U.S. Department of Veterans Affairs
Veterans Health Administration
*Office of Rural Health*
***April 2025***

# ORH PROJECT OVERVIEW

# Evaluation of Access to Dementia Specialty Care Among Rural Veterans in VA and VA Community Care

## Background

In 2019, 409,000 Veterans were living with dementia, a number expected to increase by 20% (to 500,000) by 2033.[1] Rural adults with dementia report more hospitalizations (22.6% vs. 12.8%),[2] less survival time (for example, 1.5 fewer months post-diagnosis),[3,4] and 23% higher odds of emergency department visits than their urban counterparts.[5] Outside the Department of Veterans Affairs (VA) Veterans Health Administration (VHA), rurality-based disparities in dementia care access have been reported: fewer physician and home health visits,[3,4] low access to telehealth,[6] and lower use of dementia specialty care.[4,7] Less access to dementia specialty care, such as specialist visits, including a neurologist, geriatrician, or neuropsychologist; and dementia-related medications, important for optimal quality of life and outcomes,[8,9] may contribute to these disparities. Additionally, high rates of dual healthcare system use (use of services through VA, VA Community Care [CC], and/or Medicare)[10,11] among Veterans with dementia, particularly rural Veterans, increases the risk for care fragmentation, worse outcomes, and higher costs to VA.[10-12]

The goal of the VHA Office of Rural Health (ORH) Veterans Rural Health Resource Center-Iowa City project, *Evaluation of Access to Dementia Specialty Care Among Rural Veterans in VA and VA Community Care*, is to improve access to dementia specialty care and outcomes for rural Veterans. In prior work, our team found that visits to dementia specialists among Veterans with Alzheimer's disease, a type of dementia, increased by 12% over a 5-year period (2013-18) in VHA.[13] We do not know, however, whether this utilization differed among rural vs. urban Veterans, or rural Veterans' preferences around dementia specialty care. Greater understanding of rural Veterans' dementia care use, experiences, and preferences will help VA determine how to best leverage VA and CC resources to optimize dementia specialty care for this high-risk group.

## Goals and Objectives

The objective of this mixed methods project is to identify Veteran-centered evidence-based strategies to improve rural Veterans' access to dementia specialty care in VA and CC. This project will address ORH and VA priorities focused on rural health, aging, and access to care.

Specific project goals are:

1. Quantitative goal: Compare dementia specialty care utilization for rural vs. urban Veterans using national VA data from 2022 to the current year for which data is available. We will also identify patient- and site-level factors associated with this utilization for rural Veterans in VA.
2. Qualitative goal: Through interviews in the VA New England Healthcare Network (VISN 1) and VA Midwest Health Care Network (VISN 23), assess the perspectives and experiences of dementia care specialists and rural outpatient clinical staff to: 1) understand usual dementia care for rural Veterans and barriers to this care; 2) experiences coordinating care for rural Veterans with dementia (within VA and with CC providers); and 3) potential strategies to improve dementia care for rural Veterans, including through telehealth

## Methodology

**As the number of Veterans with dementia rapidly increases, work is needed to identify evidence-based strategies to improve access to dementia specialty care and outcomes for rural Veterans.**

Quantitative goal 1: We will link national VA patient- and encounter-level data available in the VA Corporate Data Warehouse (CDW) to establish dementia diagnoses in VHA. The population will include Veterans aged 50 years and older with documentation of at least two International Classification of Diseases codes for dementia at two or more encounters in VHA from 2022 to the current year available. Outpatient visits to dementia specialists in VHA will be identified using a combination of provider types, clinic stop codes, and provider taxonomy codes. Current Procedural Terminology codes will be used to identify neuropsychological testing. Receipt of dementia-related medications will be identified using National Drug Codes. Patient-level data, including rurality, demographics, social stressors, co-morbidities, and site-level data will also be obtained from CDW. Veterans will be characterized as rural, highly rural, or urban based on Rural-Urban Commuting Area codes in VA data.

Qualitative goal 2: The population for Aim 2 will include VA dementia care specialists and rural community-based clinical staff from VISNs 1 and 23. An initial list of VA dementia care specialists will be identified in consultation with the project advisory group and expanded through snowball sampling. We will seek input from the project advisory group on which rural community-based outpatient clinics to target. Staff interviews will focus on their perspectives related to usual dementia care for rural Veterans, perceived barriers to dementia specialty care access and use among rural Veterans, such as geographical, cultural, or digital barriers;[14] experiences coordinating care for rural Veterans with dementia (within VA and with CC providers), and potential strategies to improve dementia care for rural Veterans, including through telehealth. Interviews will be analyzed to identify themes.

## Impact on Rural Veteran Health

Quantitative Goal 1 findings will determine rural-urban variation in: 1) utilization rates of dementia specialty care, at national VA, regional, and VISN levels; and 2) patient- and site-level factors associated with this utilization in VA among rural Veterans.

Qualitative Goal 2 findings will identify: 1) usual dementia specialty care; 2) needs and preferences around this care; 3) evidence-based strategies to improve access to this care for rural Veterans; and 4) potential implementation barriers to these strategies.

Project findings will serve for benchmarking usual rural dementia specialty care against which future improvements can be made. These findings will also provide data to our operational partners on how to improve access to dementia specialty care for rural Veterans. Project findings and input from our advisory group will further inform rurally oriented Veteran-centered evidence-based strategies, which we will pilot and implement in future work to improve dementia specialty care access for rural Veterans in VA and CC.

## Key Takeaways

Next steps for FY2026

- Quantitative Goal 1: We will examine dementia specialty care utilization in CC, and identify patient- and site-level factors associated with this utilization among rural Veterans in CC.
- Qualitative Goal 2: We will conduct interviews with family caregivers of rural older Veterans and rural older Veterans at risk for dementia in VISNs 1 and 23.
- Project advisory group activities: We will obtain input from the advisory group on the qualitative sampling for family caregivers and rural older Veterans in VISNs 1 and 23 and on our draft interview guides. We will provide advisory group members with an interim report at the end of FY 2026.

## References


1. U.S. Department of Veterans Affairs. Dementia System of Care; 2019.
2. Thorpe JM, Van Houtven CH, Sleath BL, Thorpe CT. Rural-urban differences in preventable hospitalizations among community-dwelling veterans with dementia. The Journal of Rural Health. 2010 Mar;26(2):146-55.
3. Rahman M, White EM, Thomas KS, Jutkowitz E. Assessment of rural-urban differences in health care use and survival among Medicare beneficiaries with Alzheimer disease and related dementia. JAMA network open. 2020 Oct 1;3(10):e2022111-.
4. Arsenault-Lapierre G, Bui TX, Le Berre M, Bergman H, Vedel I. Rural and urban differences in quality of dementia care of persons with dementia and caregivers across all domains: a systematic review. BMC health services research. 2023 Jan 31;23(1):102.
5. Wang N, Albaroudi A, Chen J. Decomposing urban and rural disparities of preventable ED visits among patients with alzheimer's disease and related dementias: evidence of the availability of health care resources. The Journal of Rural Health. 2021 Jun;37(3):624-35.

6. Amaize A, Barath D, Wang MQ, Chen J. Reducing rural and urban disparities in potentially preventable hospitalizations: evidence of hospital-based health information technology and enabling services. Telemedicine and e-Health. 2023 Oct 1;29(10):1455-64.
7. Xu WY, Jung J, Retchin SM, Li Y, Roy S. Rural-urban disparities in diagnosis of early-onset dementia. JAMA network open. 2022 Aug 1;5(8):e2225805-.
8. Jennings LA, Hollands S, Keeler E, Wenger NS, Reuben DB. The effects of dementia care co-management on acute care, hospice, and long-term care utilization. Journal of the American Geriatrics Society. 2020 Nov;68(11):2500-7.
9. Thyrian JR, Hertel J, Wucherer D, Eichler T, Michalowsky B, Dreier-Wolfgramm A, Zwingmann I, Kilimann I, Teipel S, Hoffmann W. Effectiveness and safety of dementia care management in primary care: a randomized clinical trial. JAMA psychiatry. 2017 Oct 1;74(10):996-1004.
10. Thorpe JM, Thorpe CT, Gellad WF, Good CB, Hanlon JT, Mor MK, Pleis JR, Schleiden LJ, Van Houtven CH. Dual health care system use and high-risk prescribing in patients with dementia: a national cohort study. Annals of Internal Medicine. 2017 Feb 7;166(3):157-63.
11. Thorpe CT, Gellad WF, Mor MK, Cashy JP, Pleis JR, Van Houtven CH, Schleiden LJ, Hanlon JT, Niznik JD, Carico Jr RL, Good CB. Effect of dual use of Veterans Affairs and Medicare Part D drug benefits on antihypertensive medication supply in a national cohort of veterans with dementia. Health Services Research. 2018 Dec;53:5375-401.
12. Lei L, Cooley SG, Phibbs CS, Kinosian B, Allman RM, Porsteinsson AP, Intrator O. Attributable cost of dementia: demonstrating pitfalls of ignoring multiple health care system utilization. Health services research. 2018 Dec;53:5331-51.
13. Miller DR, Jasuja G, Davila HW, Palnati M, Shao Q, Dinesh D, McDannold S, Zhang Q, Monfared AA, Xia W, Palacios N. Care processes related to clinical detection of Alzheimer's disease in the US Veterans Affairs Health Care System. Alzheimer's & Dementia. 2021 Dec;17:e054149.
14. Fortney JC, Burgess JF, Bosworth HB, Booth BM, Kaboli PJ. A re-conceptualization of access for 21st century healthcare. Journal of general internal medicine. 2011 Nov;26:639-47.

## Contact

Guneet K. Jasuja and Heather Davila, Project Leads, Veterans Rural Health Resource Center-Iowa City, Iowa City VA Health Care System, Iowa City, IA. Guneet.Jasuja@va.gov. Heather.Davila@va.gov

*Funding Acknowledgement:* Department of Veterans Affairs, Veterans Health Administration, Office of Rural Health, NOMAD # PROJFY-010176.

*Suggested Citation:* Jasuja, G.K., & Davila, H. (2025). *Evaluation of Access to Dementia Specialty Care Among Rural Veterans in VA and VA Community Care*. Department of Veterans Affairs, Veterans Health Administration. Washington, DC: Office of Rural Health.