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## Rural Veterans: Invisible Heroes, Special People, Special Issues

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**RURAL VETERANS:  
INVISIBLE HEROES, SPECIAL PEOPLE, SPECIAL ISSUES\***

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**PART I: WHY A SPECIAL ISSUE ON RURAL VETERANS**

This special issue of the *Journal of Rural Social Sciences* (JRSS) seeks to introduce and explore the topic of rural veterans, their characteristics and demographics, the challenges they face in accessing health and mental health care in rural America, and the efforts being made to serve and assess this special population through research-based studies and analyses. The issue will begin to fill the gaps in the literature and augment our knowledge on the issues faced by rural veterans and their families. It is our hope that this issue will stimulate discourse among a wide range of thought leaders engaged in service, policy, and research on needed policy and practices to better address rural veterans' challenges.

There are four primary reasons why this special issue is useful and relevant to many areas of science and practice concerning rural veterans: (1) it is the first ever peer-reviewed journal issue dedicated solely to the issues faced by rural veterans and those who care for them; (2) it is an attempt to highlight the gaps in our current research and policy work; (3) it is an attempt to challenge researchers and policy makers to view these issues across many disciplines, as our authors represent a wide range of social science and health science fields; and (4) it is time to provide a singular focus on these issues.

*Overview of Rural America*

Rural Americans are blessed and challenged by social, cultural, economic, and geographic differences from their urban counterparts. These differences can simultaneously contribute to rural health disparities and provide solutions to closing the service gap. The population living in rural areas constitutes one of the largest underserved U.S. population groups. Rural residents are more likely to: be elderly, be from a lower socioeconomic status, be uninsured, report fair or poor health, suffer from chronic disease, and have higher mortality rates associated with

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chronic disease (Braden and Beauregard 1994; Eberhardt and Pamuk 2004). Simultaneously, rural residents are more likely to serve in the military, maintain strong family ties, live in communities with lower crime rates, and work in high risk occupations. Rural residents are also less likely than their urban counterparts to visit a primary or ambulatory care provider, contributing to lower rates of preventive services and higher rates of potentially avoidable hospitalizations (Laditka, Laditka, and Probst 2009; NACHC 2009). Furthermore, an enduring feature of the U.S. health care landscape is the uneven distribution and relative shortage of rural health care providers, where only 9 percent of the physician workforce is available to serve 20 percent of the total U.S. population (HHS HRSA 2010). As a result, nearly one-third of all rural counties contain Health Professional Shortage Areas (HPSAs), and there are twice as many rural HPSAs as there are urban ones (Probst et al. 2004).

#### *Rural and Minority Military Service*

Rural and minority Americans serve in the military at disproportionately higher rates than are represented in the general population. Rural Americans often join the military at higher rates than non-rural Americans: while only 20 percent of Americans live in rural areas, roughly half of all military recruits come from small towns and rural areas compared with 14 percent from major urban cities (DOD 2008; Heady 2007). When analyzing active duty military components in terms of race and ethnicity, the U.S. military is quite diverse. Black, Native Hawaiian and Pacific Islander, and American Indian and Alaskan Native racial minority groups are often overrepresented among active duty enlisted personnel in all military components (Army, Navy, Marines, and Air Force) when compared with relevant civilian comparison group populations (DOD 2008). For example, blacks are often overrepresented in military components, making up roughly 20 percent of all active duty enlisted personnel, but only 13 percent of the civilian comparison group (DOD 2008). Hispanics considered an ethnic rather than a racial group, are often underrepresented, making up 11.6 percent of active duty enlisted personnel while accounting for nearly 18 percent of the comparable civilian population (DOD 2008).<sup>1</sup>

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<sup>1</sup>However, data on race and ethnicity can be difficult to analyze, because military personnel are not required to report their race and ethnicity. There are military personnel whose race and identity are unknown, making it difficult to compare military racial and ethnic proportions to those in the general population.

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Consequently, due to their high rates of military service rural and minority Americans also represent a substantial proportion of the U.S. veteran population. Approximately 41 percent of veterans (3.3 million) enrolled in the Department of Veterans Affairs (VA) health care system live in rural or highly rural areas of the country, with the majority living in the southern or central portions of the country (VA ORH 2011). Of the 21.8 million veterans identified in the Census Bureau's American Community Survey in 2010, approximately 19 percent (more than four million) identified themselves as racial minorities and 7 percent (1.6 million) were female (U.S. Census Bureau 2011).

Whether motivated by tradition and values, the need for education and job skills, or economic concerns, rural and minority Americans respond to the call to war at higher rates than their counterparts. However, there are serious gaps in our research on the motivations influencing rural and minority populations' decision to enlist. The research that is available focuses primarily on material factors such as educational benefits and improved economic opportunity. This research ignores the influence of personal and social values on decision making, such as the value of service to others a characteristic attributed to rural and some minority populations (Heady 2007). When faced with the decision to enter the military, especially in war time, it seems reasonable that possessing a value of service to others could more easily facilitate this decision. However, the literature is critically limited in the areas of minority and rural populations and how their values and culture relate to military service.

One article examining the motivations for serving in the National Guard (Griffith 2008) found that personal values play a role in the recruitment and retention of soldiers. Those intrinsic values are associated with assisting and protecting others, loyalty to completing goals, and feeling obligations to others. While those specific values relate to rural and minority values and culture, the article did not specifically consider rural values or rural communities. The study concluded that soldiers who joined for intrinsic reasons were more committed to reserve military service, influenced by social context (such as family and friends in the unit), and perceived themselves as more combat ready than those who joined for other, often economic reasons. Other studies have analyzed factors influencing enlistment into the military, which again may apply to rural populations, but have not specifically focused on rural values and culture. These studies have shown that the institutional and cultural presence of the military within an area significantly influences the decision to join the military. Therefore, the presence of military family members, such as grandparents, parents, or siblings; military bases; military

personnel; veterans; and military-related institutions increase the propensity to enlist (Cebula, Menon, and Menon 2008; Kleykamp 2006; Segal et al. 1999).

Furthermore, Cebula et al. (2008) found that the military is a vehicle for upward social and economic mobility. The same study found that youth from states where a higher percentage of the population is without health insurance coverage show a higher tendency to enlist, but the authors concluded that there was insignificant prior research to support this finding, and that further research would need to be conducted to make any conclusions regarding this association.

Rates of military service among rural populations remain relatively unchanged when analyzing the impact of both the discontinuation of the draft and enlistment following 9/11. Changes in the recruitment-to-population ratio after 9/11 show that large increases (of greater than 10 percentage points) occurred in Iowa, Wisconsin, Kansas, Washington, Arizona, Indiana, Oregon, Nebraska, Colorado, Minnesota, and North Carolina (Kane 2005). While rates of military service have remained relatively unchanged, information from the Department of Defense (DOD) in 2005 demonstrated that a significant proportion of service members killed in action in Iraq and Afghanistan were from small towns and rural areas (Battles 2005). Using DOD casualty figures updated through February 12, 2005, 42.9 percent of the service members killed in action during Operation Iraqi Freedom (OIF) and 43.9 percent of the service members killed in action during Operation Enduring Freedom (OEF) originate from rural cities and towns with populations below 20,000 (Battles 2005). However, according to the U.S. Census Bureau in 2005, only 22.5 percent of Americans live in towns with populations at or below 20,000 (Battles 2005). These data enforce the importance of rural and minority populations in military service.

#### *Rural and Minority Veterans*

Research on the health care status and needs of rural veterans compared with their urban counterparts is growing, but there are still many issues, topics, and specialty populations that remain undeveloped. Current data on enrolled rural veterans suggest that, as compared with urban veterans, rural veterans are often older, have greater physical and mental co-morbidities, have lower physical and mental quality-of-life scores, and reside further away from VA and non-VA health care facilities (Weeks et al. 2006). While the data indicate that the rural veteran population experiences a higher burden of disease, they have a lower utilization rate of VA health care services than urban veterans. Rural populations face unique access

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barriers including cost, travel distance, travel time, and weather that limit rural veterans' ability to utilize care (Booz Allen Hamilton 2008).

However, most of these data focus upon rural veterans enrolled in the VA health care system. The VA Veteran Rural Health Advisory Committee (VRHAC 2009) suggests that there are insufficient data regarding non-enrolled rural veterans. Data on this population could reflect both the adequacy of outreach efforts conducted by the VA and the health status of those veterans not utilizing VA services. These data could provide a more comprehensive picture of the health issues and barriers to care facing all rural veterans, not merely those already enrolled in the VA health care system. In addition, data suggest that the demographic composition of the rural veteran population is changing. Minorities serve in the U.S. military at higher rates than their representation in the U.S. population (Heady 2007) and population estimates from the VA suggest that the percentage of minority veterans, including African Americans, Hispanics, and female veterans, is on the rise (VA NCVAS 2010). Similarly, as the military continues to draw recruits from rural areas, the rural veteran population potentially will get younger. Currently, most of the male enrolled rural veterans are between the ages of 55 and 64 (VRHAC 2009). In contrast, almost half of all Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans residing in rural areas are under the age of 35 (VRHAC 2009). These demographic shifts will result in changes in the types of services requested and utilized. Therefore, more focused research on the unique health care needs and access patterns of these populations is necessary to enrich the field of rural and minority veteran health care.

*Impetus for Change*

In November 1997, I suggested to my rural health colleagues in a policy board meeting of the National Rural Health Association (NRHA) that we develop a policy statement on rural veterans and their needs. While I had hoped for an immediate and passionate response, I discovered that many were not aware of the needs of this group I termed "invisible heroes": invisible because the public is unaware of their disproportionate rate of military service, and heroes because of their deeply personal decision to serve. Fortunately, two colleagues who were Vietnam veterans came up to me following that meeting and agreed that there was a need for such a policy paper and volunteered to help. What ensued was a highly frustrating experience as I researched the literature for existing research and policy statements regarding rural veterans and found almost nothing specific to this issue. My first search efforts on any material concerning rural veterans uncovered proceedings of congressional

hearings concerning the health care of veterans living in rural areas. One was conducted before the Senate Committee on Veterans Affairs on November 15, 1989; and another field hearing by the Senate Committee specific to the health care needs of rural veterans in West Virginia held in Beckley on July 19, 1993 (U.S. Senate Committee on Veterans Affairs GPO 1990, 1993). None of these early searches of the literature found any studies focused on rural veterans or comparisons of rural and urban differences among veteran populations. I did not understand why the literature had such a void concerning an issue I believed merited investigation and national attention. Finally, in 2004 I found and reviewed the article by Dr. Bill Weeks outlining the differences in health-related quality of life in rural and urban veterans. As a society we were experiencing the aging of approximately eight million Vietnam era veterans, more than two million having served in combat, and many living, working, and seeking care in rural America. As the administrator of a small rural hospital years earlier, I was keenly aware of the number of veterans seen in our emergency room for numerous primary and mental health care issues for which they had limited or no resources for appropriate care. As a former dependent spouse of a Vietnam combat veteran, I had personal experience with many of these issues. In March 2001, while providing testimony before the Senate Committee on Aging in Rural Areas, I took the opportunity to include information on rural aging veterans.

Finally, the first draft of a very modest policy statement was completed in 2002, revised and passed by the NRHA policy board in 2004, and revised in 2007. Others became interested in this effort, but the events of 9/11 and the initiation of our wars in Iraq and Afghanistan generated an increased attention to the rural veteran issue. Writers in the popular media began reporting on the disproportionate number of rural and small town service members serving in these wars as a new phenomenon. For those of us raised in rural America, this was nothing new as family members had been enlisting or being drafted and going off to war since the founding of our nation. I was elected president of NRHA in 2004 and took on the issue of rural veterans as a significant portion of my platform over the following three years. I delivered several speeches on rural veterans from 2004 to 2009, the first as the keynote to the Washington State Rural Health Association in Spokane. I was amazed by how that presentation resonated with members of the audience. Five WWII and Vietnam veterans and family members came up to me afterward to simply thank me for what I had said. That experience pushed me to further my efforts to bring national attention to this issue.

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With the assistance of the JRSS editors, I organized the call for papers for this special issue around a core group of themes and distributed it widely to a broad audience of researchers, practitioners, and policy leaders. The reason for a broad audience was to gather many perspectives on what was a developing coalescence of core themes. The papers presented here have been organized around those themes to give the reader an introductory and broad view of who rural veterans are, why learning more about them is important, and how some are going about learning more and addressing these themes. We were uncertain of the potential response to this call and initially hoped for at least five or six submissions. A total of 18 abstracts were submitted. Some declined to proceed or withdrew for a variety of reasons. The nine manuscripts published here received two, and sometimes three, blind reviews from 23 different peer reviewers. The core themes represented in these papers are: defining rural veteran demographics and epidemiology; the unique needs of rural, women, and minority veterans and the models of outreach and practice to address these special needs; the needs of Reservists and National Guard service members and their families; the economic impact of veterans in rural areas; rural-urban veteran health care expenditures; and the use of collaborative models of care to serve VA and non-VA rural veterans through health information exchange.

I am a fortunate professional in that I have seen the fruits of my labor as I near retirement and focus on rural health policy and research which impacts rural veterans. I can do this with Atlas Research, a small business owned by a service-disabled veteran, whose visionary leadership provides both a nurturing and supportive environment and a challenging platform from which to launch ideas. I am privileged to work with and for rural, minority, and women veterans with other dedicated professionals. I supervise and mentor case managers working with homeless veterans and develop and launch outreach services that target rural, women, and minority veterans and their family members. I am driven to do this work because I am a rural person by birth and by choice, and I believe the veterans in my family and rural communities across the country deserve to be noticed and the services designed for them need to be improved. I am honored to work with passionate people to get this job done. I do what I do simply because it needs to be done. The point of this special issue is to increase awareness of the many issues surrounding rural veterans. Rural veterans are special people who should not be taken for granted and should not remain invisible to the American public.

PART II: THE ROADMAP FOR ADVANCING RURAL VETERAN RESEARCH, POLICY, AND PRACTICE

Research and policy regarding rural veterans is a new and developing field of science. A useful roadmap for advancing this field should reflect our best thoughts and current understanding to inform policy and practice. Each article presented in this special issue offers valuable research information, insights, and recommendations for improving care for rural veterans by VA researchers, rural sociologists and other rural social scientists, psychologists, physicians, and other professionals; some of whom are also rural, women, and/or minority veterans. The issue covers a wide range of topics concerning rural veterans and their families. These articles represent high quality thought and research needed to inform policy, identify best practices, and further articulate the research and policy agenda on rural veterans.

Davis et al. (2011, this volume) conducted a study, funded by the VA's Office of Rural Health, to better understand the health care needs, health status, and barriers facing rural veterans. Their study focused on veterans residing in rural counties of Alabama who were either not enrolled in the VA health care system or were enrolled and had not utilized the VA health care system in more than two years. Their research sheds light on the relatively unknown topic of non-enrolled veterans and, while relatively limited in geographic scope, provides an excellent example for future replication in other states. Similarly, Proctor et al. (2011, this volume) sought to further explore the demographics and epidemiology of rural veterans' health care using a prospective study to examine post-service, health-related quality of life (HRQL) scores for rural versus urban veterans, paying particular attention to OEF/OIF veterans. Their results suggest that the newer cohort of veterans has unique demographic and epidemiologic characteristics that require further consideration and research.

Several articles included in this special issue focus on challenges related to women and minority veterans. Szelwach et al. (2011, this volume) examined employment trend data from the Bureau of Labor Statistics and conducted formal interviews with professionals working for government and nonprofit supportive workforce programs for veterans. Many of those interviewed were also females and veterans. Their study has identified specific challenges facing rural women veterans upon reentry into the civilian workforce, and developed a set of recommendations to meet the needs of this growing population. Noe et al. (2011, this volume) assessed the health needs of Native American veterans by examining the current challenges, barriers, and issues related to health care. Their paper not only

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highlights the difficulties facing Native American veterans, but also offers strong recommendations on improvements for health care for this population.

Bennett et al. (2011, this volume) and Duke, Moore, and Ames (2011, this volume) addressed the topic of mental health care for rural minority veterans. Bennett et al. conducted a study of rural and non-rural Appalachian National Guard and Reserve troops recently returned from deployment. Their study assessed these populations' demographics, mental health symptoms, mental health-seeking behaviors, perceived barriers to mental health care, and attitudes toward mental health care to determine whether there were significant differences. Their results offer readers keen insight into the attitudes of rural veterans. Duke, Moore, and Ames focused particularly on post-traumatic stress disorder (PTSD) in rural Latino veterans. The literature on this topic is extremely limited, and they addressed this research gap by synthesizing the mental health literature for veterans, Latinos, and rural populations to identify overlap and provide direction for future research. As the proportion of minority veterans serving in the U.S. military continues to grow, the initial research conducted on minority veteran populations becomes increasingly important and these four articles greatly contribute to the field of research and literature.

Three articles provided case studies on the economic impact of veterans, rural-urban health care expenditures, and health information exchange networks respectively. Krier, Stockner, and Lasley (2011, this volume) examined the economic and cultural impact of rural veterans using the state of Iowa as a case study. They demonstrated the importance of rural veterans in sustaining rural economies and examined the role of veterans and the military in rural culture. West et al. (2011, this volume) examined rural-urban differences in medical spending by third party payers for male veterans compared with male non-veterans during a 10-year span from 1996 to 2006. Researchers and policy experts often cite cost as a barrier to accessing health care for rural veterans, and the rising cost of health care in America is one barrier that has gained increased attention with health care reform. Their study provides useful information regarding trends related to expenditures. Lampman and Mueller (2011, this volume) examined the health delivery model for rural veterans utilizing both VA and non-VA care through two pilot studies. They conducted focus groups with non-VA providers who treat these dual-use patients to highlight the challenges related to serving rural dual-use patients, and have offered recommendations for improving the continuity of care between the two systems. They also presented two case studies on current VA projects that attempt

to improve the coordination of care through the development of electronic health information exchange networks in rural areas.

Each article in this special edition enhances the field of rural veteran health care through well-conducted research and quality recommendations. These articles serve not only to inform readers, but to provide a starting point for developing a quality roadmap for better-informed policy, improved services, and further research. It will only be through further research that we clearly gain a more informed perspective on the heavily-burdened contributions made by rural, women, and minority service members. These invisible heroes, most of whom have received little attention in research and policy commensurate with their contributions, deserve nothing less than our best as a means to honor them.

#### ACKNOWLEDGMENTS

Serving as the guest editor for this special issue has been an honor and a challenge. I have been honored to work with a dedicated group of authors, and I have been challenged to think about these core issues in a broader context. I want to thank Dr. Douglas Constance and the JRSS Board for their invitation to lead this effort, and especially for Doug's advice and guidance. I want to especially thank all of the authors who submitted abstracts and stayed with the project throughout this publication, through the review process and various revisions required. I thank Sara Cherico for her superb assistance with background research and copy editing. I want to thank Dr. Amy Wallace, Dr. Alana Knudson, Dr. Harold Kudler, and Alan Morgan for their advice and guidance in developing the call and reviewing manuscripts. I want to extend a special thanks to the 20 other friends, colleagues, and authors who served as blind reviewers for the manuscripts. I also extend my gratitude to my colleagues, who serve with me on the Veterans Rural Health Advisory Committee for their supportive ideas and to Dr. Mary Beth Skupien, Director of VA's Office of Rural Health for her support, distribution of the call, and recommendations of reviewers. I am grateful to Dr. Ryung Suh, CEO and Mr. Mark Chichester, President, Atlas Research for their support, guidance, and confidence in my work and abilities. I especially want to extend a special message of gratitude to Dr. Bill Weeks who initiated some of the first studies and analyses of data to define the experience of the rural veteran. Finally, to my family I extend my gratitude for their patience with my travel schedule, and their love, respect, and belief in my work. I thank all in my family and others who have served and those who love them. All are very special people representing many American generations of rural people who have made personal sacrifices by putting their country first.

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## AUTHOR BIOGRAPHY

**Hilda R. Heady** is a social worker, speaker, consultant, and rural health leader with 40 years of experience working in rural communities as a community organizer and advocate. Her experience includes work in health care facilities, and in academic settings to further practice, policy, and research impacting the lives of rural and minority people. She is known for her national advocacy and work on a variety of issues including rural veterans' access to health and mental health care, women's health, and rural health professions training and education. She currently serves as the Senior Vice President for Rural Health Policy and Research for Atlas Research, a service-disabled veteran owned small business (SDVOSB) based in Washington, D.C. Ms. Heady lives and works in Morgantown, West Virginia. Email: [hheady@atlasresearch.us](mailto:hheady@atlasresearch.us)

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