U.S. House Committee on Veterans Affairs

Committee Hearing: Rural Access: Is VA Meeting All Veterans Where They Live?

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Written Testimony

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Chairman Bost, Ranking Member Takano, and Members of the Committee:

My name is Mark Holmes. I am the Director of The Cecil G. Sheps Center for Health Services Research and North Carolina Rural Health Research Center at the University of North Carolina at Chapel Hill. I am also a professor in the UNC Gillings School of Global Public Health. I have been a rural health researcher for 25 years; my expertise is in hospital finance and health policy, especially federal public insurance payment policy. Growing up in Michigan's rural Thumb, I witnessed firsthand some of the health challenges facing our rural communities.

The Cecil G. Sheps Center for Health Services Research is one of the nation's leading institutions for health services research. Our interdisciplinary researchers undertake innovative research and program evaluation to understand health care access, costs, delivery, outcomes, equity, and value. The Sheps Center has a long-standing reputation for conducting high-quality, objective research that informs science, practice, and policy. The Center's Program on Rural Health Research is one of many Sheps Center programs generating the evidence to inform policy makers about the challenges and opportunities in ensuring access to health care services. For today's hearing, I will speak primarily about challenges facing the *non-VHA* rural health care system. Rural veterans may qualify to access community ("non-VHA") providers, so it's important to recognize the fragility of the rural health care system as part of their care. I am unable to cover all the salient issues in rural health today, so I will focus my comments on three main points relevant to today's topic:

1. Rural health care infrastructure continues to erode, and this threatens the health and well-being of the 60 million Americans – including the 4 million veterans -- who live in rural areas.
2. Congress can improve the health of rural communities by addressing some specific policy issues in rural health workforce.
3. The common narrative of rural places having sicker, poorer, and older populations is mostly accurate, but is too fatalistic — many rural communities have also shown remarkable ability to use their strength to overcome challenge.

Threats to a Robust Rural Health Care System

Since 2005, **nearly 200 rural communities have seen their hospital close**, or close its inpatient service.[1] Although roughly half of these hospitals have continued to provide some kind of health care to their community, the remainder have not; they've become condominiums, a car wash, or more often completely abandoned. In addition to providing health care, we also know how important hospitals are to **rural economies**. Recent research has shown that hospital closures can lead to decreases in the size of the labor force and the population living in the community.[2] Those hospitals that do survive have

[1] Rural Hospital Closures. The Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

[2] Malone, TL, Planey, AM, Bozovich, LB, Thompson, KW, Holmes, GM. The economic effects of rural hospital closures. *Health Serv Res*. 2022; 57(3): 614- 623. https://doi.org/10.1111/1475-6773.13965

steadily gotten smaller. **Rural hospitals have cut services** like maternity care and home health services,[3] and inpatient care in rural hospitals has fallen by 13 to 20 percent in the last decade,[4] with most of this decrease driven by rural residents being increasingly likely to receive inpatient care at urban hospitals (**bypassing local care**).[5] Access to specialty care is also affected. Approximately 20 percent of Americans live more than 60 minutes from a medical oncologist,[6] and the financial burden of increased travel time reduces the use of life-saving treatments and, paradoxically, *increases* the cost of care; geographic barriers to care actually lead to higher costs in the long run.[7] Rural residents who drive an hour a day – each way – for five weeks in a row to get their radiation treatment are facing fatigue of long car travel while fighting cancer.

This diminishing access has led to increasing rural-urban disparities in health outcomes. In 1999, the **death rate in the most rural counties** was six percent higher than it was in large urban counties; in 2019, it was **28 percent higher**.[8] Meanwhile, research led by experts at the Centers for Disease Control and Prevention (CDC) found that communities where a rural hospital closed saw an increase in preventable admissions.[9]

Hospitals have had weak and declining finances for years. In 2018, roughly half of rural hospitals were unprofitable, and financial distress is one of the leading causes of rural hospital closure. As hospitals close, residents face a decrease in access to health care. Facing this decline in access, Congress, the Medicare Payment Advisory Commission and others have often proposed new models of care that focus on a hospital's emergency department services. The Consolidated Appropriations Act of 2021 created a new type of health care provider—the Rural Emergency Hospital (REH). This model has some appealing elements, and at this time 18 rural hospitals have officially converted to REHs, but interest has been more modest due to some program design elements that can only be addressed legislatively. I applaud Congress for acting innovatively to address rural health needs. Continued monitoring of this provider type will be necessary to ensure it is meeting the needs Congress intended.

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[3] Knocke K, Pink G, Thompson K, Randolph R, Holmes M. Changes in Provision of Selected Services by Rural and Urban Hospitals between 2009 and 2017. NC Rural Health Research Program, UNC Sheps Center. April 2021. FB 174.

[4] Malone, T.L., Pink, G.H. and Holmes, G.M. (2021), Decline in Inpatient Volume at Rural Hospitals. *The Journal of Rural Health,* 37: 347-352. https://doi.org/10.1111/jrh.12553

[5] Friedman HR, Holmes GM. Rural Medicare beneficiaries are increasingly likely to be admitted to urban hospitals. *Health Serv Res*. 2022 Oct;57(5):1029-1034. https://doi.org/10.1111/1475-6773.14017.

[6] Levit LA, Byatt L, Lyss AP, Paskett ED, Levit K, Kirkwood K, Schenkel C, Schilsky RL. Closing the Rural Cancer Care Gap: Three Institutional Approaches. JCO Oncol Pract. 2020 Jul;16(7):422-430. https://doi.org/10.1200/OP.20.00174.

[7] Rocque GB, Williams CP, Miller HD, Azuero A, Wheeler SB, Pisu M, Hull O, Rocconi RP, Kenzik KM. Impact of Travel Time on Health Care Costs and Resource Use by Phase of Care for Older Patients With Cancer. J Clin Oncol. 2019 Aug 1;37(22):1935-1945. https://doi.org/10.1200/JCO.19.00175.

[8] Analysis of United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 2021. Data are compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[9] Khushalani JS, Holmes M, Song S, Arifkhanova A, Randolph R, Thomas S, Hall DM. Impact of rural hospital closures on hospitalizations and associated outcomes for ambulatory and emergency care sensitive conditions. *J Rural Health*. 2022 May 5. https://doi.org/10.1111/jrh.12671.

While REHs try to take root, the growth of hospital systems and consolidation continues to raise questions. Increasingly, rural hospitals are becoming part of a larger health care systems, and this can lead to further service erosion. Work by researchers out of the Agency for Healthcare Research and Quality has found that rural hospitals that merge are more likely to close their obstetric and surgical units.[10] Given that one study concluded female veterans may be more dependent on non-VHA providers to receive certain gender-specific services, like obstetric and gynecologic care,[11] the erosion of these services in rural communities is especially notable.

Rural Areas are Facing Acute Health Workforce Shortages

Rural places have faced persistent workforce shortages. Over the past 20 years, it has become even more difficult to recruit, retain, and sustain rural health care workers ranging from doctors to nurses to emergency medical service (EMS) personnel in rural areas.[12] Without an adequate health workforce, it is becoming more difficult for individuals in rural areas to access health care.[13] Many proposed policy solutions to address these workforce challenges focus on one profession, for example nurses, or one stage of the career, such as graduate medical education. To shore up and grow the rural health workforce, it is critical that we look to solutions that aren't siloed in this fashion and support health care workers across their entire career trajectory.[14]

Evidence-based investments that increase the number of health professionals training in rural areas, increase the number of preceptors and faculty, provide support to early career health care workers, and focus on retaining mid to late career health care professionals can be further scaled. Health professionals that train in rural areas are five times as likely to remain in practice in rural areas.[15] By growing the number of rural training opportunities and then ensuring that resources are available to retain that workforce across their careers, we can ensure that the workforce needed to support rural areas is there for decades to come.[16]

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[10] Henke RM, Fingar KR, Jiang J, Liang L. and Gibson TB. Access To Obstetric, Behavioral Health, And Surgical Inpatient Services After Hospital Mergers In Rural Areas. *Health Affairs* 2021 40:10, 1627-1636

[11] Marshall V, Stryczek KC, Haverhals L, Young J, Au DH, Ho PM, Kaboli PJ, Kirsh S, Sayre G, The Focus They Deserve: Improving Women Veterans' Health Care Access, *Women's Health Issues 2021*, 31(4): 399-407. https://doi.org/10.1016/j.whi.2020.12.011

[12] Rural Health Research Gateway. Trends in Health Workforce Supply in the Rural. U.S. https://www.ruralhealthresearch.org/projects/926

[13] Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities Council on Graduate Medical Education 24th Report. 2022. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/reports/cogme-april-2022-report.pdf

[14] Fraher E, Brandt B. Toward a system where workforce planning and interprofessional practice and education are designed around patients and populations not professions. J Interprof Care. 2019 Jul-Aug;33(4):389-397. https://doi.org/10.1080/13561820.2018.1564252.

[15] Russell DJ, Wilkinson E, Petterson S, Chen C, Bazemore A. Family Medicine Residencies: How Rural Training Exposure in GME Is Associated With Subsequent Rural Practice. J Grad Med Educ 1 August 2022; 14 (4): 441–450. https://doi.org/10.4300/JGME-D-21-01143.1

[16] Kumar S, Clancy B. Retention of physicians and surgeons in rural areas—what works?, *Journal of Public Health* December 2021, 43(4), 689–700, https://doi.org/10.1093/pubmed/fdaa031

Decades of research have taught us that one of the most effective ways **to boost health workforce** in rural and underserved areas **is to *train* them in rural and underserved areas**.[17] Efforts to expand physician training have paid great dividends; for example, during the four years of the Rural Residency Planning and Development program, there have been more **new rural residency slots** (463) than were established during the prior decade (418). Meanwhile, the VHA has increased the number of residency slots by 1,500, with many rural VHA facilities receiving priority for additional slots.[18]

Congress has enacted legislation to address rural physician shortages via training. The Consolidated Appropriations Act of 2021 included provisions that expand rural resident training opportunities. Section 126, for example, increased the number of physician residency slots, to be phased in over several years. To qualify, training programs must meet one of four criteria, including being located – or being *treated* as being located – in a rural area. Legal decisions have led to a rapid **increase in the number of urban hospitals that reclassify as rural**; this means that, under current legislation, they are treated as rural hospitals in all respects, including eligibility for residency slots. Despite a ten percent floor on the number of expanded residency slots allocated to rural hospitals, **only five percent of slots were allocated to hospitals <u>located</u> in rural areas**; **another 42 percent were allocated to urban hospitals that have been reclassified as rural**.[19] This may not have been Congress's intention.

Behavioral health is a particularly important health care service for our veterans. Veterans experience certain conditions – notably, traumatic brain injury and substance use disorders – more often than their civilian counterparts.[20] Although behavioral health remains a crisis across the country, compared to urban residents, residents living in rural areas receive less care, from providers with less specialized training, and the care they received is less likely to be innovative.[21] This creates a particularly acute challenge for rural veterans – **there are fewer health care providers to treat and manage their more prevalent behavioral health needs**.

Rural Can Innovate and Lead When Policies Are Rural-Appropriate and Supportive

[17] E.g. Holmes G.M. Increasing physician supply in medically underserved areas. *Labour Economics.* Volume 12, Issue 5, 2005, Pages 697-725, ISSN 0927-5371, https://doi.org/10.1016/j.labeco.2004.02.003.
[18] Klink KA, Albanese AP, Bope ET, Sanders KM. Veterans Affairs Graduate Medical Education Expansion Addresses U.S. Physician Workforce Needs. Acad Med. 2022 Aug 1;97(8):1144-1150. https://doi.org/10.1097/ACM.0000000000004545.
[19] Rains J, Holmes GM, Pathak S, Hawes EM. The Distribution of Additional Residency Slots to Rural and Underserved Areas. *JAMA.* 2023;330(10):968–969. https://doi.org/10.1001/jama.2023.14452
[20] Olenick M, Flowers M, Diaz VJ. US veterans and their unique issues: enhancing health care professional awareness. Adv Med Educ Pract. 2015 Dec 1;6:635-9. https://doi.org/10.2147/AMEP.S89479.
[21] Morales DA, Barksdale CL, Beckel-Mitchener AC. A call to action to address rural mental health disparities. J Clin Transl Sci. 2020 May 4;4(5):463-467. https://doi.org/10.1017/cts.2020.42.

We commonly hear about rural America being sicker, poorer, and older. It is also relatively well-known rural residents are less likely to have health insurance,[22] more likely to travel farther for health care,[23] and more likely to have chronic diseases. The CDC found that rural residents are more likely to die of the five leading preventable causes of death.[24] These are accurate descriptions of a population that provides much of America's food, fun, and fuel. Although accurate, I often worry that it suggests government is powerless to improve rural health. **Historically, when Congress and policymakers have developed policy to address rural needs, it has led to dramatic improvements** in conditions for relatively small expenditures. In the early 1990s, rural hospitals were closing at a dramatic pace, and Congress introduced the Critical Access Hospital program in 1996. That program has stabilized the rural health care system for over 1,300 rural communities. Although roughly one quarter of acute care hospitals are CAHs, the program only accounts for five percent of total hospital outlays by Medicare.[25]

Perhaps because of the more limited resources in rural communities, there are many **examples where rural health care innovation has led the way**. Telehealth, community health workers, expanded scope of practice and task shifting, drones, new payment models, and leveraging strong trust in community leaders (faith leaders, agriculture, other community organizations) are all examples where lessons from rural innovation has helped fuel transformation throughout the health care system. One word of caution, however; the pandemic saw dramatic increases in the use of telehealth, which seems particularly well-suited to the challenges described today. Telehealth-based solutions may be one promising strategy, but will not be effective for all veterans; roughly **one quarter of rural veterans do not have internet** in their home.

Conclusion and Future Directions

Although rural residents – and those who visit rural communities – face real barriers to achieving their full health potential, there are policy strategies that Congress can consider to mitigate some of the barriers. History has shown that thoughtful legislation designed to address rural-specific challenges and leverage the assets of rural America has been successful in improving the lives of the 60 million who live in our rural communities. It is important to continue to recognize that **rural health care systems are different, and not simply "small versions of urban"** and can yield similar outcomes, when given the opportunity.[26]

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[22] Turrini G, Branham DK, Chen L, Conmy AB, Chappel AR, and De Lew N. Access to Affordable Care in Rural America: Current Trends and Key Challenges (Research Report No. HP-2021-16). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. July 2021.

[23] Ostmo P Rosencrans J. Travel Burden to Receive Health Care. Rural Health Research Gateway. 2022. https://www.ruralhealthresearch.org/assets/4993-22421/travel-burden-recap.pdf.

[24] National Center for Chronic Disease Prevention and Health Promotion. Rural Health: Preventing Chronic Diseases and Promoting Health in Rural Communities. https://www.cdc.gov/chronicdisease/resources/publications/factsheets/rural-health.htm

[25] Medicare Payment Advisory Commission. Critical Access Hospitals Payment System. https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_cah_final_sec.pdf

[26] Centers for Medicare & Medicaid Services. Rural-Urban Disparities in Health Care in Medicare. November 2020. https://www.cms.gov/files/document/omh-rural-urban-report-2020.pdf