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Written Statement accompanying testimony to US House Veterans' Affairs Subcommittee on Health. Cannon House Office Building. June 27, 2006

Thank you for the opportunity to testify before this committee. I was a member of the Institute of Medicine's Committee on the Future of Rural Health which met throughout 2004 and released its report early in 2005: *Quality through Collaboration: The Future of Rural Health* (IoM 2005). That committee continued work that began with *To Err is Human*, and *Crossing the Quality Chasm* and applied it to rural health. Key recommendations of the rural IoM report are relevant to the quality of care available to rural veterans. My career, for the past three decades, has included delivering mental health and substance abuse services and conducting research on such services in rural areas.

Throughout the Chasm series, the IoM has called for care that is safe, timely, effective, efficient, equitable and patient-centered (STEEEP). In *Quality through Collaboration*, we brought these principles to bear on rural services and rural communities, and suggested that they can improve both the quality of personal care and the health of whole rural populations. We suggested ways to modify quality indicators and processes to reflect the unique characteristics of rural communities, ways to address human resource issues, and especially ways to strengthen the health information infrastructure, which our national leaders have identified as an essential condition for quality improvement. Our report includes twelve recommendations and four key findings.

Several of those recommendations are particularly relevant to rural veterans. Since it is now estimated that 44% of new recruits come from rural places (Tyson 2005), we can expect an increase in the numbers of veterans from Iraq and Afghanistan who will be returning to rural

America recovering from complex combat-related injuries, both physical and emotional. As a member of the IoM committee, I see much common ground between the needs of rural veterans and the needs of rural populations more generally.

Among our recommendations, there are three areas that seem to me most relevant to the current issues facing rural veterans and those who are committed to their healing. First, we recommended an agenda to strengthen the rural workforce that included outreach programs to recruit young people into health professions, more rural-based educational programs, and rural training tracks and fellowships that emphasize rotations in rural sites. Second, we made several recommendations regarding health information technology, including a need to include a rural component in the National Health Information Infrastructure (NHII) strategic plan, and a specific plan for rural health providers to convert to electronic health records (EHRs) over the next five years, initially targeted to Indian Health Service provider sites, rural community health centers, rural health clinics and critical access hospitals. Third, we examined the delivery of mental health and substance abuse services in rural areas and found a fragmented, under-funded, non-system. We recommended a thorough assessment of the availability and quality of these services in rural America. As we seek to serve our rural veterans better, I believe we have an opportunity to make advances in these three areas that will assure STEEEP care to those veterans, and accelerate the agenda for providing STEEEP care to all rural residents.

The Department of Veterans' Affairs has arguably the best integrated health information network in the nation. It also has extensive, evidence-based, patient-centered performance measures and a monitoring system to assure that all patients receive high quality, guideline concordant care. That system gets good outcomes for those veterans who receive care from VA

clinics, and from Community-Based Outpatient Clinics and contract providers who can meet the VA's high standards of care.

The VA also offers training sites through an extensive residency program including affiliations with 107 medical schools, accounting for 9 percent of all residencies nationwide. The IoM committee struggled with the long-standing issue of graduate medical education (GME) with its emphasis on urban teaching hospitals. We have had minimal success in redirecting Medicare's GME payment structure to incentivize rural GME. In its 2005 Report to the Secretary of Veterans Affairs, the Advisory Committee on VHA Resident Education recommended that the VA should "…maintain training of a significant proportion of US residents in areas of importance to the VA and to the nation," and acknowledged that "geographic redistribution should be undertaken… only when an appropriate training environment and infrastructure are in place." (Advisory Committee on VHA Residencies 2005).

It is well-established that physicians who grew up in rural areas, and those who receive a major portion of their training in rural practices, are more likely to locate in rural communities when they begin their careers (Rabinowitz 2001). I suggest that the needs of 20% of VA's enrolled veterans and 44% of our recruits now serving in the military warrant investment in the VA residency training environment and infrastructure to assure that well trained physicians are available to meet the needs of rural veterans. The state-of-the-art information infrastructure I described above will help to assure that residents trained in VA sites are well-prepared to meet the high standards set by the VA.

The second highly relevant recommendation of the IoM Committee on the Future of Rural Health calls for a five-year demonstration program for information and communications technology (ICT) that would result in the establishment of a state-of-the-art ICT infrastructure

that is accessible to all providers and consumers. There are many rural areas of the United States where veterans do not have ready access to a VA clinic. However, many veterans may reside in rural areas that are served by HRSA-designated rural providers such as community health centers (CHCs), rural health clinics (RHCs) and critical access hospitals (CAHs). If the existing infrastructure of these types of providers were combined with the VA's information infrastructure, veterans living in such areas could receive high-quality care, and these providers could more rapidly establish 21st century information systems. Such collaborations would benefit veterans immediately, and, eventually, other rural residents.

As I mentioned earlier, my research emphasis has been in the area of rural behavioral health. A third very relevant issue from the IoM rural report addresses the quality and accessibility of mental health and substance abuse services. Much of my research has sought to document the lack of specialty mental health services in rural areas, and to discover alternative models for delivering such services in the absence of psychiatrists, psychologists and psychiatric facilities. The need for mental health services in rural America has been repeatedly identified as one of the topmost issues facing state-level officials and policymakers.

Evidence of the need for mental health services among veterans can be found in the high rates of combat zone suicide (Army News Service 2004), post-traumatic stress disorder, often not manifesting until a year or more after returning home, and in the VA's recently published studies of rural-urban disparities in health-related quality of life, both for veterans with psychiatric disorders (Wallace et al. 2006) and for veterans in general (Weeks 2004). Although rural veterans were found to have lower overall rates of psychiatric disorders than their urban counterparts, those with mental illness experienced a greater burden of disease and higher costs, and these disparities were associated with access to mental health care.

Lacking specialty mental health services, rural people with psychiatric problems have typically sought help from their primary care practitioner. Research tells us that such care has not always been of the highest quality, and often does not follow evidence-based guidelines for conditions such as depression, anxiety disorders and children's mental health issues (Rost et al. 2002). Two specific conditions of veterans now returning from Afghanistan and Iraq may not be accurately diagnosed by primary care practitioners who are not familiar with these conditions: post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). Once such disorders are suspected, it may be possible to refer vets to a VA specialist, and travel from a rural to an urban area for specialty care may simply be the only way to get quality care. In many of our most rural states, however, there is no VA TBI program. Moreover, the symptoms of PTSD typically affect the whole family, and may lead to domestic violence, child abuse, divorce, substance abuse and suicide. Here too, the lack of services in rural areas poses a significant barrier to effectively addressing these problems. My research suggests that creative solutions are needed to meet the need for mental health and substance abuse treatment in rural areas. Behavioral health research is dominated by well-funded precisely designed trials of various clinical interventions, many of which are unlikely to be implemented in rural areas. If creative solutions are to be found to meet the behavioral health needs of rural veterans, it may be necessary for the VA to establish its own rural behavioral health research center.

In summary, the Veterans Administration has an opportunity to build on the foundation established by the Institute of Medicine's rural report, to improve access to quality care for rural veterans, and to bring its unique resources for quality improvement and information management to rural providers. Clearly a win-win opportunity.

This concludes my testimony. I will be happy to answer any questions.

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Dr. Hartley holds a PhD in Health Services Research from the University of Minnesota. He is Director of the Maine Rural Health Research Center and a Professor of Health Policy and Management at the Muskie School of Public Service, at the University of Southern Maine, where he has been on the faculty since 1994. Prior to his academic career, he had a twelve-year career in health services management, directing both public and private substance abuse treatment programs. His research is focused on access to mental health services in rural areas, rural substance abuse prevention, rural safety net issues, Critical Access Hospitals, and community hospitals in the UK. His publications include research addressing the treatment of depression, the licensure and reimbursement of the mental health workforce, scope of services in rural hospitals, and geographic disparities in health status. In 2003, his sustained research in rural mental health was recognized by the National Rural Health Association (NRHA) with their Distinguished Researcher Award. He served on the NRHA's Policy Board from 1998-2006. In 2004 he served on the Institute of Medicine's committee on the future of rural health, which published *Quality through Collaboration: The Future of Rural Health* in 2005.

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Statement Disclosing Support by Federal Grant funds.

My employer, the University of Southern Maine, has received the following funds from the Health Services and Resources Administration, US Department of Health and Human Services over the past two years.

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Rural Hospital Flexibility Monitoring Project

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Mental Health Encounters in Critical Access Hospital Emergency Rooms