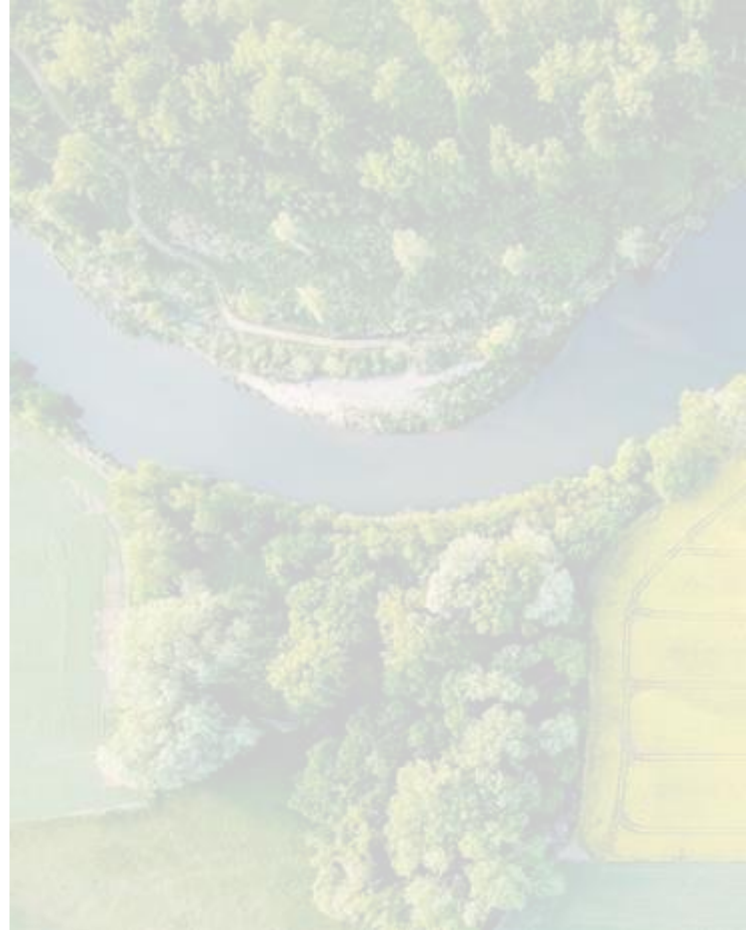
VA Healthcare Facility Use: Rural Aging Veteran Perspectives



Traben Pleasant, PhD., Sarah Ono, PhD., Elizabeth Hulen, PhD., Rachel Matsumoto, MS., Helen Harrison, BA., Sarah Gothard, BA., Rachel Wall, MS. & Lisa Silbert, MD.

Veterans Rural Health Resource Center (VRHRC), Portland, Oregon
VHA Office of Rural Health, Department of Veterans Affairs & OHSU

Today's

PRESENTATION

The views expressed in this presentation are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

The authors have nothing to disclose and no conflicts of interest.

Background

- The 2018 “MISSION Act”
- VA Community-Based Outpatient Clinics (CBOC)

These benefits expand VA healthcare options for Veterans while increasing its complexity

Rural Aging Veterans

- > 50% of all living Veterans are 65 years of age or older
- Rural Veterans are more likely than urban Veterans to be over 65

A few common challenges to VA healthcare access are:

- Distance, bad experiences, long wait times, primary care clinician turnover and limited options – particularly for specialty care
- Tracking a Veteran’s healthcare across institutions can also be difficult

VA Community-Based Outpatient Clinics

- More than 800 CBOC are located across the US
- CBOC are VA-based facilities established in the 90s to expand primary care (PC) and specialized care (SC) for Veterans
- CBOC support Veterans who face geographic, age, or health-related challenges accessing VA healthcare

The MISSION Act

- Increases PC and SC access for Veterans facing healthcare challenges

- Offers eligible Veterans outsourced, non-VA private care options (“community care”)

MISSION Act eligibility includes:

- Veterans living more than 40 miles from a VA clinic, or who have a 30-minute drive for PC/60 minutes for SC, or more than a 20 day wait for PC/28 days for SC

- Continuity between VA and non-VA healthcare institutions can be challenging

Research Objectives & Questions

Objectives

To examine rural aging Veteran perspectives on VA and non-VA healthcare use

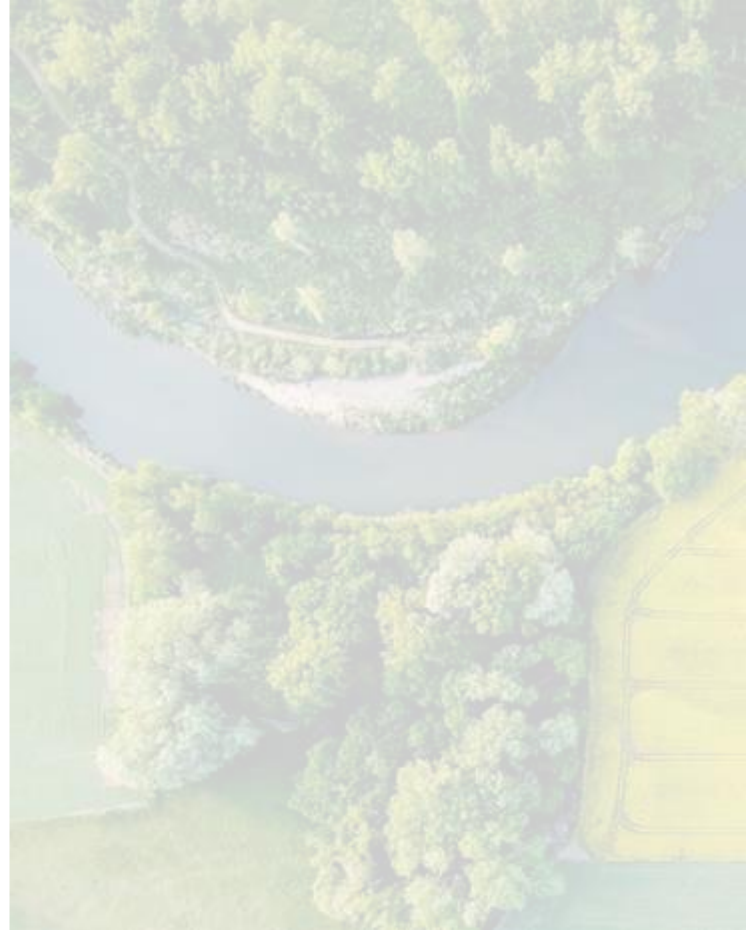
Questions:

1. Where do these mostly rural aging Pacific-Northwest Veterans access healthcare?

2. What influences their decisions to use or not use VA healthcare?

Methods

- The Collaborative Aging in place Research using Technology initiative (CART)
- Inclusion Criteria: At least 62, living independently or with one cohabitant; internet access and can use email
- No dementia, terminal illness or non-ambulatory
- USDA Rural-Urban Commuting Area codes (RUCA) were used to determine Veteran rurality



Veteran Aging and Wellbeing Survey

- Survey sent via email in 2021
- Designed to assess Veteran VA and non-VA healthcare decisions, VA healthcare use and preferences
- Variables were created based on recent literature, team member suggestions and consensus

Results

Table 1 Participant demographics, military service history and RUCA codes.

Characteristic (N=48)	Totals
Age (in years as of 2020)	Mean (sd) = 73.8 (5.40); ages 63-88
Sex	45 Males, 3 Females
Race/Ethnicity	96% White, 4% Other Unspecified
Education (in years)	Mean (sd) = 14.91 (2.20)
Marital status	34 married, 2 widowed, 9 divorced, not remarried, 1 separated, 2 never married
Branch of Service	Air Force 15%, Army 31%, Coast Guard 2%, USMC 21%, Navy 29%, n/a 2%
Served in a War or Conflict	54%
Vietnam War (1965-1975)	43%
Gulf War (Kuwait 1990-1991)	2%
Afghanistan War (2001-2021)	2%
Iraq War (2003-2011)	4%

Table 1 Participant demographics, military service history and RUCA codes.

Characteristic (N=48)	Totals
Reported military-related disability (MRD)	68%
RUCA	Mean = 4.93
Urban 1-3 **Large Rural 4-6** **Small /Isolated Rural 7-10**	25% 42% 33%
Distance to PVAMC RUCA	Mean (sd) = 67.62 miles (31.97)
Urban 1-3 **Large Rural 4-6** **Small /Isolated Rural 7-10**	19.22 85.36 82.87

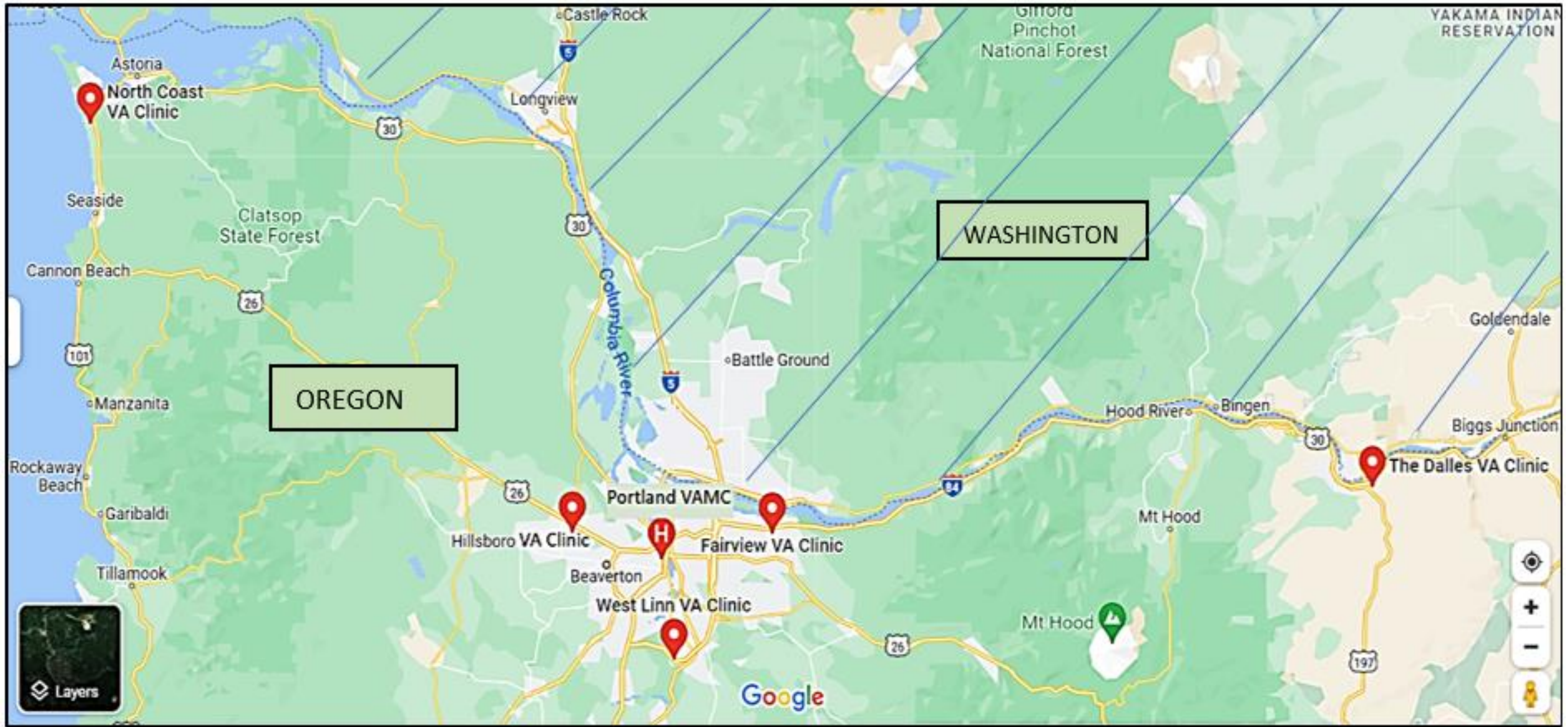


Figure 1. Adapted Google Map highlighting the Portland VA Medical Center and the five Community-Based Outpatient Clinics used by Veterans in this study.

Analysis of closest VA healthcare facility use

Why do you use or not use your closest VA healthcare facility?

VA user variables

- VA quality
- Close to home
- It is free
- Only option
- Other

VA non-user variables

- VA quality poor
- Bad experience
- Lack of transportation
- Distance
- Wait time/red tape
- The MISSION Act

Analysis of closest VA healthcare facility use

We assigned variables and illustrative quotes as qualitative data to the following three categories:

1. Distance
2. Quality/Experience
3. Policy/Costs

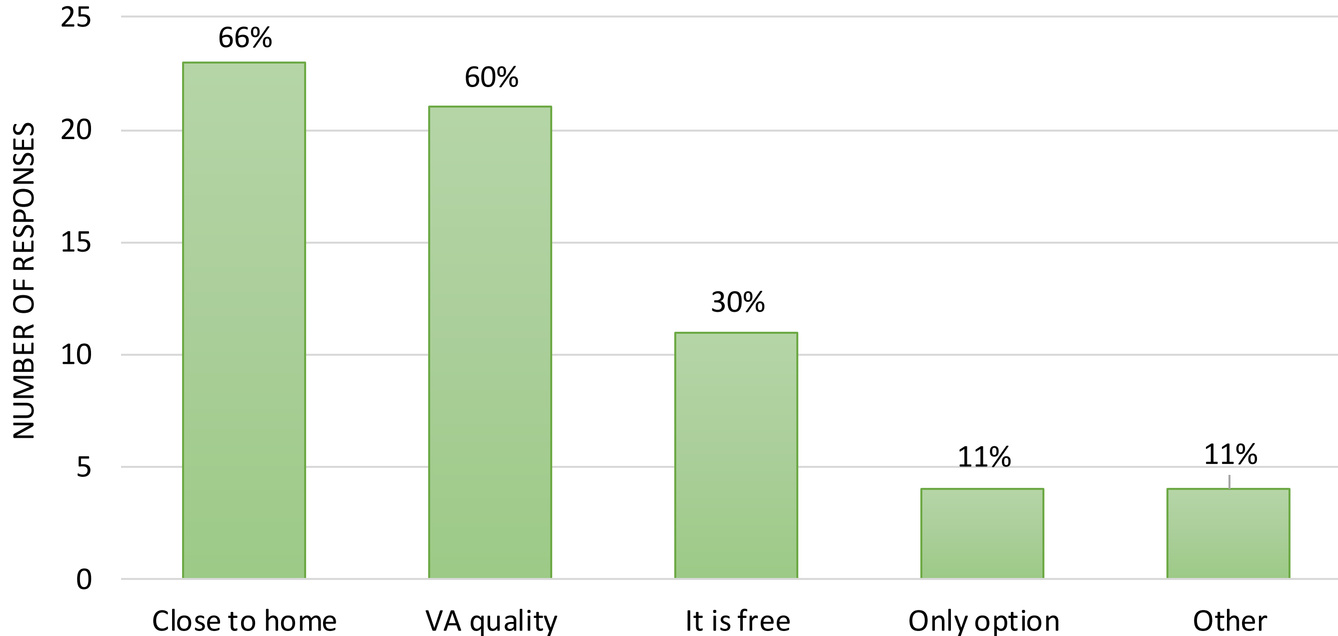


Figure 2. Percent of responses on why Veterans used their closest VA medical facility. Veterans could select multiple variables (35/48 responded).

Why do you use the VA facility closest to you?

Distance: *"It's the closest—one hour away,"* [RUCA 10, age 80];
"It just makes sense…VA PDX [Portland, OR] is closest to me" [RUCA 4, age 80]

VA Quality/Experience: A participant illustrated a wavering relationship with the VA stating he's *"committed to the VA when they [serve] us well" [RUCA 5, age 72]*

Policy/Costs: *A* Veteran mentioned using their closest VA *"when community-care isn't available" [RUCA 4, age 76]*; While another used their closest VA, instead of Medicare-covered non-VA healthcare, because *"the Medicare penalty is too high to get back into"* if you don't sign up before the enrollment deadline [RUCA 5, age 72]

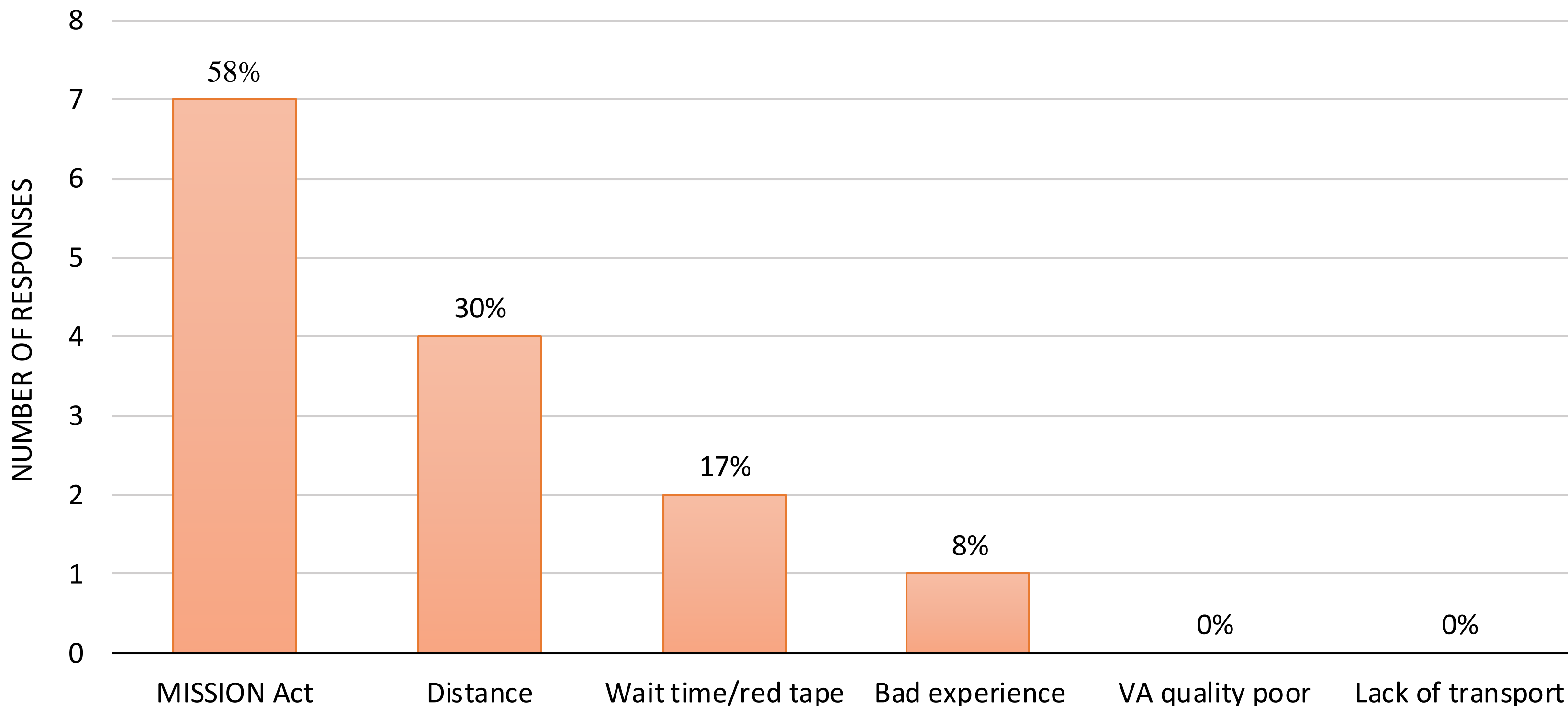


Figure 3. Percent of responses on why Veterans do not use their closest VA medical facility. Veterans could select multiple variables (12/48 responded).

Why do you *not* use the VA facility closest to you?

Distance: Distance to a VA was very influential on Veterans' decisions to not use VA healthcare. No open ended quotes were received.

Quality/Experience: A Veteran did not use their closest VA due to bad experiences with care continuity because *"…the primary care physicians kept changing"* [RUCA 7, age 76]; Another mentioned delayed appointments for non-use [RUCA 4, age 63]

Policy/Costs: A Veteran mentioned not using their closest VA facility because *"Covid 19 made them stop outpatient visits"* at their closest VA [RUCA 4, age 73]

Why do you use private healthcare *rather* than VA healthcare services?

- 35% of Veteran respondents (17/48), including those implying use of the MISSION Act, reported using private healthcare services rather than VA.
- Veterans were influenced by location options, VA wait times and MISSION Act community care benefits.

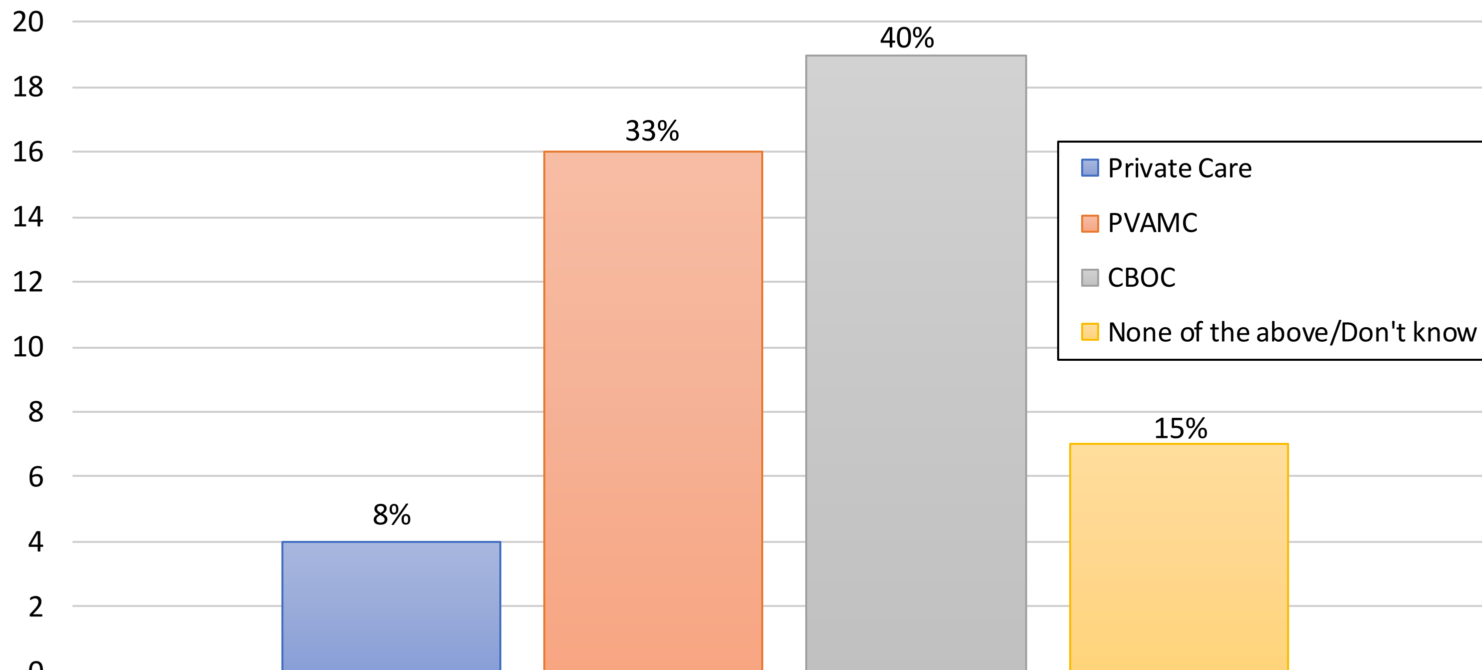


Figure 4. Percentage of all Veterans who received PC at the PVAMC. Veterans who chose the Vancouver, Washington VA Medical Center (VVAMC) were designated as using the PVAMC because the VVAMC is a branch of the greater PVAMC (46/48 responded; 2 n/r).

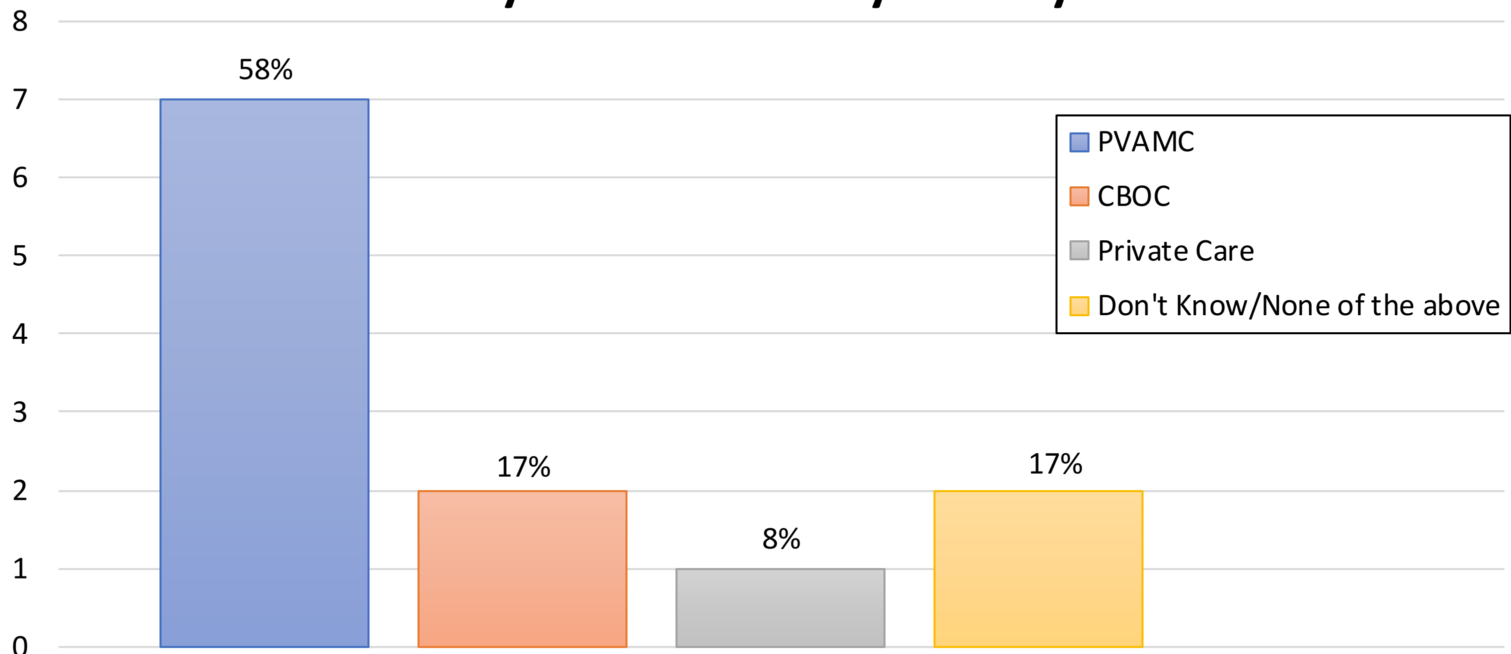


Figure 5. Facility use for primary care RUCA 1-3 (n=12)

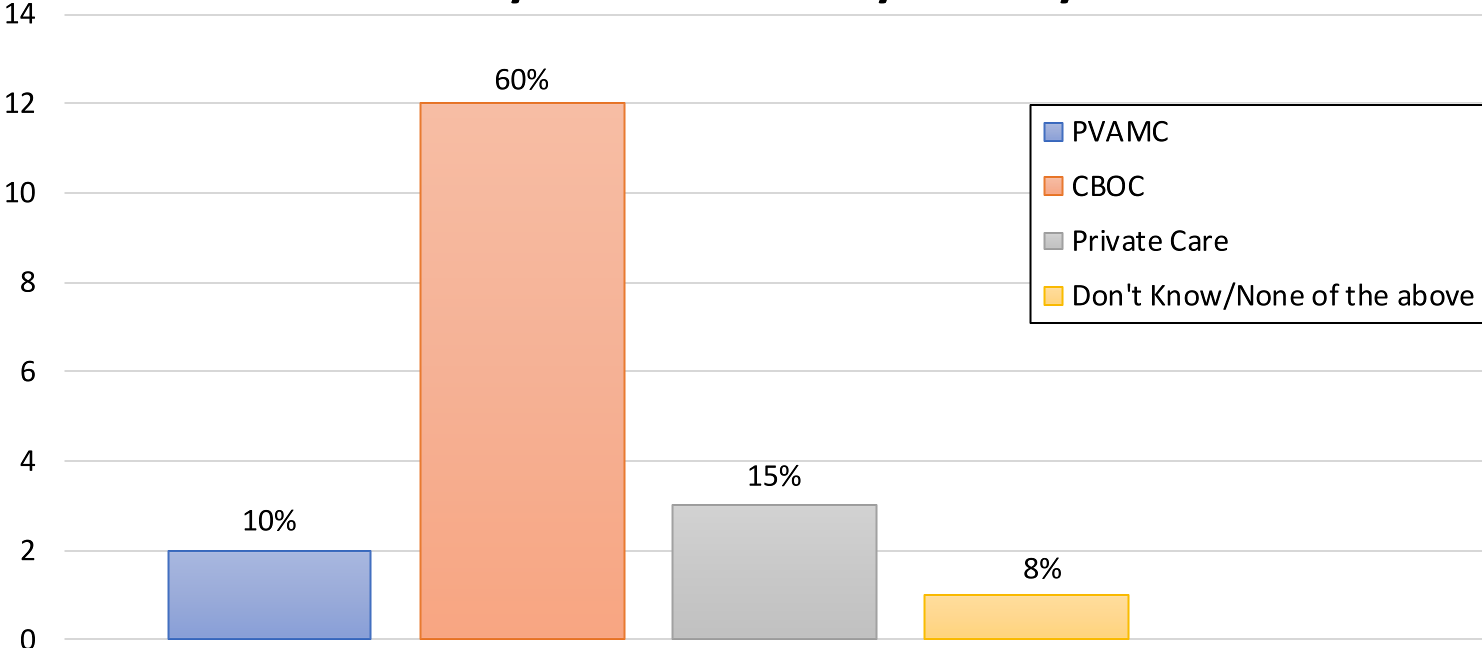


Figure 6. Facility use for primary care RUCA 4-6 (n=20; 2n/r)

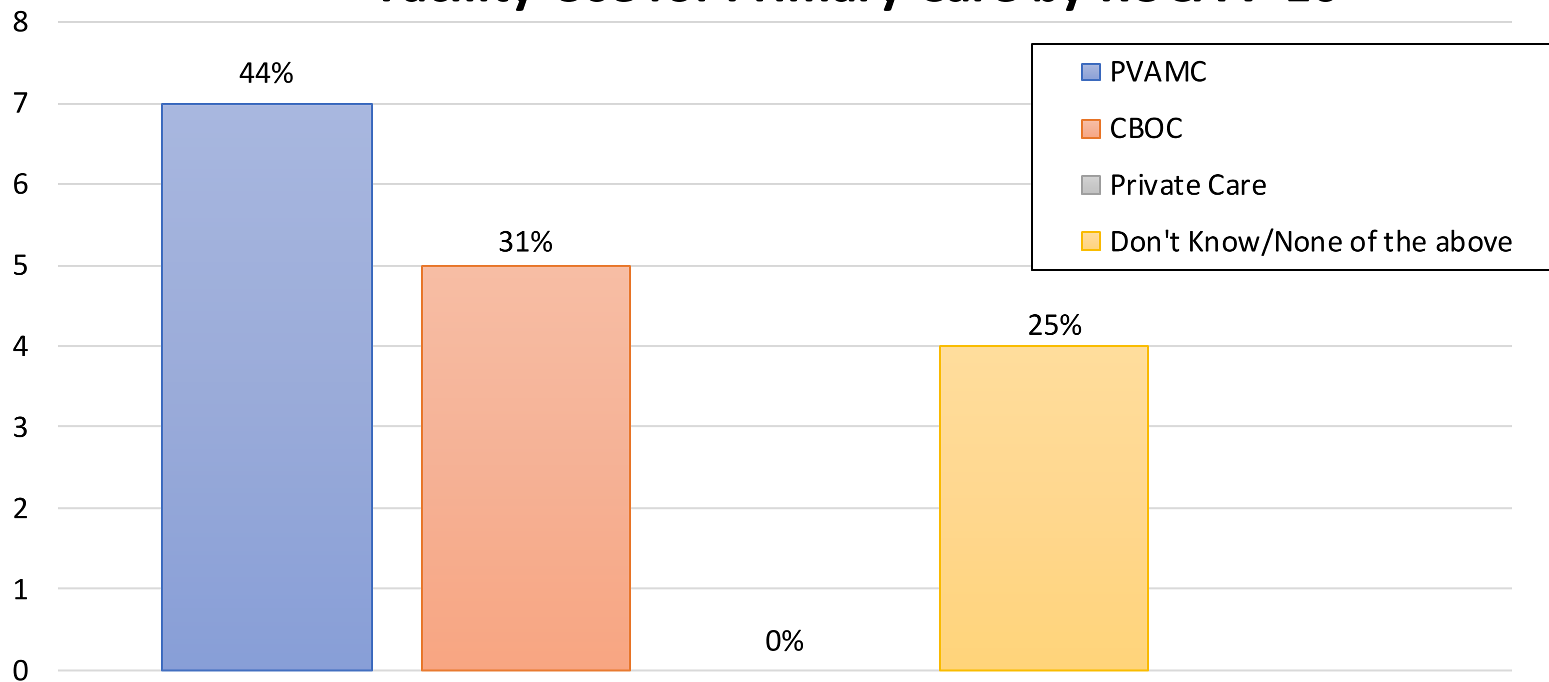


Figure 7. Facility use for primary care RUCA 7-10 (n=16)

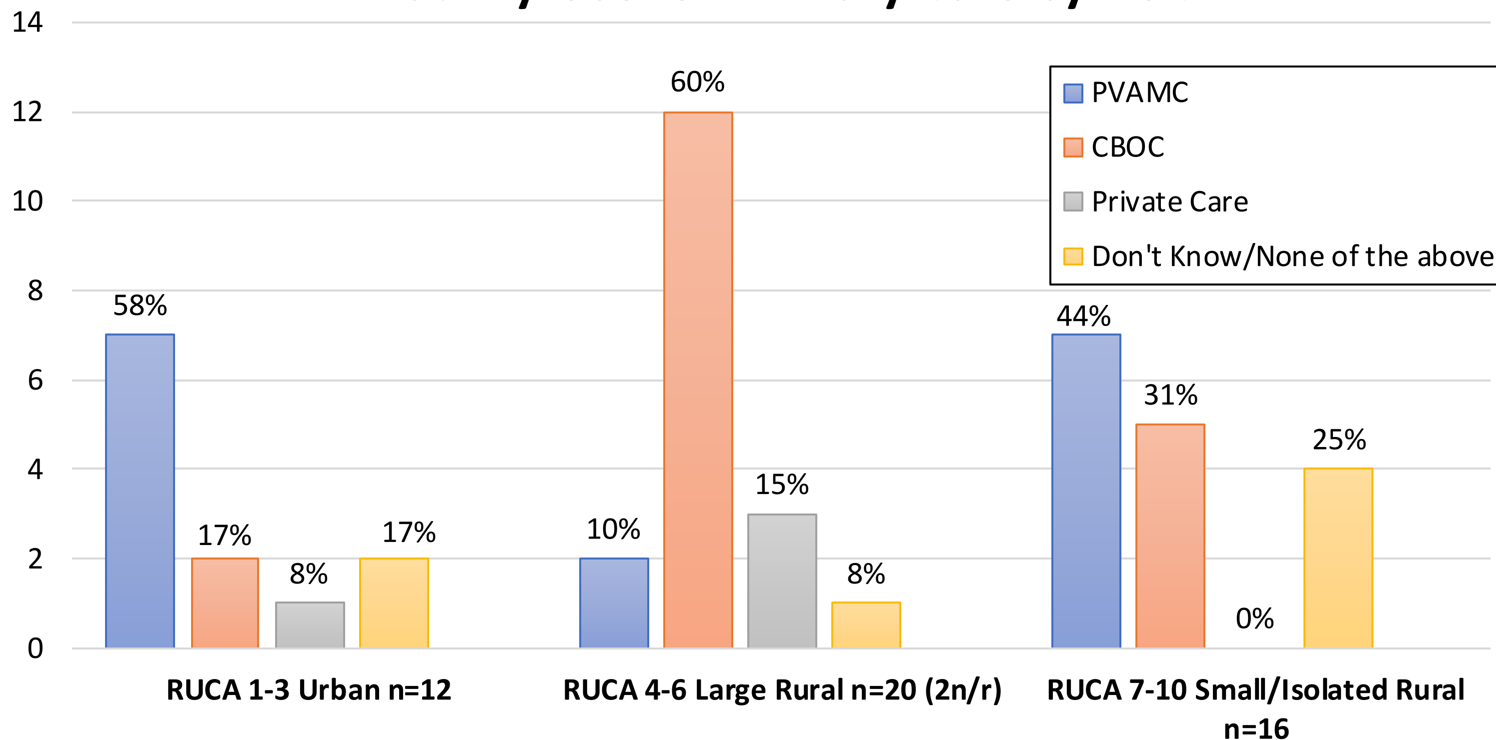


Figure 8. Facility use for primary care all RUCA (N=48; 46/48; 2n/r)

Discussion

- The MISSION Act, distance to a VA facility, VA experiences, quality, policy and costs influenced Veterans' decisions to use or not to the VA for PC.
- While more urban (RUCA 1-3) Veterans were more likely to use the Portland VA Medical Center (PVAMC) for PC, Small/Isolated rural Veterans (RUCA 7-10) used the PVAMC for PC more than the Large Rural (RUCA 4-6) Veterans.
- RUCA 4-6 Veterans used CBOC for PC more than RUCA 1-3 and 7-10 Veterans.
- RUCA codes are based on a mix of factors.
- Primary care deserts/isolation

Implications

- VA healthcare, CBOC and the MISSION Act work well for some but not all.
- Most of these Veterans rely on the VA for PC, however, MISSION Act purchased care—"community care"—use is increasing for PC.
- VA and non-VA affiliates should prepare for an increased reliance on VA healthcare, including purchased care, by aging Post-9/11 Veterans.
- The most isolated rural Veterans may live in "healthcare deserts" and bypass CBOCs to use the PVAMC for primary care for a variety of reasons; more research is needed.

Limitations

- This study is based on Pacific-Northwest Veterans in Oregon and Southern Washington; homogeneity
- Covid, shutdowns and appointment delays played a role in Veterans' healthcare decisions.
- This study only reflects Veterans who were participating in a PVAMC study, which might bias towards urban residing Veterans.
- Defining rurality is subjective. We used 2010 RUCA codes for this study as they were used in the primary dataset. RUCA codes were updated in 2020.

Conclusions

- Rural aging Veterans use their VA healthcare benefits strategically.
- The MISSION Act and distance had the greatest influence on Veterans' decisions to use or not use VA healthcare.
- Future studies should explore the healthcare decisions made by Small Rural/Isolated Veterans living in areas classified as RUCA 7-10.

Addressing these issues will help researchers, clinicians and administrators to better understand rural Veteran healthcare decisions, and how policies like the MISSION Act impact VA healthcare use and the quality of care Veterans receive.

Traben.Pleasant@va.gov

Department of Veterans Affairs, Veterans Rural Health Resource Center (VRHRC), Portland, Oregon.

OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

Thank You Partners!