be a significant budget deficit in veterans' health care, and quality indicators will decrease. Important, innovative, and quality health programs will be downsized to allow for the influx of veterans into the VA health system.

With the current economic climate, the cost to the VA health care system of H.R. 315 will be significant if passed. The unintended consequences are significant. Until H.R. 315 can be revised to include a dedicated funding stream, its future is bleak and it should be voted down.

## References


1. Heady HR. Rural veterans: A special concern for rural health advocates. Policy Brief of the National Rural Health Association. Washington, DC: NRHA.
2. Behrman A. National Rural Health Association: Written testimony . . . for the Health Subcommittee of the House Committee on Veteran's Affairs Oversight Hearing on "Access to VA Health Care: How Easy is it for Veterans? Addressing the Gaps," April 18, 2007.
3. Rogers IP. Texas Rural Area Veterans Association Rural Veteran Study. Available at: http://www.ruraltx.com. Accessed June 18, 2009.
4. United States Department of Veterans Affairs. State Summary: Texas and the U.S. Department of Veterans Affairs, May 2007.
5. National Rural Health Association. Health disparities in rural populations: An introduction. Washington DC: NRHA; 2006.
6. Pearce S. Help establish access to local timely healthcare for hour vets (HEALTHY Vets) Act of 2007, H.R. 315, 110th Congress, 1st Session, Jan 5, 2007.
7. Amery M. Testimony by Mr. Michael Amery, Legislative Council, American Academy of Neurology on Veterans Health Care Legislation. Washington, DC: House Committee on Veterans' Affairs.
8. Middleton S. Testimony by Shannon Middleton, Deputy Director for Health, American Legion, Veterans Affairs and Rehabilitation Commission. Washington, DC: House Committee on Veterans' Affairs.
9. Cullinan DM. Testimony by Dennis M. Cullinan, Director Veterans of Foreign Wars of the United States, National Legislative Service. Washington, DC: House Committee on Veterans' Affairs.
10. Hinojosa R. Testimony by the Honorable Ruben Hinojosa, Representative in Congress from the State of Texas. Washington, DC: House Committee on Veterans' Affairs.
11. Ortiz SP. Testimony by the Honorable Solomon P. Ortiz, Representative in Congress from the State of Texas. Washington, DC: House Committee on Veterans' Affairs.
12. Cross GM. Testimony by Dr. Gerald M. Cross, MD, FAAFP, Acting Principal Deputy Under Secretary for Health, U.S. Department of Veterans Affairs, Veterans Health Administration. Washington, DC: House Committee of Veterans' Affairs.
13. Blake Carl. Statement of Carl Blake, National Legislative Director, Paralyzed Veterans of America. Washington, DC: House Committee of Veterans' Affairs.
14. Weidman R. Testimony by Richard F. Weidman, Executive Director for Policy and Government Affairs, Vietnam Veterans of America. Washington, DC: House Committee on Veterans' Affairs.
15. Atizado AM. Testimony by Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans. Washington, DC: House Committee on Veterans' Affairs.
16. Hollingsworth KS. Statement of Kimo S. Hollingsworth, National Legislative Director, AMVETS. Washington, DC: House Committee on Veterans' Affairs.
17. Priest D, Hull A. Soldiers face neglect, frustration at Army's top medical facility. *Washington Post,* February 18, 2007. Available online at: http://www.washingtonpost.com/wp-dyn/content/article/2007/02/17/AR2007021701172.html.